A CHOIR IN EVERY CARE HOME

SURVEY RESULTS:
MUSICIANS IN CARE HOMES, CARE HOMES WITH MUSIC

WORKING PAPER 2

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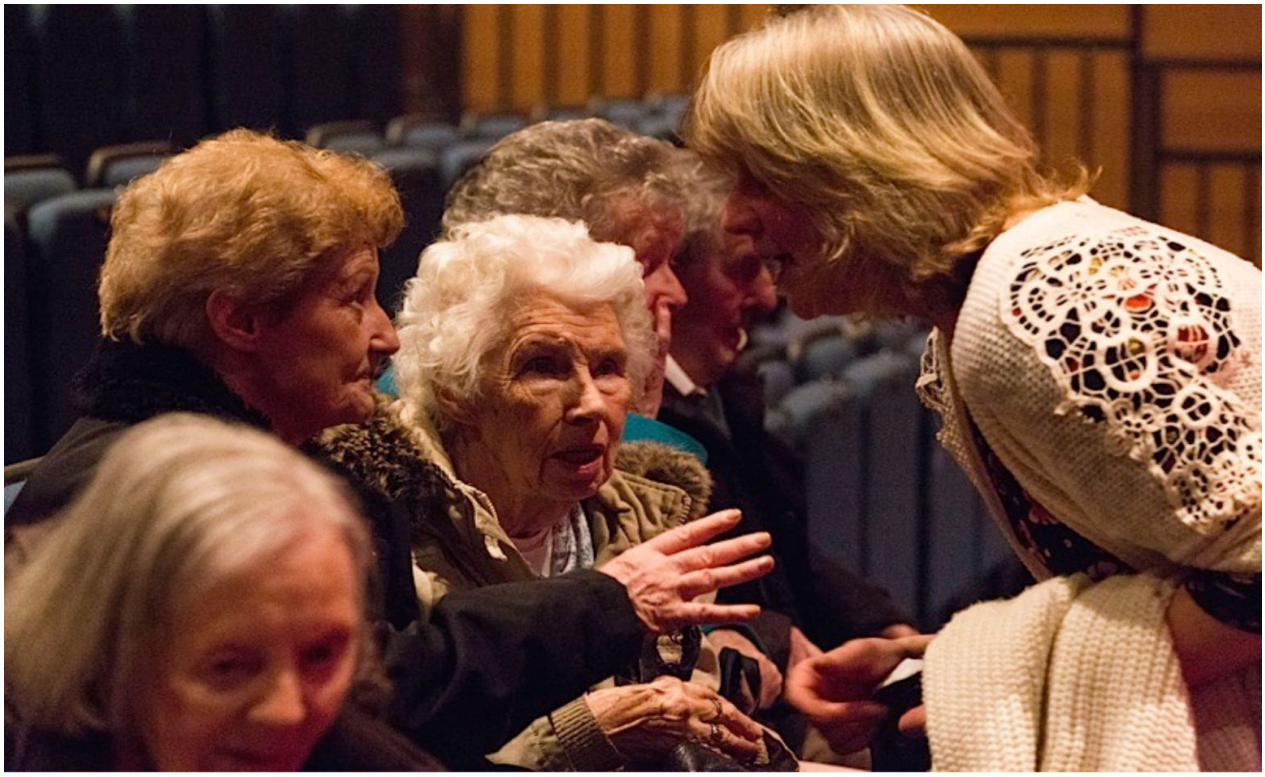

'A Choir in Every Care Home' is an initiative to explore how music and singing can feature regularly in care homes across the country. Funded and initiated by the **Baring Foundation,** it is a unique collaboration between 30 leading national organisations from adult social care, music and academic research. It is led by **Live Music Now**, **Sound Sense** and **Canterbury Christ Church University**.

The Baring Foundation

Canterbury Christ Church University

SOUND SENSE
The voice of community music

LIVE MUSIC NOW
INSPIRING MUSICIANS TRANSFORMING LIVES

About *A choir in every care home*
This enquiry is an initiative of the *Baring Foundation* which since 2010 has focused its arts programme on older people, especially those in care homes. Following a roundtable discussion in October 2014 the Foundation decided as a first step to undertake a short-term investigation into singing in care homes which would:

- Collate the existing evidence for the benefits (for staff, family and friends, choir members as well as residents) of singing/choirs for older people/in care homes/links to the wider community.
- Map existing activity
- Explore different models of activity: benefits, challenges and ways forward
- Collate existing materials that support choirs in care homes and produce new materials where needed.
- Consider issues of quality of the artistic experience and art achieved, with special reference to dementia
- Describe what more can be done without extra resources and cost what more activity could be achieved with further resources.
- Launch and widely disseminate this work in a way that will encourage the greater use of choirs in care homes.

Following an open application process a consortium of three organisations, led by Live Music Now, was awarded funds to carry out the investigation.

Our working approach
The worlds of singing, arts and wellbeing, and care homes are all well understood by a wide range and large number of organisations working at both practical and policy levels. These organisations – nearly three dozen at the last count – not only know about the subject, the results of this enquiry matter deeply to them. No investigation could successfully research the issues – nor, crucially, be able to "disseminate the findings in ways that will encourage the greater use of choirs in care homes" – without genuine buy-in from these organisations.

Our working approach therefore invites these organisations to form not a steering group, but a *working* group that shares and learns from each other, that determines work that needs to be done – and that then is involved in carrying it out.

Compared with conventional practices of evidence-gathering and recommendation generating, our approach:

- involves the sector fully from the start – so they own the solutions
- makes full use of the knowledge, expertise and experiences in the sector – it is efficient
- creates a community of practice that is worthwhile in its own right – so leaves a legacy
- creates solutions already agreed by the sector – so are much more likely to be adopted.

About working papers
Our working papers distil the sharings and emerging learnings of both the working group and the consortium, to provoke further debate and discussion. They are subject to change as the initiative develops. Together, they form the evidence for our actions and recommendations for future work. A list of proposed working papers is on the outside back cover.

Cover image
Hedda Kaphengst of Klawitter Theatre Group, Dublin, with participants in an interactive performance

Care homes and choirs: what they think of singing

Contents

PART 1 WHAT SORT OF WORK

1 Introduction

1.1 Terminology

- This report covers mainly two open Survey Monkey surveys ("main surveys"), one addressed to care homes, the other to practitioners working in them
- It also takes into account the findings of membership-based surveys carried out by Natural Voice Practitioners Network and Making Music (coded as NV and MM here).
- Some of the question sections in this report formed breakout group topics at the second working group meeting (WG2) on 30 November 2015, and those responses are also included here.

