Day Centre Resources Hub

These resources are for older people's day centres and organisations who may work with them. They aim to support day centre sustainability by improving knowledge about them, supporting their operation and encouraging joint working.

NIHR | Applied Research Collaboration South London

KING'S College LONDON

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About this document

This document forms part of the Day Centre Resources Hub which can be found at https://arc-sl.nihr.ac.uk/day-centre-resources-hub. These resources are for older people's day centres and organisations who might work with them. They aim to support day centre sustainability by raising awareness and improving knowledge about them, supporting their operation, and encouraging joint working.

People who might be interested are those whose roles involve planning, funding, evaluating and referring or signposting to day centres. They might be people working in community organisations or considering partnership working with day centres. Others might work or volunteer in day centres or support other stakeholders, research service provision, or be carers of people who attend day centres.

This Resources Hub contains seven sections.

- About this Resources Hub
- Why research matters
- Research evidence on day centres for older people
- Understanding outcomes and measuring impact
- A guide to marketing communications
- Workforce: staff and volunteer recruitment
- Case studies and inspiration

Each section is available as a downloadable Adobe Acrobat document. Alternatively, you can download one document that includes all seven sections. There are also Word or Excel templates that can be downloaded and used locally.

Documents can be printed in black and white by selecting 'printer properties' and 'print in grayscale'.

Each section is a compilation of useful material. We hope people will dip in to find specific resources relevant to their work and appropriate to their needs. A broad range of day centre stakeholders were involved in developing these resources. They address priority support needs identified by day centres and their stakeholders in various roles. They were created because a survey found that day centres felt unsupported and under-prepared for current and future environments. Day centre providers, professional decision-makers and community groups felt there needed to be more supportive and informative resources, and they had an appetite for joint working.

This work was funded by the National Institute for Health and Care Research Applied Research Collaboration (NIHR ARC) South London, which brings together researchers, health and social care practitioners, and local people under different themes. It focuses on 'applied' research designed to solve practical problems faced by local people and their health and social care services. This work falls within the Social Care theme, which aims to support the sustainability of social care services.

People who 'road-tested' the Day Centre Resources Hub said:

My overall reflection is that this is the type of resource I wish I had when I first started commissioning day services 7 years ago. I can see this being like a 'one stop shop' resource that collates examples of what good looks like and valuable hints and tips that can be considered by professionals from different sectors, whether it's policy makers, commissioners, or providers.
Commissioner

I found the resources really helpful and have already shared some with my team.
Assistant Locality Team Manager (adult social care social work team)

I found it very useful and I am sure that it will be used to enhance understanding and joint working.
Senior Social Worker

I would direct "commissioners" or those looking at local health and social care spending to see these pages and find the evidence to inform their plans for local services.
GP

The website is well structured and offers detailed information. The presentation is clean and easy to read. The content is right to the point on the topics. I particularly like the links to research and marketing.
South Croydon Day Centre for the Retired Co-ordinator

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Disclaimer and approvals

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Ethical approval was awarded by King's College London (ref: LRS/DP-21/22-27013).

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Documents marked with a star * are downloadable from the website in Word or Excel format for local use

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1. About the Day Centre Resources Hub

1.1 Aims of the Resources Hub

This Resources Hub aims to help support day centre operation and improve knowledge about day services.

It provides resources for day centres for older people and the professionals and organisations who refer or signpost to them. It also provides information to those who make funding decisions about them, who have local relationships with them, or who might consider engaging with them in other ways. All of these are stakeholders.

These resources are not a guide on how to set up and run a day centre. The Hub does not provide contact information about individual day centres and the services they provide.

Day centres are often valued places for people with social care and support needs who want to remain living in their communities. Day centre providers would like them to be more central to health and social care systems and are keen to develop local relationships with professionals, other services, businesses and community groups.

1.2 Who are these resources for?

These resources are primarily for people working in roles that have, or could have, connections with day centres for older people and older people with dementia. This includes day centres themselves and their external stakeholders.

Day centres

Day centres are building-based community services. They provide care and activities, specifically for people need support services and/or are disabled.

Day centres vary in many ways. Services take place in different types of buildings with different facilities, programmes (activities etc) and staffing. They cater for different numbers and types of people, and services are provided by different types of organisations. People may attend them for a whole day or part of a day (at least four hours [1].

Day centres are potentially valuable places attended by people with low level needs to multiple and complex social care and health support needs. They reduce isolation by offering

companionship and, as well as care, they provide emotional and practical support to people who attend. This can support them to continue to live at home in the community (including by reducing some of the risks associated with frailty and social isolation). They also help to support carers to continue to provide care at home. Desired outcomes or goals are usually set with people who use their services.

The role of day centres goes beyond a source of companionship or respite. They can also play a safeguarding role and are a safe place that carers can trust to look after the person they care for. They also provide wellbeing benefits for their volunteers. Home care workers may wish to know if their clients attend a day centre because it gives them another topic for conversation.

Please also see section 3 which summarises the research evidence about day centres and their benefits.

The social care regulatory body, the Care Quality Commission, does not monitor, inspect, or regulate day centres for older people.

During the Covid pandemic, day centres for older people faced mandatory, temporary closure. While some have re-opened, some did not survive.

Day centre stakeholders

Aside from people who use services and their carers, other day centre stakeholders are a wide range of people working in social care, health care or public health. Their roles might involve planning, taking decisions about funding, monitoring, reviewing or referring or signposting to day centres. Others who work in community organisations might consider undertaking shared activities and/or partnership working with day centres, and those who work or volunteer there.

This broad group may include (potential) commissioners, social workers, occupational therapists, district and community nurses, social prescribing link workers, GP practice nurses, allied health care professionals working in the community (e.g. rehabilitation teams), service reviewers, local Councillors, specialist and professional social care related organisations and bodies, local community and neighbourhood groups. Further stakeholders, who are slightly further back than these 'frontline' people, are those involved in researching service provision or those who support people working in any of these frontline roles.

Lack of regulation and varied typology of day centres mean that they are often 'invisible' to planners, funders, and practitioners. Local authorities are responsible for shaping the market and, to an extent, commissioning what services are available for people to use, so it is crucial that day centre services are made prominent.

People with a personal interest in day centres (for example carers and older people who attend them), are also important day centre stakeholders. Although they are not the primary audience for these resources, they were involved in its development.

1.3 Introduction to the Resources Hub

The name 'Resources Hub' reflects the way we hope this resource will be used – as a compilation of potentially useful documents. It is not intended as a 'how to' guide to be worked through from beginning to end. We hope that people will dip in to find specific resources relevant and appropriate to their particular needs or circumstances.

> **Day centre sustainability matters: evidence and real examples show their importance to planners and funders.**

No one service model suits everybody, but experience and research demonstrate that some people wish to support people to attend day centres. A study participant told us *"There have to be buildings of some sort where people can go and be safe. It's what else goes on in those buildings that's important."*They knew of a county that had closed all its day centres and employed a consultant to train the voluntary sector to support people to find alternative things to do. While successful for some people, the local authority realised that there was a group for whom nothing else was suitable. A decision was made to open a large day centre for this group, for whom support at home would have cost more.

> **This hub aims to support knowledge exchange. Having a single resources hub for multiple stakeholders can help to improve understanding and build trust between them. Day centre providers are keen to learn from each other and commissioners are keen to find out about new ideas, what works well and how best to manage these initiatives.**

Building on what already works rather than always starting afresh can be both a reward and a challenge. Finding information is time-consuming and some stakeholders want to know what the research says about day centres. Others are interested in learning how best to monitor whether a service they have commissioned or provide is working for the people it aims to benefit. People who refer older people to day centres benefit from knowing about the research evidence. Some commissioners have expressed a wish for real examples that bring to life the impact of a service.

Exemplifying the value of a service in a succinct, person-centred way through real case studies can help commissioners to share information with elected members and to access funding sources. Case studies can also help to illustrate the impact of service provision that can be tricky to measure with numbers. In the absence of a forum for information exchange or a local or national umbrella body, they also help to reduce wheel reinvention. They also help to demystify day centres for people unfamiliar with them and who may have preconceived ideas about them.

A 2022 report by the **Local Government Association, Strategic collaborative planning and commissioning: A guide**, may be a useful source of practical pointers to support health and care strategic systems, in creating the right conditions for effective collaboration for strategic planning and commissioning. The LGA would like health and care systems and leaders to use it to think about areas for development and exploration together.

What does the hub include and how is it structured?

In terms of content, our co-design process revealed that all information is useful because people, services and organisations are at different stages and there is scant material about day centres gathered in one place.

This Resources Hub is structured into 7 sections:

- About this Resources Hub
- Why research matters
- Research evidence on day centres for older people
- Understanding outcomes and measuring impact (incorporating tools, questionnaires and other ways day centres might gather data)
- A guide to marketing communications
- Workforce: staff and volunteer recruitment
- Case studies and inspiration.

This document includes all the Resources Hub content. Each of the seven sections is also available as a separate downloadable document.

Some templates are editable Word or Excel documents for local use/printing that can be downloaded from the website.

About this Resources Hub sets out the aims of the Resources Hub, who it is for and how it was developed. It explains how it is structured and can be used. Contributors are acknowledged and contact details are provided if you would like to get in touch with us.

Why research matters explains why becoming aware of the research evidence can benefit day centre providers and their external stakeholders, and the value of academic research.

Research evidence on day centres for older people looks at some of the recent research about day centre outcomes and summarises the main findings.

Understanding outcomes and measuring impact explains what is meant by 'outcomes', or 'impact'. It introduces different types of outcomes data and discusses the collection of this information in English day centres and sets out how it may be useful. Some ways to gather different kinds of data are listed and examples provided. It introduces some tools, questionnaires and other approaches that may be useful for day centres to consider using when monitoring or gathering their evidence about outcomes. All tools are free of charge to use unless otherwise stated.

A guide to marketing communications explains why it is important for day centres to carry out marketing communications and who their potential audiences might be. It suggests ways that day centres can communicate and share information about themselves and the communication routes that might help them to do that. Local examples appear throughout and further resources are signposted to.

Workforce: staff and volunteer recruitment outlines staff and volunteer roles in day centres. It shares recruitment and retention tips and signposts to useful resources about values-based recruitment. It also shares tips about role descriptions and adverts and highlights the value of sharing testimonials. It then suggests ideas for bringing young people and people with support needs and specific skills-sets into day centres.

Case studies and inspiration shares, in the form of case studies, examples of local day centre initiatives and partnership working as well as external resources in five topic areas:

- Supporting the NHS and social care
- Enhancing service quality
- Activities in day centres
- Outreach that might involve bringing in the community and local partnership working
- Day centre service expansion or re-design.

1.4 Why and how the Resources Hub was developed

Why were these resources developed?

The resources on the hub address the priority support needs identified by day centre stakeholders in various roles. They were developed after a survey found that day centres felt unsupported and under-prepared for current and future environments. The survey also found that evidence and information about day centres would be welcomed by day centre providers, professional decision-makers and community groups and that there is an appetite for joint working.

Resources were felt to be lacking, particularly about and for day centres for older people, including those living with dementia. Survey respondents were keen on a web-based centralised information resource to support these day centres and their stakeholders.

How were these resources developed?

These resources were developed in three stages: resource needs were identified, the resources developed and then tested and refined.

This was a co-design study which means that a broad range of day centre stakeholders were involved throughout, with stakeholders and researchers being partners in the process. We aimed to empower, collaborate, involve and consult with our stakeholders.

In the first stage, we spoke to ten people from day centres (nine managers, one volunteer and service user) and nine external stakeholders, in a variety of roles, in four diverse south London boroughs. We asked them about any tools or questionnaires they had used or that they might like to use. We also asked what other resources and what other tools/questionnaires or resources might be valuable to them. We discussed priorities raised by our earlier stakeholder survey and whether it would be helpful to make available any resources of that type (e.g. supporting the workforce). Finally, we asked about suitable formats for resources and whether interviewees had examples of local practice. We categorised this information into topics.

The Stakeholder Reference Group was central to the second stage. This stage involved prioritising, identifying, assembling and developing resources that were prioritised and that aimed to meet the needs expressed in stage one. Members included day centre providers and other professional and lay stakeholders. Members decided which topic areas to prioritise and what resources to include and they were invited to submit case studies and examples. The Stakeholder Reference Group reviewed the content and structure of individual resources that had been collected and drafted, mainly by the lead researcher. This researcher-led input and feedback model was chosen in recognition of members' time constraints. Members contributed to the design of this website and document presentation formats.