- This report uses these terms:
- "Choir" means the model of a music leader (paid/unpaid) in a home with a group that sings together in one place at the same time
- "Singing Activity" means all the other ways singing happens in care homes – two models being:
- "MM choir" means the model mostly reported in the Making Music survey: a group of voluntary singers going into a home mostly to provide a performance activity
- "NV choir" means a model reported by the majority of respondents to the Natural Voice Practitioners Network: based around community choirs who perform or create interactive performances in care homes and elsewhere. Some of these are choirs specifically set up for older people or for specific health reasons.
- References in the document are shown thus, eg 2:3 (for part 2, section 2) or 1:3.3.1-4 (part 1 sections 3.3.1 to 3.3.4 inclusive) or 1:Q6.4.1 (part 1 Q6.4.1)

1.2 Headline findings

- Singing produces benefits:
- not only to residents, but crucially to staff.
- But the model of singing the "arts side" largely envisions (a music leader (paid/unpaid) with a group that sings together in one place at the same time) is quite a small part of:
- what the "care side" thinks of as singing,
- most of which manages very well without an outside paid professional.

- Singing is an important part of the activities mix
- and there are some examples of very favourable disposition to it
- but it's by no means the only show in town.

- Most homes say they're doing as much singing as their residents want.
- The most frequently cited barriers to doing more are money, time, staff buy in
  - which are just ways of saying singing is not top priority
- For musicians, the overwhelming barrier to doing more is lack of personal capacity.

- Music budgets in homes were twice as big as for other activities
  - but still very small at around £100/month.
- Musicians were typically paid this or less for a session.

- Where choirs are involved, the model is fairly typical of institution-based community choir work: 10-25 participants led by a single professional musician.
- The musician is generally paid, though there are significant examples of volunteer activity.
- The pedagogy is based on existing songs rather than, say, creative improvised work.
- Repertoire is mostly popular songs from pre-60s, with lesser use of more modern material.
- Care staff weren't always present at sessions.

- The results throw up fundamental questions about the remit for ACIECH.

1.3 **Introduction**

This report covers four surveys carried out in the second half of 2015. The majority of the report relates to two open Survey Monkey surveys ("main surveys" when we need to distinguish them from the below) – one addressed to care homes, the other to practitioners working in them, as detailed in part 3. It also takes into account the findings of surveys carried out by Natural Voice Practitioners Network and Making Music (coded as NV and MM here) also detailed in part 3.

Some of the question sections in this report formed breakout group topics at the second working group meeting (WG2) on 30 November 2015, and those responses are also included here.

1.4 **Membership bodies**

Several membership, infrastructure, and similar bodies were involved in this work – not only creating their own surveys but also commenting on drafts of the main surveys, and providing dissemination and publicity routes to ensure as wide a range of contacts as possible heard about the surveys. Main protagonists and their activities were:

1.4.1 **Sound Sense** is the UK professional association for community musicians. About a third of respondents to the main musician survey who gave their names (and filtering out the Mindsong contacts: see below) were Sound Sense members.

1.4.2 **Natural Voice Practitioners Network** (for community choir leaders) and **Making Music** (amateur choral societies and many others) are the umbrellas for their respective members. A number of Sound Sense members are also NVPN members and vice versa.

1.4.3 **Live Music Now** has an extensive database of musicians it works with.

1.4.4 **Mindsong** (a Gloucester-based charity which puts singing teams of three or four volunteers into care homes) representatives in the musicians survey, and **MHA** (a Methodist-based charity providing care homes) homes in the homes survey formed significant parts of the main survey samples: see 3:2.1

2 Outcomes

2.1 What's the point of singing work in care homes? It has to:

- produce benefits to residents and/or staff
- produce benefits which either can't be got elsewhere, or which are more cost-effective than other solutions.
- for voluntary music groups, provide perceived benefits to themselves.

We asked similar questions of both Musicians (**QM16 QM18**) and Homes (**QC2 QC3**): do you think the residents benefit and if so in what ways?; do you think the care staff benefit and if so in what ways?

Responses – both the categories and the numbers of responses in each category – were very similar in both surveys: any major differences are noted.

2.2 Resident benefits

2.2.1 The question "do you think residents benefit" was as un-leading as we could make it. But it's still hardly surprising that no-one said no; and the main problem for analysis in this section is the extent to which we are hearing objective, observed effects rather than articles of faith. The latter sounds more likely, especially given the similarities of language between respondents. Nevertheless, the answers at face value raise useful issues.

Respondents to both surveys identified four main groups of ways in which they thought residents benefited, which can be categorised as:

- Personal emotional
- Memory
- Personal physical
- Socio-personal
- Emotional regulation.

2.2.2 The biggest number of descriptions fell into the **socio-personal** category, with the biggest sub-category being *engagement*. Typical comments:

- They are engaging in an activity together giving a sense of community
- Singing activities help older people engage with one another

Next, at half the number of descriptions, were *valorisation* and *sociability*:

- They feel that they are valued
- Increased sense of the self created possibly by hearing their own voice in relation to the facilitator/other residents
- It helps them to socialise and meet other people
- Social interaction – is a shared activity and can engage the residents.

2.2.3 Next up: **personal emotional** benefit. Biggest sub-category (in number, between engagement and valorisation) – **fun**.

Then, **memory** benefits (the homes survey cited memory benefits twice as often as the musicians survey) specifically, evoking memories:

- Memory – remembering the words and bringing back autobiographical memories associated with the music.
- Remembering words, tunes, asking for favourites
- They remember happier times and can share these with a group.

2.2.4 **Emotional regulation** was interesting. The claim is that the work is capable of making residents better-disposed: making them stimulated or calm: alert or distracted:

- If a residents is feeling low or depressed a happy musical/singing atmosphere helps to change people's mood
- Reduces agitated behaviours
- Has a definite calming effect
- Staff have said the residents are more alert after the session
- Emotional regulation – singing can divert attention away from distressing thoughts and lifts the resident's moods.

2.2.5 MM choirs were aware of the benefits and joy their activities could bring to residents. This overlapped with the benefits they perceived to themselves – overwhelmingly related to giving back or doing something for their community or fulfilling their charitable objectives.

Ancillary benefits mentioned were satisfaction for the group in seeing what a difference they could make, team building, confidence building for groups who don't otherwise perform, ability to try out different repertoire and a different way of engaging with audiences.

2.2.6 Music as such was hardly mentioned.

2.3 Staff benefits

2.3.1 Responses to questions about the benefits to care staff of taking part in the singing produced a set of many-layered benefits and interlocking arguments which built a case for involving care staff in the activity.