In stage three, resources were read in three day centres and by eight professional stakeholders in south London. Their feedback was used to further refine the resources.

Before its development started, we requested feedback on draft plans for this study from the NIHR ARC South London Social Care theme's PPIE lead (and member of the ARC's PPIE Strategy Oversight Group (SOG)) and deputy.

How were these resources funded?

This work was funded by the National Institute for Health and Care Research Applied Research Collaboration (NIHR ARC) South London which brings together researchers, health and social care practitioners, and local people under different themes. It focuses on 'applied' research that is designed to solve practical problems faced by local people and their health and social care services.

This work falls within the Social Care theme which aims to support the sustainability of social care services. Developing the Resources Hub is part of its work focusing on filling gaps in

knowledge around the value of day services and other social care services and strengthening them as community assets or anchors within South London and beyond.

NIHR ARC South London covers the London Boroughs of Bexley, Bromley, Croydon, Greenwich, Kingston-upon-Thames, Lambeth, Lewisham, Merton, Richmond, Southwark, Sutton and Wandsworth.

1.5 Acknowledgements

The researchers involved in this study were Dr Katharine Orellana (lead), Dr Kritika Samsi and Professor Jill Manthorpe. We thank everyone who has contributed to this work, some of whom remain anonymous while others have chosen to be identified.

We thank the Health Improvement Network and NIHR ARC South London Implementation Science teams for their help in designing the study, and NIHR ARC South London social care theme's PPIE lead and deputy for their feedback on initial plans.

We are grateful to interviewees and Stakeholder Reference Group members for sharing their knowledge and examples, and to others who agreed to share examples with us. This group included day centre providers, professional stakeholders and lay stakeholders who, between them, have an enormous wealth of many different kinds of experience and expertise. Membership varied a bit over time, but the following people all contributed:

- Andy Lorentson (Central Hill Day Services, London Borough of Lambeth)
- Anne Bren (Staywell, Kingston)
- Anne Donaghy (Merton and Morden Guild, London Borough of Merton) who, sadly, passed away during the project
- Cat Forward (Occupational Therapist, Lambeth and Southwark NHS)
- Christina Newton (lay stakeholder)
- Janine Lane (Central London Community Healthcare Trust, Merton)
- Jen Goddard (Age UK Merton, London Borough of Merton),
- Nathalie Wilson (commissioner, London Borough of Kingston)
- Nick Andrews (Wales School for Social Care Research, Swansea University)
- Rashmi Kumar (lay stakeholder)
- Rekha Elaswarapu (lay stakeholder, ARC Social Care theme's PPIE lead and member of the ARC's PPIE Strategy Oversight Group (SOG))
- Anonymous commissioner, London borough.

We are grateful to the 'road-testers' who set aside time to consider these resources and how they might (or might not) support them, and colleagues, in their roles and who gave us feedback to further improve them.

Day centre road-testers:

- South Croydon Centre for the Retired, London Borough of Croydon
- Saxon Day Centre (Age Concern Orpington & District), London Borough of Bromley
- Raleigh House (Staywell), London Borough of Kingston-upon-Thames

Stakeholder road-testers:

- Local authorities: Two senior social workers, an Assistant Locality Team Manager, a Senior Commissioning Manager (Older People, Physical and Sensory Disability) and an Interim Project Manager (commissioning team supporting older people and people with a physical disability) Manager in the London Boroughs of Kingston-upon-Thames, Wandsworth and Richmond.
- Health: A Neighbourhood Clinical Team Manager and a GP in the London Boroughs of Bromley and Kingston-upon-Thames.
- A social care researcher.

We are grateful to the ARC South London Communications Team for their advice, for facilitating the web design and build process and for uploading and revising all the content.

Effusion built the website and designed the document layouts.

The Day Centre Resources Hub website's home page photo is courtesy of the Centre for Ageing Better.

1.6 Get in touch

Please let us know whether this Resources Hub has been useful by emailing **Katharine.orellana@kcl.ac.uk** with the subject being 'Feedback on Day Centre Resources Hub'.

Please let us know if any of the links to external materials no longer work by emailing **Katharine.orellana@kcl.ac.uk** with the subject being 'Broken link on Day Centre Resources Hub'.

We run a **Day Centre Research Forum** that shares research and facilitates local and national collaboration between researchers and stakeholders working in the day services field. If you would like to be on the Forum mailing list to be kept up to date with details of forthcoming meetings, please contact Katharine Orellana: Katharine.orellana@kcl.ac.uk.

For information about the NIHR ARC South London, see **https://arc-sl.nihr.ac.uk/.**

2. Why research matters

This section explains why becoming aware of the research evidence should be of interest to day centre providers and their external stakeholders, the value of academic research and how to find it.

2.1 Why is being aware of research evidence about day centres important?

Commissioning/funding decision-makers. People involved in decisions about commissioning or funding services (in both health and social care) are expected to make evidence-based decisions to ensure that public resources are being used as effectively as possible. Commissioning is the process by which health and care services are planned, purchased and monitored. It involves assessing local needs, planning services, procuring services and monitoring quality. People involved in commissioning and funding decisions include local policymakers, commissioners, members of committees such as Health and Wellbeing Boards or Integrated Care Systems (ICS), people on funding panels, local councillors, or local grant-giving bodies that may be charitable. Service user expertise should, but does not always, play a significant role in the decision-making process. [2]

People working directly with older people and carers. Being aware of day centre research may help professionals working in health or social care and others who have direct contact with older people and carers. It may help them to feel more confident about suggesting day centre attendance.

See the two-page information sheet for professionals to give to older people and carers: *Day centres for older people: what do people say about them?* in section 3.6.

It summarises some of the main messages coming from six recent UK research studies and illustrates these with quotes from some of the older people and family carers interviewed for these studies. It can be **downloaded as a pdf from the Resources Hub website**.

Day centre providers. Knowledge of the evidence about day centres may strengthen day centre providers' messaging (i.e. how they present the service) about what their services offer. They can be clearer about how their service benefits potential service users, their carers or volunteers as well as staff and others they work with, including social care and the NHS.