2.3.2 The argument is not about the importance of staff just attending sessions. Crucially it's about them taking part, singing with residents. The case was:

- care staff build a *different, equal relationship* with residents. They see the residents outside their normal frame of reference, observe them being differently capable, understand them more as people.

- staff develop *skills and confidence* in leading music themselves (much more strongly noted in the musicians survey). They use these new skills not only to lead sessions themselves, but to use singing in their everyday duties. They gain a new perspective on resident-centred care

- as a whole-home activity, there is a *change of atmosphere* in the home.

- care staff accrue specific *in-work but personal benefits* (much more strongly noted in the homes survey): emotional release and stress reduction, offers a break and eases a demanding job.

- staff also of course accrue the usual benefits of singing: emotional wellbeing and *enjoyment*.

2.3.3 Perhaps the only benefit that might accrue whether care staff join in the singing or not was *emotional management of residents*: happy singing = compliant residents

(as previous question) = happy staff = happier residents etc.

2.4 Benefit comparisons

2.4.1 Care homes carry out a range of activities, in a variety of ways. How does singing stack up? We asked:

- How frequently singing took place; and what the activity/ies consisted of (**QC1**)
- Whether the benefits of singing that homes reported at QC2 and QC3 were also provided by other activities, and if so how they compared (**QC4**)

As expected for a self-selecting sample, almost every home reported some activity (n=139, N=144), overwhelmingly (n=120, N=139) taking place at least once a week, with only nine reports of activity once a month or less frequently.

2.4.2 *But* – it wasn't necessarily all singing, or all participatory, or all in the form of a group coming together at a set time for a fixed activity (aka "choir"). Rather, out of 182 examples given (multiple examples of activities were allowed):

- 10 were not necessarily vocal work (eg, music and movement, Music for Health)
- 41 were probably limited or no participation ("entertainment", "concerts" etc)
- 22 were spontaneous rather than structured ("staff sing with clients all the time", "music is constantly played and residents have singalongs")
- 45 examples were music therapy (disproportionately in MHA homes)
- 17 were hymn singing (disproportionately not MHA)
- Perhaps only 30 of the 182 examples were likely to be of the model of a "choir" described above.

2.4.3 In other words, the arts side may think singing is about taking a music leader (paid/unpaid) into a home to set up a group that sings together in one place at the same time. That's what the musician survey consciously or unconsciously envisaged. But care homes don't think like that. Singing is music. Singing takes place everywhere. Singing is used for: relaxation, movement, entertainment, quizzes, other activities, reminiscence. Singing is led above all by staff, trained or not. Singing happens spontaneously.

2.4.4 What else goes on in care homes? The list includes exercise, food ("eating together" or "dining"), reminiscence work, arts and crafts. And: "one of our most sucsessfull activities is any animal or birds that we get to come in the home this is the most reactions than any other activity."

How did singing stack up against pet birds?

2.4.5 Singing compared to other activities: see next page.

Singing cf other activities	*N = 144*
very favourable to singing	4
fairly favourable to singing	11
favourable to music generally	16
fairly neutral/horses for courses	17
not favourable to singing	0
highly unfavourable towards singing	0
no comparison made	96

So no-one was anti-singing. But only 31 out of 144 were evidentially favourable to it, and that includes the 16 talking about music generally.

3 Confounding factors

3.1 Barriers

3.1.1 What stops care homes from singing or (given this sample) doing more singing? Questions here were what are the barriers, what would encourage you to do more? (**QC5 & 6, QC7 & 8**)

- Roughly a third agreed they faced barriers, mostly:
  - care staff have too many other duties, and no time for singing activities. (17)
  - no staffer could lead/is confident to lead singing (13)
  - there isn't the budget (10)

No time/no money is an excuse rather than a reason, and means "singing is not a high enough priority."

3.2 Encouragements

Homes are open to persuasion, it seems: 92 out of 144 said they could be encouraged further; and only 20 out of 144 said they couldn't. What would help?

- More money (35)
- More enthusiasm from care staff (22)
- Evidence of benefit for residents 14
- More knowledge about how to set this up. (12)
- Availability of accompanists (4)

Given most had previously said they did all the singing they wanted or needed, this is perhaps speculative.

3.3 Musicians

3.3.1 Do the musicians want to do more (**QM22**)of this kind of work? 51 out of 80 said yes; 18 didn't reply (so presumably were ambivalent at best).

What's stopping (**QM23**) those who want to do more? [NB: the rubric for this question was maybe not entirely clear] Overwhelmingly personal capacity (17 out of 26), then funding (4) and one of each of musical, people and pitching skills. No-one picked difficulty with repertoire, and only one each not knowing how to approach care homes and not having the right people skills.

Of course, as we have already said, this was a survey of those who did work in care homes, so we wouldn't expect them to lack skills and resources.

3.3.2 MM choirs faced particular barriers to doing more:

- Home prefers activity in daytime – difficult for many amateurs
- No money for activity, so difficult for groups to bring their MD or accompanist
- Space often too small
- Often there is no piano, when there is, it's likely to be in poor condition
- Finding dates is tricky
- High staff turnover leads to poor communication and fragmented connections.

4 Business models

4.1 This section looks at the nuts and bolts of the operation of singing in care homes. It also explores to what extent it is possible to build different business models of the work.

4.2 Choirs: How big, how often, how many, what types

4.2.1 *Group sizes* (**QM3**) seemed reasonable – mostly between 10 and 25.

4.2.2 *Session frequency* (**QM4**) was mostly weekly, or monthly at worst. Most homes sang in between times (**QM5** and for other singing **QC1**). Nearly a quarter of MM choirs undertook activity only once a year, at Christmas.

4.2.3 *Repertoire* (**QM6**) was fairly traditional. Most homes sang popular songs. Those of the pre-60s (the oldest category we specified) were the most frequently picked (66 out of 80 responses); only 12 out of 80 used 1980s music. Folk (41) was more used than classical and jazz (26, 21). But repertoire was wide-ranging: on average, musicians used half of the music categories we suggested for this question.

There were a few instances cited of working with show tunes and musicals; one or three instances of spirituals, gospel, world. A bit of non-music activity: singing for physical exercise, to allow for resident's wishes.

4.2.4 *Singing leaders* (**QM9**) were: (see next page)

Type of leader	Responses
A singe paid musician	20
More than one paid musician	7
An unpaid musician	4
A volunteer and not a musician	5
A member of staff, and musician	5
A member of staff, not a musician	6

These are adjusted results, Mindsong and the music therapists skewing the raw data. Work was mostly led by a single paid musician.

4.2.5 Except for Mindsong, *volunteers* (**QM10**) were not often seen in the main surveys. We didn't ask – but only one respondent thought it worth saying they'd like more volunteers. The MM survey noted that in about a quarter of cases a home had approached the MM choir; in half the cases there was an existing personal connection between the MM choir and a home.

4.2.6 How many *care staff* attended sessions (**QM11**). Half of respondents claimed one or two staff attended sessions, a quarter had more than two staff attending. But 20% either said no staff attended or didn't answer this question. Though we didn't make the issue specific, there was generally little evidence that the staff who were present actually joined in.

4.3 Who pays, how much?

4.3.1 Musician respondents told us about sessional costs (**QM20**):

Sessional cost	Responses
no cost	16
less than £10	4
£10 to £50	21
£50 to £100	13
£100 to £200	0
£200 to £300	2

The no-costs were Mindsong; the £200 to £300 were a orchestra project and (we think) a group. For the rest, the costs and fees are low.

4.3.2 Musicians also told us about who paid (**QM19**).
Largely, this was the care home (35 out of 87 responses).This survey gives little indication of whether the home fundraises, or pays this out of core revenue. 23 noted no charge or donations (16 were Mindsongs); 22 listed charities; 0 local authorities and 3 NHS.

On the other hand, when asked (**QM21**) who supported the work 14 responses included:

- 5 local authorities
- 3 health bodies
- 1 each housing association, Alzheimer's Society, community fund, local church

The NV survey reported "There are many examples of work which is covered by public health funding, charities and foundations, arts associations, education authorities or arts providers."

4.3.3 Homes were very generous in giving us their activity budgets (**QC9**). The data are somewhat fragile, as the bases for calculations are likely to be different. Few figures were likely to include an activity coordinator's salary, even when they had been directly delivering work.

We asked about annual budgets for:

- musical activities
- other arts activities such as dancing or painting
- entertainment activities (such as bingo or watching films)
- physical exercise (such as yoga)

Where we could, we reallocated music entertainers from music to entertainment.

4.3.4 Music budgets were:

- on average twice (£1,200) those of other categories,
- with the highest maximum (£8,500 cf entertainment, the next highest, at £7,000);
- and the most likely category to have at least some budget allocated.
- MHA homes budgets were smaller on average (£1,000) than non-MHA homes (£1,250);
- so were those running music therapy sessions (£1,100 cf £1,800).

Nevertheless, the average of all music budgets was still only £100 a month: enough for one, maybe two or three sessions with a paid professional musician.

4.4 **What types?**

4.4.1 At the highest category level, the surveys between them note the following types of provision:

- "Choir" means the model of a music leader (paid/unpaid) in a home with a group of that home's residents to sing together in that place at the same time
- "MM choir" means the model mostly reported in the Making Music survey: a group of voluntary singers going into a home mostly to provide a performance activity
- "NV choir" means a model reported by the majority of respondents to the Natural Voice Practitioners Network: based around community choirs who perform or create interactive performances in care homes and elsewhere.

Some of these are choirs specifically set up for older people or for specific health reasons.
- "Singing Activity" means all the other ways singing happens in care homes.

4.4.2 The NV survey provides a further breakdown of types, some of which go beyond the care home setting. One categorisation for these types might be:

- Care home specific
  - Community choirs which run interactive performances in care homes (see also branded)
  - Funded choirs in collaboration with charities (eg AgeUK) and social services
  - Combined residents, staff and families care home performances

- Specific conditions (may or may not be care home related):
  - Singing for the Brain
  - Singing and breathing with Parkinson's groups
  - Singing for breathing

- Non care-home settings:
  - Singing afternoons for groups in sheltered housing
  - Singing groups in day centres (some in deprived areas)
  - Choirs specifically for retired people
  - U3A choirs

- Branded choirs and singing groups:
  - Mostly community choirs
  - Mostly single-outlet (Elder Voices Brent) or local (Hoot)
  - Some geographical-extended operations (Singing for Fun)

- There was also:
  - Singing Ambassadors group – training existing choir members to bring work out into care homes

5 Respondent final comments

5.1 Editor's choice of comments (6 out of 44) to **QC10** Is there anything else we should know?

- We have an individual to whom music is a huge part in her entire well being. Whenever music is playing she sings along and when in her room alone she feels settled and happy purely due to music playing. We have music playing every morning through to lunchtime the residents often dance along even when using Zimmer frames plus staff dance and sing too. It doesn't have to be professional music although I do pay for this at minimum once a month... Just playing music in the background can have a major impact (positive) on the atmosphere.

- The project is about a choice in every home but this is probably unrealistic as the cognitive abilities of most of our residents would not allow them to sing in a chief as such. They can cope with singing rounds, but would find it very difficult to learn new and unfamiliar songs. I have been asked to organise a

choir in my care home but due to lack of my own musical knowledge can not do this. However I have been practising Xmas rounds and seasonal songs so the ground(dementia) floor entertain the other floors for a few songs at Christmas this year.

- Good idea but will need a lot of support from staff and residents, which can be difficult.

- Interaction not just performance is of utmost importance

- having good value singing entertainment available

- I try to rely on 'free' musical activity as charges seem high, most are £100 an hour and sometimes only benefit 10% of home

5.2 Editor's choice of comments (6 out of 25) to **QM24** Is there anything else we should know?

- I'm aware I'm not doing the sort of work you want a response about as we "perform" but work very hard to get real engagement and participation with people (we work mostly with people far on in dementia) And I am passionate about the good work we do in these units, and though I also work as a Natural Voice practitioner I can't see how a Choir approach would work in the settings we work in.

- I am keen to do more of this type of work, and to develop my skills in this area through training. The session in question was particularly geared towards one resident, who was largely mute due to advanced stage of dementia. She started to sing and speak as a result of the music sessions. She now responds very actively with percussion. A previous resident, who has now passed away, responded through movement, and by holding her hands and moving, she started to dance in larger movements.

- The responses that I have seen from care home residents have been extraordinary and often enables us to "contact the person within" that is sometimes hidden by the disease.

- The benefits to older people of singing are palpable and well-documented. It seems particularly good for people with dementia. The biggest problem of establishing singing in care homes on a regular basis is fitting it into the institutions routines and ensuring that its not just an occasional thing done by volunteers but a regular therapeutic activity which is properly funded and supported. Care homes are notoriously bad at paying for what they see as 'extras'. We need to convince them that this is essential for good care practice and probably saves them money in the long term as the health /wellbeing benefits are so great.