Relevance to local/national policy or strategies. Important insights into day centres for older people, 'interventions' that take place at them (e.g. exercise classes) and their relevance to policy or strategies can be gained by reading relevant research. Research articles summarise the background to the particular research study being presented. For example, prevention and encouraging people to be more proactive about their health and wellbeing are central to the vision of the NHS Long Term Plan [3] and in social care [4]. People involved in local strategies to tackle loneliness may be interested in knowing the research about how day centre attendance impacts on loneliness (in individuals and what this means for the NHS, for example).

2.2 Locating academic evidence can be tricky but it is worth finding

There are different types of evidence used in commissioning decisions. Academic research evidence might be formal research or performance data (e.g. about what works), the lived experience of people using services and their families, or the experience of front-line staff. Barriers in accessing academic research means that relevant research articles may not be consulted.

Research with LA and NHS commissioners found that they tend to use easily accessible and trusted publications from a variety of sources. These include national policy guidance, reports of government-funded pilots, quangos, industry advice, voluntary sector best practice reports, professional or sector publications, experiences of people using services ('case studies' or 'stories'), local knowledge or local service evaluations. They may also undertake pilots to create evidence.

Academic research evidence is an overlooked yet important source of evidence [2, 5].

Commissioners working in the NHS have said that it is difficult for them to find, review, interpret and make useful conclusions from relevant academic research because they lack the time and skills to do so, and also because articles are often not accessible to them. [5]

2.3 How to find academic research

Carrying out a search on Google Scholar (**https://scholar.google.com**) is a good way to start looking for research articles about day centres because it saves looking at the contents pages of multiple journals.

Findings of research studies are often published in 'peer reviewed journals' which means that other experts working in similar fields in the academic world (universities) have thoroughly checked them before they are published. Articles in these journals report and interpret findings of different types of research study.

Articles covering **'primary research**' - which involves gathering data that has not been collected before – involves reporting themes and data collected that illustrate these (e.g. statistics or representative quotations from people who were interviewed), so that readers know the findings are genuine. They also provide contextual information to help readers understand the findings better (for example an overview of reasons why the research was undertaken, other relevant research, policy, theories).

Articles may also report '**secondary research**' which uses already existing data. One form of secondary research is the 'literature review'. A literature review aims to answer a specific question, and involves subject specialists searching for, evaluating and examining published research (UK and international) and explaining how the body of literature found addresses the question.

Research published in journals usually includes a short summary at the start. This is called the 'abstract'. The abstract is always available to read free of charge. Many journals charge to read research articles in full. However, some articles in these journals are openly accessible which means that readers don't need pay a fee to access them. These 'open access' articles are usually flagged with an open padlock 🔓. Some journals never charge fees to read published articles (e.g. BMC Geriatrics, Health and Social Care in the Community, Journal of Long-Term Care).

Overviews of research findings are sometimes also published in professional/sector press (e.g. Community Care, Health Service Journal).

People unfamiliar with day centres may wish to read a report that gives in-depth details of four day centres, ***What happens in English generalist day centres for older people? Findings from case study research***, published by King's College London [6]. It aims to further the understanding of these diverse services.

3. Research evidence on day centres for older people

This section summarises the main messages from some of the recent research about day centre outcomes including the impact of in-person service withdrawal during the Covid-19 pandemic.

3.1 Introduction to the research evidence

There is strong research evidence that attending a day centre helps maintain quality of life and can be helpful to people attending them and to family and other unpaid carers who get a break. Overall, the underlying nature of day centres is for long-term maintenance and monitoring, rather than being services that deliver specific improvements (e.g. in physical strength, continence, depression, Activities of Daily Living) and from which people are then 'discharged' after a defined period (like post-hospital discharge reablement service support which, typically, lasts for six weeks). However, short-term improvement 'interventions' (e.g. health condition management initiatives, targeted exercise programmes) might also take place at day centres as day centres are convenient community-based locations in which to run these.

Several research studies conducted in the United Kingdom have found that day centres have a positive effect on the older people who attend them and on their carers. Benefits for older people with or without dementia and their carers are both long-term and short-term. Most studies carried out in other countries have reached similar conclusions. Over the years, the amount of research about English day centres and interventions in them has fluctuated. Overall, nationally and internationally, there has been more research about centres for people with dementia and their carers than about generalist day centres.

The following sub-sections present the research evidence in more detail.

See the two-page information sheet for professionals to give to older people and carers: *Day centres for older people: what do people say about them?* in section 3.6

It summarises some of the main messages coming from six recent UK research studies and illustrates these with quotes from some of the older people and family carers interviewed for these studies. It can be **downloaded as a separate pdf from the website.**

3.2 The impact of temporary in-person service closure during the Covid pandemic

Day centres for people living with dementia closed to regular users as the impact of Covid-19 or the Coronavirus pandemic unfolded, and lockdown was announced on 23 March 2020.

The withdrawal of regular, structured social contact and stimulation was harmful to the wellbeing of many day centre attenders and their family carers and led to people living with dementia experiencing functional decline and mood problems. This was the case in the UK and elsewhere [7-16]. Furthermore, the Association of Directors of Adult Social Services (ADASS) reported that higher levels of help were sought from other social care services while day centres were temporarily closed [17].

3.3 Reviews of the research literature

Reading a literature review is a good way to get an overview of a topic. Reviews gather together findings of research articles to answer a specific question. Details and conclusions of the most recent literature reviews about day centres are summarised below, alongside each review's focus. Most literature reviews include UK and international research. Publication details and url links to the articles themselves can be found in the relevant numbered reference at the end of this document (see numbers in square brackets below).

> **Outcomes of older people with long-term conditions and their carers and types of long-term conditions included in research.**

This review covers 45 articles published between 2004 and 2020 and is by Catherine Lunt and colleagues (2021). [18]

- There was some evidence (albeit limited) of improved levels of perceived psychological health, quality of life, perceived general health, physical health and functioning for older people with long-term conditions attending day care services.
- Day care's respite function resulted in positive outcomes for carers.