- The group has recently folded due to retired members being so busy (bowling club clashes with practice nights, grandchildren commitments, etc) and there was not much take up from care homes (I was often given the impression they thought that making arrangements for us to come along may be more hassle than it was worth, despite our reassurances that we would set up piano, hand out song sheets, etc, and generally run the whole half-hour

sing-along session). Some did not even reply to our offers to run a session which was quite disheartening.

- Active singing is better than passive listening, although the latter is also helpful.

5.3 So, singing activity is beneficial; there are some reservations over choirs in appropriateness and logistics. There is a need for buy-in, There are conflicting views on participation, and the finances – not just the cash but the perception of cost – is a huge barrier.

6 Exploration

6.1 What is a choir?

A Choir? Or Singing Activity? Is by far the biggest question. Homes seem clear that a) singing activity is much more prevalent than choirs; b) that they don't distinguish in outcomes between the two, indeed, they don't distinguish between a choir and a pet bird. So:

Q6.1.1 Are we barking up the wrong tree by fixating on the Choir model?

Q6.1.2 Or to put it another way, what evidence is there that the choir model – whether in addition to or replacement of singing activity – brings additional, cost-effective benefits? Where would we look for such evidence, if that was thought desirable? Which of the following questions (or rather their answers) are best addressed by the choir model or singing activities?

Q6.1.3 Or if we were to promote singing activity, how would we define that, package that? isn't it more of a construct than a deliverable?

6.1.1 Working group 2 meeting (see 3:2.2) was asked in breakout 1: "For generating more singing in care homes – what are the pros and cons of general singing activity vs a more structured song group."

Respondents thought there were balancing pros and cons to each model, They wanted a mixed economy model, some of everything, a menu of choices. Interesting mentions were:

- General singing activity, *embedded in culture* of care home (our emphasis)
- (One reason for embedding would be to ensure high staff turnover didn't scupper provision)
- A general air that a "professional led" singing activity was "better" – but no evidence cited to support that claim
- Whatever the scheme, good practice requires resident-centred, even -led, approach: ownership and participation, residents picking song lists
- Choir terminology is too formal and off-putting.

6.2 What is the business case?

This investigation is charged with exploring what could be done with no more money; and to cost what could be done with more. We therefore need to examine and analyse different business models for delivery.

Q6.2.1 How many are there? Are the following all business models anyway? if so, are they all separate models or are some subsets of others? What models are missing:

- Choir led by paid professional
- Mindsong
- Sing for Your Life
- Singing activity
- The MM choir model
- The NV choir model
- etc

Q6.2.2 Assuming that the business model for each is based on successfully answering home managers' basic questions:

- what are you selling me
- what benefits will it bring me
- why should I believe what you are telling me?

then, for which of the models in the list above a) do we know the answers b) would we need to research the answers? c) would we like the answers to be when we got them?

Q6.2.3 What improvements in what areas of each model would generate better bigger benefits that would result in more and more profitable sales?

Q6.2.4 Or doesn't the quality of the delivery model matter two hoots?

6.2.1 Working group 2 was asked in breakout 2 topic 4 "Could training (of practitioners, of care staff) be more universal, hence efficient? How? (Alison Tender C&C, Jacqui Walker, Barbara Eifler, Anthea Holland). These two responses seem to fit more comfortably here:

- How to get care homes to understand how music can work; how to support musicians? Get an organisation that works with musicians and one that works with care homes to work together.

- If you can show how music can really help with key challenging issues/staff morale/staff retention/CQC then you will get homes on board.

6.2.2 Working group 2 was asked in breakout 3: "For generating more singing in care homes. Based on all you've heard today what one thing (model, improvement to a model, marketing (of what to whom?) etc) would generate the greatest change?" Of 15 respondents (sharing eight report-back cards), eight (largest single number: wanted:

- a media/advocacy campaign, with suggestions from two to specifically link to CQC; and others to impact on politicians

Other votes (one each) were for practices:

- a technology solution, leaving trained musicians as trainers and mentors
- a voluntary solution: singing model led by volunteers; trained by professional community musicians; perhaps backed up by Music Box
- a whole-system model, embedding a model which combined training, support and delivery
- a resident-centred model.

6.3 **Emotional regulation**

As a specific example, emotional regulation of residents would seem to be an important benefit – not only to the residents, but also to a care home's financial and regulatory bottom lines. So:

Q6.3.1 Is the issue of emotional regulation a serious one? How can we prove singing addresses it? How can we then sell it as a benefit? Can it be monetised?

Q6.3.2 Do we know anything/can we find out anything about what sort and type of singing best generates emotional regulation? Is there an issue about whether you want your residents alert or relaxed. .. .?

Q6.3.3 The benefits to the staff are of course benefits to the home: who wouldn't want relaxed, happy, emotionally intelligent staff? But how can we sell that?

Q6.3.4 Is fun monetisable?

6.4 **Scalability**

We might not be able to do *every* care home – but we certainly want to take the work to scale.

Q6.4.1 What does scaling imply for each model? Is any model more or less inherently scalable/unscaleable than others?

Q6.4.2 Barriers to increasing work were almost entirely about lack of musician capacity. Of course, this was a biased sample – of practitioners who are already working in the field. But then, the labour pool for this work has to be "practitioners who are already working in the field" – so does that imply we have a labour shortage if we start scaling up?

Q6.4.3 Who then pays and why?

PART 2 CHOIRS AND PEDAGOGY

1 Introduction

1.1 We surveyed the choir model in some depth, looking particularly at its pedagogy (defined here as "the study and practice of how best to facilitate holistic working).

2 Pedagogy – skills and knowledge

2.1 Knowledge, skills, understanding

We asked (**QM8**) "What techniques, skills or knowledge do you think are key to successful working in these settings?" The answers could be categorised into two main groups:

2.1.1 **Social-personal** The approach includes notions of a "holistic" practice which would include characterisations in the singing leader of:

- client-centred
- facilitation of development not transmission of knowledge
- highly empathetic
- largely about group work and interaction
- emotional release and catharsis
- interested in the energy of the group
- positive reinforcement
- and much more.

Knowledge of the "challenging circumstances" (a Youth Music term) that clients live with is usually considered essential (here, dementia typically). More controversial is the extent to which the musician should or should not be fixed with knowledge about specific clients' specific conditions, behaviours and so on.

Responses citing socio-personal factors way beat (72 to 32) the next most popular topic:

2.1.2 **Musical knowledge**. Two evaluation reports for Youth Music (Deane et al 2011, Deane et al 2015) have argued (from the evaluation data) that it's not a question of music or socio-personal development: you have to have both. The music not only allows for the socio-personal developments it's central in achieving them.