> **Perceptions, benefits, and purposes of day centres.**

This review covers 77 articles published between 2005 and 2017 and is by Katharine Orellana and colleagues (2020). [19]

- Day centre attendance and participation in interventions taking place within them may have a positive impact on older attenders' mental health, social life, physical function,

and quality of life. Day centres make available social contact, activities and interventions that improve quality of life, support the management of existing conditions, and may prevent declining health and function. The group environment is important.

- Mainly in non-UK settings, day centres have proven to be convenient community venues for a range of daily, short- and long-term, preventive and health-related interventions (short-term focused programmes of activity) run by trained staff or volunteers, or by health or social care professionals which are accessible to relevant target groups of people.
- Interventions taking place in day centres that were focused on change or maintenance/prevention mainly showed positive outcomes, including cost-effectiveness and potential for cost savings.
- Day centre models vary between countries.

Effectiveness of day centres for people with dementia and their carers.

This review covers 21 articles published between 1998 and 2017 and is by Virginia Maffioletti and colleagues (2019). [20]

- Day centre attendance by people living with dementia contributed to continued living with family – that is, it delayed a move to a care home.
- The rest (respite) from caring stressors improved carers' quality of life and health.
- Staff support also increased carers' feelings of confidence and self-confidence to postpone a care home move.

The extent to which day centres support the occupational participation of people living with dementia (i.e. opportunities for inclusion and involvement with others through activities that are meaningful and significant both personally and socially), and how day centre attendance impacts on attenders' main carers.

This review covers 16 articles published between 2011 and 2016 and is by Janice Du Preez and colleagues (2018). [21]

- Day centre attendance positively impacts attenders with dementia through their social engagement and participation in activities with peers with whom they feel safe, understood and comfortable.
- Feeling validated by staff improved attenders' mood; this supported better relationships at home.
- Family carer outcomes are better and moves to care homes are delayed when service providers actively invite carers to be involved in activity planning and provide education and counselling support to carers.

Health-related outcomes for attenders and their carers, and how day centres can contribute to health systems.

This review covers 76 articles published between 2004 and 2014 and is by Moriah Ellen and colleagues (2017). [22]

- Day centre attendance leads to positive health-related, social, and psychological and behavioural benefits in people receiving care and for their carers. Both people receiving care at day centres and their carers were highly satisfied with these services.

- Overall, day centres appear to offer varying services that can address challenges in the health system such as providing appropriate care for older people, enabling them to continue to live at home (age in place), while also providing low-cost services for this growing group.

The impact of day centre use by people with dementia on their family carers.

This review covers 19 articles published before 2013 and is by Signe Tretteteig and colleagues (2015). [23]

- Family carers of people living with dementia experienced their relatives' use of day centres as:
  a) respite (i.e. they benefited from having a break from caring) and
  b) as a support service which helped to improve their competence in caring for their relative with dementia. Carers experienced feelings of safety and relief, a reduced caring burden and improved motivation to continue caring.

- Outcomes depended on the quality of treatment of their relative at their day centre and how the service met the carers' needs for flexibility, support, information, and responsibility sharing.

Service effectiveness with a focus on carer and attender outcomes and health care use.

This review covers 61 articles published between 2001 and 2011 and is by Noelle Fields and colleagues' (2014). [24]

- Day centre attendance has more positive impact on emotional wellbeing than physical functioning. Attenders experience improvements in:
  a) overall wellness, improvements in physical and emotional, perceived psychosocial wellbeing, and positive changes in social support and quality of life
  b) overall wellbeing and dementia symptoms, and
  c) in intergenerational day centres, feeling needed.

- Attenders who were cognitively impaired benefited from music therapy and art-based activity 'interventions' (programmes of activity).

- Physical 'interventions' improved gait, motor skills and reduced falls.

- The above suggests that day centres are a useful community building in which to deliver evidence-based interventions.
- Attendance can reduce carer burden and stress and contribute to overall carer wellbeing, especially for people caring for a family member with dementia.
- Evidence about how day centre attendance impacts on usage of other services is unclear.

Different types of respite services for carers of people living with dementia and their cost-effectiveness.

This review covers 52 articles about respite services, 21 of which were about day centres, published between 1985 and 2004 and is by Hilary Arksey and colleagues (2004). [25]

- Day care providing respite for carers may be cost-effective in the long term. Four economic evaluation studies were identified. All four suggested that the benefits of day care might be similar to, or greater than, those achieved through standard care. Two suggested that day care might be cost saving and two suggested that it might provide greater benefits than standard care but at a higher cost.
- Many carers placed a high value on day centres and felt there were benefits for themselves and their relative with dementia.
- People with dementia enjoy the company, the sense of belonging and the activities provided.
- Some studies showed clear improvements in carers' physical health, stress and psychological wellbeing; others showed no change.
- Some evidence suggested that day care attendance might prevent a move to residential care.

3.4 Recent research not covered by literature reviews

Research is constantly taking place and relevant articles about day centre research have been published since the literature reviews summarised above.

Studies about day centres published since the literature reviews appearing above are summarised below. UK research is covered first, followed by international research. The body of research evidence about the impact of day centres on their attenders and family carers outside the UK is larger. There are many different models of day centre but also similarities with some UK day centres, making international research evidence also important to be aware of.

UK research

> **Reimagining collective day care for older people: the current and potential role of collective day services including day centres, clubs and activities for older people in England**

A study by Laura Bennett, Ailsa Cameron and colleagues. [16, 26]

- Older people, carers and local stakeholders considered day care a vital part of the social care landscape. Day care is well-placed to play a central role in local place-based partnerships.
- Day centres support their older attenders' physical and mental wellbeing and health and provide purposeful activity.
- Older people value the supportive opportunities for connection and joy.
- Having a regular extended break benefits carers' mental health and helps them to sustain their caring role. Knowing their family member is enjoying themselves enables the break to be guilt-free.
- Day centres are a source of information and advice for carers.
- The two strongest factors that predict day centre use are not being married or co-habiting and being aged 85 or older (roughly four times more likely to use these services).

The changing role of the day centre for older people in addressing loneliness

A study by Catrin Noone. [27]

- Day centres are places in which genuine engagement and rapport-building can generate trust. In these spaces, older clients and carers feel part of a family and the day centre is not considered a 'service' or 'intervention'.
- Day centre are places in which staff and volunteers observe and demonstrate care, promote inclusivity and encourage participation, by applying a 'person-led' (which is more than person-centred) approach.
- This sort of 'relational practice' that takes place in day centres can transform the lives of the older people attending them in many ways, offering a protected space to connect, learn, feel joy, mourn, and negotiate feelings of loneliness.

Models of community day care for older people with multiple long-term conditions and the subsequent outcomes for service users and their families.

A study by Catherine Lunt and colleagues. [28, 29]

- People with long-term conditions who started to attend a day centre for the first time experienced lower levels of loneliness[1] after 12 weeks compared with when they started to attend.
- A larger proportion of people attending 'Blended' (i.e. run by a mix of paid staff and volunteers) and 'Volunteer-led' services (i.e. with no paid staff) reported a reduction in loneliness (compared with people attending services run solely by Paid staff).
- People with long-term conditions reported a positive change in health and wellbeing over 3 months.[2]
- People using Blended and Volunteer-led services reported better or the same health outcomes across most EQ5D3L (standardised questionnaire) domains than Paid (i.e. run by paid staff only) services.

The role and purpose of generalist English day centres for older people, including outcomes for attenders, their family carers and staff/volunteers.

A study by Katharine Orellana and colleagues. [30-33]

- Day centre attendance enhanced quality of life for people with mobility restrictions and at risk of declining independence. They supported their mainly socially isolated and

[11] Measured using De Jong Loneliness Scale.

[22] Measured using EQ-5D-3L (health-related quality of life scale) and VAS Visual Analogue Scale (global health rating score)

housebound attenders to age in place by focusing on their wellbeing and preventing deterioration and acted on any safeguarding or health concerns.

- Day centres were communities that 'enabled' and offset loss or isolation. They were life-enriching gateways to companionship, activities, the outside world (i.e. away from the home environment), to practical support, information and other services, to the community, and to enjoyment.
- Attenders' quality of life improvements / outcomes were directly because of day centre attendance.[3]
- The ASCOT (validated tool) domains with the highest gain (outcome) scores were social participation, occupation (the way time was spent) and feeling a personal sense of significance (feelings of dignity). Social participation/companionship and how time was spent were also attenders' favourite things about their day centre.
- Outcomes were achieved despite most people attending their day centres for only one or 2 days a week (i.e. 4.5–12 hours a week excluding travelling time).
- By monitoring attenders' health and wellbeing and providing practical support, information and facilitating access to other services, centres offered added value. This added value goes beyond the purposes for which centres are commissioned or funded, beyond what may be assumed to be covered by an aim of improving quality of life or supporting people to remain at home, and beyond what attenders may have expected, given their reasons for attending.
- Older people had low awareness, generally, of day centres before they started to attend one. Most had not known their day centre existed before attending it.
- People had started to attend their day centre because they had experienced different types of loss and/or wanted something different to do (mainly due to declining health, bereavement, retirement, service closure and the consequences of these). People wanted social contact, something to do, to get out of their home or to improve their mental health, to improve their physical health through exercise and meals, to improve their mental health or to accompany a partner for whom they provided care.
- Carer outcomes included feeling supported and encouraged in their caring role, feeling reassured, respite (free time, emotional respite, time in which to deal with practical matters, time for self-care and a sense of control), an improved relationship with their relative, social participation with people they liked, and useful information. Some described the day centre as a 'lifeline'.

[3]3 Measured using ASCOT validated Social Care Related Quality of Life scale and reported in interviews.

- Carers' quality of life improvements were directly because of their relative's day centre attendance (i.e. their relative's day centre attendance made a unique contribution to their lives that they would not have experienced otherwise).[4]
- Day centres made a unique wellbeing contribution to the lives of their volunteers (who were often older people themselves, but younger than attenders) and staff (i.e. added something to their lives that they would not have experienced were it not for their day centre role). They were a source of active ageing for their volunteers.
- Attenders, volunteers and staff particularly valued the group environment and continuity that centres provided which contributed to the development of person-centred relationships and, for staff/volunteer role satisfaction.

> **Older people's reflections on experiences and what happens after the end of a 12-16 week reablement-focused day centre attendance in Northern Ireland (a goal-oriented programme aiming to limit open-ended day centre attendance and dependency by promoting recovery, rehabilitation, confidence and independence, particularly in relation to activities of daily living).**

A study by Robert Hagan and colleagues. [34]

- Older people felt the programme was a purposeful and meaningful experience that also involved valuable social relations and resulted in learning from information presented in group activities.
- Many enjoyed attending their programmes.
- The model included obligatory attendance at each activity (whether educative or simply watching the television news) which some people did not welcome. When activities were not reablement-related, they would have preferred to choose alternative activities (e.g. sit alone or smoke a cigarette instead of watching the news).
- After the programme ended, some participants engaged with other services offering social contact, but this 'step-down' model (i.e. stopping day centre attendance after the programme ends) is not appropriate for everyone. It is important to recognise the importance of maintaining friendships made or rekindled after the programme period.

> **A comparison of Scottish and Norwegian day centres for people with dementia - with strong similarities between the two countries.**

A study by Anne Marie Rokstad and colleagues. [35]

- There were positive outcomes for both people with dementia and carers.

[4] Measured using ASCOT validated Social Care Related Quality of Life scale and reported in interviews.

- Satisfaction was linked with doing meaningful activities, getting out of the home, strengthening social connections and staff's careful facilitation of positive and welcoming atmosphere.
- Any initial reluctance to use a day centre later turned into enjoyment. Attendance provided structure, conversations, mealtimes and meaningful activities.
- Day centres provided respite and reassurance for carers. They benefited from time apart from their relative (which supported their relations when together) and from the support they received from staff.
- Day centre attenders' wellbeing increased and their function improved.

> **Identifying the ways in which volunteers participate in social care provision. Two of the seven organisations involved were day centres.**

A study by Ailsa Cameron and colleagues. [36]

- Volunteers were involved with day centres in a variety of ways. They assisted paid day centre staff, including filling gaps in provision particularly if there were staff shortages – but did not provide personal care.
- Sometimes, day centres were reliant on volunteers to open - even day centres employing staff.
- Volunteers joined in with activities alongside older people as well as providing them with support.
- Volunteers brought expertise and experience.