Musical qualities considered important here included "good enough" singing. And "musical creativity" – though neither that term nor "improvisation" are the correct concepts. What's needed is "reflection in action" (Schon 1983): the minute yet essential mid-course corrections they make as a session progresses: changing key to help someone's who's struggling; unobtrusively switching songs when they find the original choice is upsetting a participant; ensuring they bring in this resident, gently tone down that resident.

Next on the list numerically was **music therapy**.

2.1.3 The MM survey concurred with much of this, and often in the same language; see 2:2.2.3 below.

2.1.4 The NV survey noted four selected examples of good practice:

- Golden Voices (Jules Gibb): community choir, subject of long-term research by Keele University
- Pauline Down: extensive experience throughout Wales including dementia care units, training care home staff in Gwynedd
- Clair Chapwell: specialises in work with older people; trainer
- Phoene Cave: registered music therapist; pioneer of singing for COPD.

2.2 Training

What training in any of the aspects of 2:2.1 have people got? We asked (**QM12**) whether the musicians had had any training in working with older people or in dementia awareness; and (**QM13**) whether the musicians knew if the care staff or volunteers had had any musical training.

2.2.1 Most respondents could point to some sort of training, some very formal, some rather ad hoc. Main categories were:

- Music therapist
- Those musicians who were also healthcare professionals
- Musicians as community arts professionals (two or three citings of the Certificate in Music Workshop Skills, eg)
- Organisations who ran specific courses/inductions for their way of working: mindsong's half-day course, Singing for the Brain, etc
- Training from dementia charities: AgeUK, Alzheimer's Society (possibly linked to category above)
- Training from care home chain, eg MHA
- Dementia Friends training
- Less formal methods: including personal experience, personal research, "advice"

2.2.2 QM13 was relying on what the respondent did or didn't know about the home they worked in. But interesting examples of what can happen include:

- Making use of those staff who were also amateur musicians
- Many of the homes with Mindsong volunteer involvement have been offered a 12 week course of music therapy, with the singing group taking over after this course
- Other examples of ad-hoc or on the job cascaded training

2.2.3 Two-thirds of respondents suggested ideas for more training (**QM14**) or support (see 2:3.1). On the training side, suggestions included (and the list was similar for MM choirs):

- music skills for me: how to take care of my voice, how to bash out chords on a keyboard
- music skills for group work: how to lead a song group, how to do warmups
- group work more generally, including how to set up a choir

- working in care homes: how they work
- working in care homes: cascading my knowledge to care staff (whether musicians or not)

- people skills: dementia awareness but also detailed understanding of dementia

- training in admin

Many NV practitioners would be able and willing to provide training both to the musicians and to care staff.

3 Pedagogy – resources and support

3.1 Resources

3.1.1 As well as techniques, **QM8** also asked "do you need any particular equipment, materials, etc?" The right resources offered to clients at the right time are key to "how best to teach," so they are key to pedagogy. The lists run:

Music resources
range of instruments
vocal techniques
tuning
Freedom through CD
pno etc needed
something for residents to play
peer singing leader
singlalongacds

Repertoire resources
age-related repertoire
wide range of repertoire
song repertoire
lyric sheets/large print
knowledge *on* the music
using songs as a starting point for improv

Of these, getting the greatest number of mentions was a wide range of repertoire (14 mentions); next was something for residents to play (6).

3.1.2 Interesting ideas in the list which need some interpretation were:

Freedom through CD "When I facilitate with my guitar I am stuck behind the instrument. When I facilitate on the Silver Song Music Box it allows me to get closer to people and encourage them to sing and show them movements to the music that they can copy. "

Peer singing leader "A small, but loud(!) group of sound-minded singers to lead to the sing, preferably elderly as can relate easily to elderly residents/lunch club attendees. "

Singlalongacds "I use a selection of CD's which use mainly the first verse and chorus's which are repeated twice. The music is pitched so the residents find it easy to sing along. I would love to be able to find more sing a long CD's which are pitched so older people can sing a long easily."

*Knowledge **on** the music* "A little knowledge *on* the music so you can chat as well as sing. This makes it a really meaningful and enjoyable activity for the residents."

Using songs as a starting point for creative music making "A therapeutic approach provides support for individual members within the group and adapted during the group as required. Musical content can be adapted to meet the needs and interest on the day, capturing reminiscence and dialogue, group and individual preference and experiences and knowledge. Knowledge of the individual group members leads to a more successful group."

3.1.3 Most of the items at 2:3.1.1-2 are too technical to discuss here. But of strategic importance, perhaps, are:

- Repertoire – this keeps coming up, and is clearly fundamental to the usual singing model involved
- Residents playing – is important, though an added complication.
- Freedom through CD – see 2:3.1.2.
- peer singing leader – this example was probably about performance, but the idea is easily extended to staff or to non-resident peers of residents.

3.1.4 The MM survey reported in terms of what MM choirs knew worked for them. The list is similar to much above in both sections 2 and 3, including:

- Repertoire the audience knows
- When residents can participate in some way (singing, instruments)
- Staff who are engaged and practically support the activity
- Choir members being flexible and able to respond to the situation
- Choir members who know how to engage residents and who understand their medical conditions
- One to one sessions
- A social element, eg tea and cake

3.2 **Support**

3.2.1 As well as asking about training, **QM14** also asked about "support" needs. Three issues were noted:

- bigger, broader **repertoire**, in large print, with easy arrangements, on CD
- **advocacy** to care homes: so that a) they know how valuable singing is; b) they understand musicians don't come cheap.
- **practice-sharing**, networking

Repertoire, again.

Respondents don't mean advocacy, they mean marketing. Specifically, buyers want to know the answers to three basic questions:

- what are you selling me
- what benefits will it bring me
- why should I believe what you are telling me?

(Rimmer et al 2014)

Practice sharing. is perfect in theory. In practice

- online sharing doesn't work so well
- face to face sharing is hugely expensive.

(Deane et al 2015:112-121)

3.2.2 MM choirs produced a similar list, together with funding advice and a brokerage service: care homes looking for groups to perform; groups looking for homes to perform in.

4 Exploration

4.1 Part 1 section 6.2 asks about the business case for different models. The question is asked again here:

Q4.1.1 The choir model is expensive and should be more expensive – both to fund developments in quality (see below) and to pay musicians proper fees. Assuming that we want to promote this model, on what grounds can we say it's value for money for care home residents?

Q4.1.2 Assuming we could make the argument, would a marketing pack/tool kit be useful? How would we ensure that users were selling what the pack said they were selling (which of course would be pedagogically-sound work)? How could we make such a pack robust in its arguments, yet compelling?