> **An exploration of factors involved in deciding to make a care home move.**

A study by Kritika Samsi and colleagues. [37]

- If a move to a care home is a possibility for the future, using a day centre within, or adjoining, a care home will help to build relationships that may ease the transition for both the person with dementia and their family carer.

International research

An Irish study highlighted how age-friendly day centre facilities are essential to supporting local ageing in place strategies. Older people value their day centres, describing the experience as being home-from-home. Regular attendance offers the opportunity for assessment, case finding, early intervention and health promotion for health and social care professionals. District nurses were the most frequent referrers. [38]

A Norwegian study reported that self-reported quality of life[5] over two years was higher among people with dementia attending day care compared with a group of people with dementia who did not attend a day centre. Although it cannot be assumed that these were directly because of day centre attendance, other similarities between the two groups suggested that day centre attendance might have had a positive impact on their lives. Interestingly, the day centre attenders with lower awareness levels had higher self-reported quality of life scores than those who had full awareness. [39]

Japanese research reported improved cognitive function[6] among day centre service users with dementia after they had attended a day centre for six months compared with non-users of day centres over the same period. Importantly, improvements were not linked with frequency of day centre attendance. That is to say that cognitive function improved as a result of day centre attendance, and the number of days attended each week did not play a role. The conclusion was that day centre attendance is a useful non-drug therapy. [40]

Norwegian research reported that the positive impact of day centre attendance on the daily lives of people with dementia was due to addressing areas of their lives that had been affected by dementia: physical function, cognition, wellbeing, and their home situation. Day centres enhanced the rhythm, activities, and social support in their everyday lives. The staff made the centres a safe place to be by fostering a sense of inclusion and belonging among their attenders. [41]

Norwegian research found that day centres relieved family carers by meeting the person with dementia's needs for social community, nutrition, physical activity, and structure and variety in everyday life. Family members' day centre attendance gave carers a feeling of freedom and increased the time available to be spent on their own needs, to be social and to work or do practical tasks undisturbed. It also had a positive impact on the relationship between the family carer and the person with dementia. [42]

Attenders taking part in a Swedish study of social day centres described them as places that provide a structure and something to do in everyday life. Day centres enable their attenders to create new social relationships and enable a sense of belonging and feelings of being needed by others. Social day centre attendance becomes more important over time because it offers structure for daily routines after losing friends and spouses. Staff help by facilitating

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[5] Measured using the Quality of Life in Alzheimer's Disease (QoL-AD)

[6] Measured using the Mini Mental State Examination (MMSE)

interactions between attenders. They are places where doing, being, becoming and belonging are facilitated, and thus they contribute to health and wellbeing. [43]

Canadian research with an older people's community centre concluded that these services could make an important contribution to reducing social isolation and loneliness by providing leisure activities that support relationships and lead to feelings of belonging which is integral to wellbeing. Experiencing a welcoming environment and opportunities for meaningful involvement, and the ability of the service to meet diverse interests and needs underpinned contributed greatly to feelings of belonging.

Research about day centre activities in Denmark and Norway reported that day centres function as social spaces where people can share stories and news based on personal experiences from the past and present. Within day centres, facilitating communities that give attenders something new and refreshing to take back home with them can be seen to be person-centred care. Activities – whether or not organised by staff - were meaningful if they involved an enjoyable social element that led to the discovery of 'a touch of fresh news', scandals or gossip as this made people feel connected with the outside world and gave them something to pass on to others at the day centre or outside it. Thus, it was not the activities themselves that were meaningful, but the spin-off effects that boosted a persons' social life. Even when staff used activities for social and rehabilitative purposes, attenders perceived them as purely social. [44]

German research with regular day centre attenders revealed differing leisure activity preferences. Preferred activities included social, learning, productive, resting, play, travel, and physical activities. The most important activity group was revelling in memories and catching up on the news. [45]

An Australian study reported that day centre attendance had beneficial effects on older people's health, well-being and social engagement, with the diversity of activities contributing to happiness. Staff played the important role of facilitating social participation. Availability, accessibility and cost of transport and the cost of the service itself were the biggest barriers to day centre use. [46]

A Swedish study reported that day centre staff play an important role in providing opportunities for older people to maintain their health and participation in meaningful activities. Key staff actions are facilitating activities, establishing a good group dynamic while also supporting individual participation and facilitating social interaction. Activities available at centres are affected by other factors, including limitations relating to the premises, activity cost and restrictive guidelines and regulations. [43]

Japanese research reported that the most common reason for attending a day centre (among attenders who were independent and who needed support with the Activities of Daily Living) was to fulfil a need for social participation. Other reasons (among those with physical support needs) were to receive support with personal care and exercise, and carer relief. No particular reason prompted attendance by one-fifth of attenders; they simply wanted to start attending. [47]

Japanese research concluded that day centres provide a place to stay (that is safe and provides the opportunity to socialise) in which staff facilitate activities, rehabilitation, relationships between people, encourage eating and drinking, provide personal care, monitor their attenders' physical and psychiatric status and speak with carers. Key to attender outcomes was feeling a desire to revisit the day centre (i.e. continuity and familiarity were important to outcomes). Outcomes included maintenance of physical and mental health, alleviation of loneliness and reduction of family caregiving burden. [48]

Japanese research reported that day centres for older disabled people provide an age-friendly and disability-friendly safe place in which people enjoyed spending time with other people who may share similar experiences as themselves and interacting with staff. Making new friends and enjoying new interests made people feel happy and energised. Some people found that being surrounded by others with similar or worse disabilities affected their self-image positively and others found the reverse, or found it uncomfortable. [49]

A US study reported that day centre staff's expertise is under-recognised. Day centres are flexible social environments in which staff manage the behavioural and psychological symptoms of dementia in an evidence-based and person-centred way. They personalised the way they worked with individuals – monitoring, engaging, socially stimulating and, when necessary, de-stimulating them. [50]

A US study found that black carers of people living with dementia who attended a day centre over a 6-month period experienced fewer depressive symptoms than a similar group whose relative did not attend a day centre. [51]

A US study concluded that updating and broadening activity programmes and introducing technology to day centres would help support ethnically diverse older people with a sense of purpose. Such changes would necessitate financial investment. [52]