4.2 Assuming we can make the case for choir model, then sections 2 and 3 are all highly consistent with all we know about community music as an intervention designed to support change (see eg Deane et al 2015:83-86). The work is:

- multi-pedagogical: music work *and* people work;
- multi-stakeholder: residents, care staff as staff, care staff as musicians, volunteers, musicians all of whom have to be orchestrated (no pun intended, but the language of music continually intrudes), through some sort of admin or better yet project management;
- multi-outcome: for residents, for care homes.

There's a lot here to get right, and at the same time:

Q2.1 How much is *necessary* to get right for 2:Q4.1.1 to be answered positively. In other words, is there such as thing as "good enough" choir leading? if there is, what elements (as suggested in the questions below) *need* to be better, what elements are already good enough and we don't need to worry about them further?

4.3 Some elements of practice that could be improved or clarified (if they passed the 2:Q4.1 test) include:

Q4.3.1 If we have *different methods* of teaching, is one better than another? How different/similar does the pedagogy have to be to address different issues? In other words, how targeted can you make the intervention? (This is important for efficiencies.) There are lots of variables that could be tested: the use of instruments; the use of backing tracks.

Q4.3.2 How different are *community music and music therapy*? Are community music just doing a bad music therapy job?

Q4.3.3 *Training* – maybe especially on the music side – is ad hoc, probably impermanent, fragmented and over-specific. How can we develop training that's more universal, extensive, effective, above all efficient?

Q4.3.4 *Repertoire* ("the songs we sing") is clearly of importance. Would there be added-value in collecting it, centrally (presumably electronically) distributing it? What are the rights issues? What would, actually, be the take up? This is prime Sing Up territory, of course: how can we involve them to everyone's advantage?

4.3.1 Working group 2 meeting (see 3:2.2) was asked in breakout 2 topic 3: “is community music just poor music therapy? (Tom Farrell, Grace Watts, Clair Chadwell, Rod Paton):

- No, but community musicians may need levels of awareness (of impact) to avoid potential issues; plus (drawing on music therapy practice) training and supervision as well as continuing professional support. Yet this should not be an inhibiting factor (all work comes with risk).

4.3.2 Working group 2 was asked in breakout 2 topic 1: “Thinking about the practitioner or choir model of delivery, what areas of practice most need improvement? (Andrew Potter, Ken Scott, David Walters, Rebekah Gilbert) noted:

- Professional, community and volunteer musicians all have different needs, to include:
- understanding of context
- what's achievable, what success looks like
- inclusive group working
- how to advocate for the work

4.3.3 Working group 2 was asked in breakout 2 topic 4 “Could training (of practitioners, of care staff) be more universal, hence efficient? How? (Alison Tender C&C, Jacqui Walker, Barbara Eifler, Anthea Holland)

- Yes, using the mindsong model: a group of practitioners support each other to lead groups in homes, using the mindsong song book. The model could be rolled out but it needs someone with care home experience (not just musical) to run it.

(Two other issues here more properly belonged in 1:6.2.1-2)

- How to get care homes to understand how music can work – how to support musicians. Get organisations that works with musicians and one that works with care homes to work together.

- If you can show how music can really help with key challenging issues/staff morale/staff retention/CQC then you will get homes on board.

4.3.4 Working group 2 was asked in breakout 2 topic 5: “Topic 5: Could a song bank pay its way? (Stuart Brown, Jessica Storer, Kay Taylor, Jess Watson).”

- Sing for your life has a song bank of 250 items. Not sure if a bank would pay its way. We include cost in cost of the music box system. Updates free. Music is customised for older people.

4.4 Let’s hear it for the managers. Some community musicians are absolutely on the ball with their admin, and run highly efficient sole-trader businesses that sell their wares convincingly and profitably. Others aren’t. We have tended to ignore management, relegating it to the status of unprofitable overhead: this has been unwise. Good managers are much more than gig-bookers: they are strategic planners, clinical supervisors, outcome monitors, and much more. So:

Q4.4.1 Are singing managers being used well? At all? How can they pay their way? What training do they need?

PART 3 TECHNICALS

1 Survey data and analyses

The following surveys have been analysed here.

1.1 Musicians

- A Survey Monkey survey developed by members of the working group, particularly MHA and Order of St John.
- Final agreed questions are at 3:3.1, and the surveys were live at the beginning of October 2015.
- Distribution followed wide advertising through working group members, Sound Sense publications, and elsewhere.
- Responses were collected until mid November 2015, when respondents numbered about 80; almost all of whom answered almost all questions.

1.2 Care homes

- A Survey Monkey survey developed and run in parallel with the care homes survey, largely by the same members of the working group
- Final agreed questions are at 3:3.2, and the surveys were live at the beginning of October 2015.
- Distribution followed wide advertising through working group members, Sound Sense publications, and elsewhere.
- Responses were collected until mid November 2015, when respondents numbered about 144; almost all of whom answered almost all questions. See 3:1.2

1.3 Natural Voice Practitioners Network

- A survey of NVPN members (community choir leaders, running both openly advertised and closed-institution singing groups). NVPN is a working group member.
- 30 respondents, all working regularly with older people in and out of care homes
- Question areas covered are at 3:3.3. Survey results were collected during the third quarter of 2015.

1.4 Making Music

- A survey of Making Music members (in this case, amateur choirs). Making Music is a working group member.
- 152 respondents, all having worked regularly with older people in and out of care homes
- Question areas covered are at 3:3.4. Survey results were collected during July 2015.

2 Analysis

2.1 Limitations

- Reasonable, but not huge, samples.

- In the musicians survey, mindsong musicians made up 23 (out of N=80) responses, music therapists and Sound Sense members a further 12 each. In the homes survey, MHA-run homes made up at least 48 (out of N=144) responses. These aren't illegitimate responses, but they can skew results; we checked for bias by running analyses with and without mindsong or MHA respondents present

- The surveys respondents are all self-selecting samples. Their responses are all legitimate in themselves (see below) but it is not possible to extrapolate from any of the surveys to populations as a whole.

- We were offered the possibility that the profile of practitioners may be skewed: could they all be western classically trained? Or do they fit more the profile of NVPN or Sound Sense members? And how might this skew the data? We have not found anything in our tasting to suggest these issues were significant problems.

- Many questions allowed for descriptive open-ended responses. These responses were examined for themes and sub-themes to form a coding frame for the descriptions. Up to five codes could be allocated to each description. All the responses to the musicians survey were coded fully. But of reasons of time only the first 80 or so responses in the care homes survey were coded. Hand examination of the data did not suggest any cause for concern abut the validity of the sampling here.

2.2 Approach

Much of the main surveys consisted of opinion questions, with some pre-coded answers, but also a number of questions completely open-ended. in a sense, these surveys have been treated more like structured interviews; and have been analysed using a simple form of thematic analysis. the responses have then been "triangulated" by reference to tother information.

Part of that triangulation consists of feeding back results to those with expert knowledge and interest, to see if the findings – even if unexpected or counter to received wisdom – ring true or are at least reasonable. We did that exercise at the working group 2 meeting on 30 November 2015; and the responses are taken into account throughout this report.

3 Survey questions considered here

3.1 Musicians survey

QM3 How many older people take part?
QM4 How often do you run sessions with this group?
QM5 Does singing happen in the care home between your sessions?

QM6 What music do you sing? (tick all that apply)
QM8 What techniques, skills or knowledge do you think are key to successful working in these settings (and do you need any particular equipment, materials, etc?)
QM9 Who is the singing generally led by?
QM10 How many volunteers are involved in supporting the activity?
QM11 How many care home staff members are involved in supporting the singing activity?
QM12 Have you, or any of the people mentioned above (other musicians, care home staff or volunteers, as far as you know) received any training in working with older people and/or dementia awareness? If yes, please could you provide any details.
QM13 As far as you know, have any of the volunteers or care home staff members above received any musical training or ongoing musical support? If yes, please could you provide details.
QM14 What additional training or support (if any) might you find useful?
QM15 Do you think the older people you sing with benefit from the activity? If you answered "yes" to QM15, please could you describe the 3 main ways?
QM17 Do you think any of the care home staff benefit from the singing activity? If you answered "yes" to QM17, please could you describe the 3 main ways?
QM19 Who usually pays for the singing sessions? (tick all that apply)
QM20 On average, how much does each session cost to run?
QM21 Are there any local organisations or care services involved in supporting this work? Please provide details if so.
QM22 Would you like to do more of this type of work?
QM23 If you answered "no" to QM22, what is preventing you doing more? (tick all that apply)
QM24 Is there anything else we should know?

3.2 **Care homes survey**

QC1 Are there any singing activities in your care home at the moment?
QC1a If yes, please describe
QC2 Do you think there are benefits for older people taking part in singing activities?
QC2a If so, please could you tell us what these might be.
QC3 Do you think there are benefits for staff and carers taking part in singing activities?
QC3a If so, please could you tell us what these might be.
QC4 Are any of these benefits you've listed at QC2 also provided by other things you do (such as exercises, medicine, food, welcoming staff) ?
QC4a If yes, please tell us more, and how they compare.
QC5 Do you think there are any barriers to providing singing (or more singing) in your care home?
QC6 If you answered "yes" to QC5, please tell us what barriers you face (tick all that apply).
QC7 Would anything encourage you to provide singing activities (or more of them)?
QC8 If you answered "yes" to QC7, please could you tell us what would encourage you to provide singing activities (or more of them) ?
QC9 Approximately how much does your care home spend each year on the following activities? (We promise to keep this data anonymised). (If you can't provide these figures, it will be helpful to know any reasons for that, which

you could put in QC.14.)
QC10 Is there anything else you could tell us that might be helpful to the project?
QC13 Which of the following most closely describes your job title or role?
QCx (please tell us if you are part of a wider chain or similar).

3.3 **NVPN survey** – areas covered
- Q1 Geographical location
- Q2 Range of work:
- Q3 Receiving Training
- Q4 Providing training
- Q5 Research activity
- Q6 Repertoires and genres
- Q7 Funding

3.4 **Making Music survey** – areas covered
- Q1 Existing and future activity counts
- Q2 Existing activity descriptions
- Q3 Making connections with care homes
- Q4 Reasons for doing this work; benefits to the group
- Q5 What works
- Q6 What problems may arise
- Q7 Role of Making Music
- Q8 Activities Making Music could provide

4 References

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Schön D (1983) *The reflective practitioner* New York: Basic Books

Working on *A choir in every care home*
Leader Evan Dawson, executive director Live Music Now
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Lead consortium
Live Music Now was founded in 1977 by Yehudi Menuhin and Ian Stoutzker CBE to train the best young musicians to give workshops in a range of challenging settings. It now delivers over 2,500 sessions each year, in care homes, communities, special needs schools, hospitals and more.
LMN project manager: Douglas Noble, strategic director for wellbeing
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Sound Sense is the UK membership body and development agency for community music. It represents some 1,000 community musicians, promoting the value of the work and assisting in their professional development. Community musicians work in all areas of disadvantage, (health, social care criminal justice and more) almost a half of them with older people, largely through singing.
Sound Sense project manager: Kathryn Deane, director
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The Sidney De Haan Research Centre for Arts and Health, Canterbury Christ Church University is one of the UK's leading research units in the growing field of arts, wellbeing and health, and is known internationally for its work on the role of singing in promoting health and wellbeing through its research and community projects
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Working group
The latest list of working group members is at W: www.achoirineverycarehome.co.uk

Arts sector
British Association of Music Therapists
Creative and Cultural Skills
Live Music Now
Making Music
Mindsong
Natural Voice Practitioners Network
Nordoff Robbins
Sing for Your Life
Sing Up
Sound Sense
Superact
Tenovus Choirs
Voluntary Arts
Welsh National Opera

Care sector
Abbeyfield
Age of Creativity
Age UK
Care England
MHA
My Home Life
National Care Forum
Orders of St John Care Trust
Skills for Care
West Kent Dementia Action Alliance

Wellbeing
Arts and Health South West
Creative and Credible
National Alliance for Arts Health Wellbeing
Mental Health Foundation
Royal Society for Public Health
Sidney De Haan Research Centre
South East Arts and Health Partnership

Working papers planned
This list is subject to change as the initiative develops

1	Jul 15	Gathering 1: preliminary learnings and later observations
2	Dec 15	Survey results: musicians in care home; care homes with music
2a	Dec 15	Surveys: raw data
3	Dec 15	On quality
4	Jan 16	Trends in care homes
5	Dec 15	Gathering 2: learnings and observations
6	Mar 16	Thematic literature review
6a	Mar 16	Literature review: raw data
7	Feb 16	How to run a great campaign
8	Mar 16	Models of singing
8a	Apr 16	Case studies of singing
9	Mar 16	Resources for singing
10	Apr 16	Barefoot singers

This working paper
Citation
Deane, K (2015) *Survey results: musicians in care homes; care homes with music A Choir in Every Care Home working paper 2,* London: Baring Foundation

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