Chinese research found that day centres provided a place for people to socialise, eat meals and bathe, compensating for difficulties in doing these things at home or elsewhere. However, the concept of 'day care' was culturally foreign to many people who made assumptions about types of activities they would be able to do or meals they would be given at centres. These assumptions hindered service uptake, as did costs. [53]

Spanish research found that, overall, (relatively active) older women attending day centres increased their activity slightly compared with women who did not go to a day centre, whereas men attending day centres did less activity than those who did not. Women engaged in more physical activities at day centres, increasing their light activity by 8% and doubling their moderate-to-vigorous activity. Men chose to join sedentary activities (e.g. playing cards, reading the newspaper). [54]

Norwegian research investigated cost-savings over a two-year period. Findings are interesting but should be treated with caution because of the types of services being compared and may be of limited relevance in a UK context (because home care is not part of primary health care in UK as it is in Norway). It compared use of specialist dementia day centres with 'usual care'

which, in many cases, included attendance of non-specialist/generalist day centres and day care in care homes. At the start and after 12 months, overall costs were higher in the specialist dementia day centre group, but there was no difference between the groups after two years. It concluded that specialist dementia day centres offered no potential cost-saving effect as the use of this type of day care did not reduce the use of secondary health care (outpatient clinics, in-patient stays and Accident & Emergency attendance) or primary health care (defined as home care, home nursing and generalist day centre attendance) or informal care, nor did it delay care home admission. It should be noted that dementia among those not attending the specialist day centres was less advanced and many people in this group also attended day centres (albeit non-specialist/generalist ones). **Researchers highlighted that it will be important to balance the non-monetary benefits of day care against its costs for a full cost-effectiveness analysis**. [55]

Research is taking place in Finland to discover the effectiveness and cost-effectiveness of day centres for older people who also use home care services. It focuses on health and wellbeing, maintenance of physical, psychological, and social functional ability, and enhancing social inclusion. It is comparing groups of people who use day centres with those who do not at baseline (before using the service), after 3 and then 6 months. Using validated scales, social inclusion, loneliness, and Social Care Related Quality of Life is being measured. Perceived outcomes and process of the day centre will be explored in focus groups to find out what makes the day centre effective or ineffective. The research runs from 2021-2025. [56]

3.5. Research about targeted, short-term programmes in day centres ('interventions')

Day centre attenders can benefit from being involved in short-term programmes of activity at day centres. These can be planned or run in cooperation with local partners, for example health services or universities. Such interventions point to the suitability of day centres as venues for many different types of interventions.

Tuohy and colleagues' reviewed 45 research studies (published from 2011-2023) of psychosocial interventions used in day centres for people living with dementia [57]. They grouped these interventions into five types: social, memory/cognitive, physical or sensory, nature, and animal. Benefits of these interventions included increases in functioning (social, cognition, physical activity, activities of daily living), social outcomes, health and wellbeing and enablement.

Many of the interventions in generalist day centres (those not specifically for people living with dementia) reported are social and preventive, such as humour-based activities, self-help programmes, exercise, psychosocial group work, brain fitness activities of the type that may ordinarily take place in day centres, discussion groups or intergenerational work. Some interventions are more focused on physical function, management of health conditions or quality of life and involved external experts, for example a weight-bearing exercise programme, a core stability and flexibility exercise programme, walking with poles at day centres and a programme of education-focused falls prevention. Interventions include blood pressure monitoring, self-management education, behavioural intervention to increase walking and reduce urinary incontinence, pelvic floor muscle training to reduce urinary incontinence, medication reviews by pharmacy students, a lifestyle modification programme delivered by trained lay people, and a programme of low-impact exercise, nutrition education and weight management for people with multiple chronic conditions.

Interventions that have taken place in generalist day centres and may be of interest are listed below. All took place outside the UK. This does not mean that similar programmes have not been undertaken in the UK. Further details about these interventions appear alongside references at the end of this document.

- A humour-based programme significantly improved life satisfaction and led to new social networks that extended beyond day centres. (US) [58]
- Another humour-based programme significantly lowered anxiety and depression and significantly improved psychological wellbeing but did not impact on general health, health-related quality of life and psychological distress. (Israel) [59]
- An eight-week 'life review therapy' programme led to significantly higher life satisfaction for day centre attenders taking part compared with a similar group of day centre attenders who did not. (Taiwan) [60]

- Psychosocial group work lowered mortality and reduced use of health services over a two-year follow-up period. [61] Cognition improvements were also experienced by lonely older people; these remained significantly improved after one year. (Finland) [62]

- Brain fitness activities of the type that may ordinarily take place in day centres improved self-perceived health and improved general wellbeing, perceptions of happiness and living an interesting life. (Canada) [63]

- Discussion groups to promote social engagement and learning improved social engagement, mutual understanding and tolerance and intellectual stimulation. They also improved relationships with staff and bettered staff understanding of attenders. (Ireland) [64]

- Participating in an intergenerational programme supported nutrition, leading to day centre attenders with and without dementia eating more solid food than usual on the days they participated in a centre's intergenerational programme. (US) [65]

- A transport, exercise and self-help programme led to small improvements in levels of depression - although higher with mild depression. New social networks that extended beyond day centres were developed. Although 40% of women reported developing new friendships, men did not develop any. One conclusion was that the model tested was not the most appropriate. (Norway) [66]

- Organised volunteering improved self-perceived health, improved feelings of purpose and self-esteem. However, after intervention had finished, participants' self-esteem and self-perceived health significantly lowered, although this remained above baseline (i.e. before having volunteered) measurements. (US) [67]

- A health outreach programme addressed individual need and targets for both partners (housing provider and public health). (US) [68]

- Hearing screening for people with sight loss improved links with a co-located support programme for hearing impaired people. (Canada) [69]

- An evidence-based, moderate-intensity weight-bearing exercise programme significantly improved lower body strength, agility, balance, walking speed and right-hand grip in older people needing help with one or more Activities of Daily Living (ADLs). (Australia) [70].

- A core stability and flexibility exercise programme improved spinal ranges of motion, but sacral/hip and thoracic flexibility, improvements in the lumbar area were not significant. (Italy) [71].

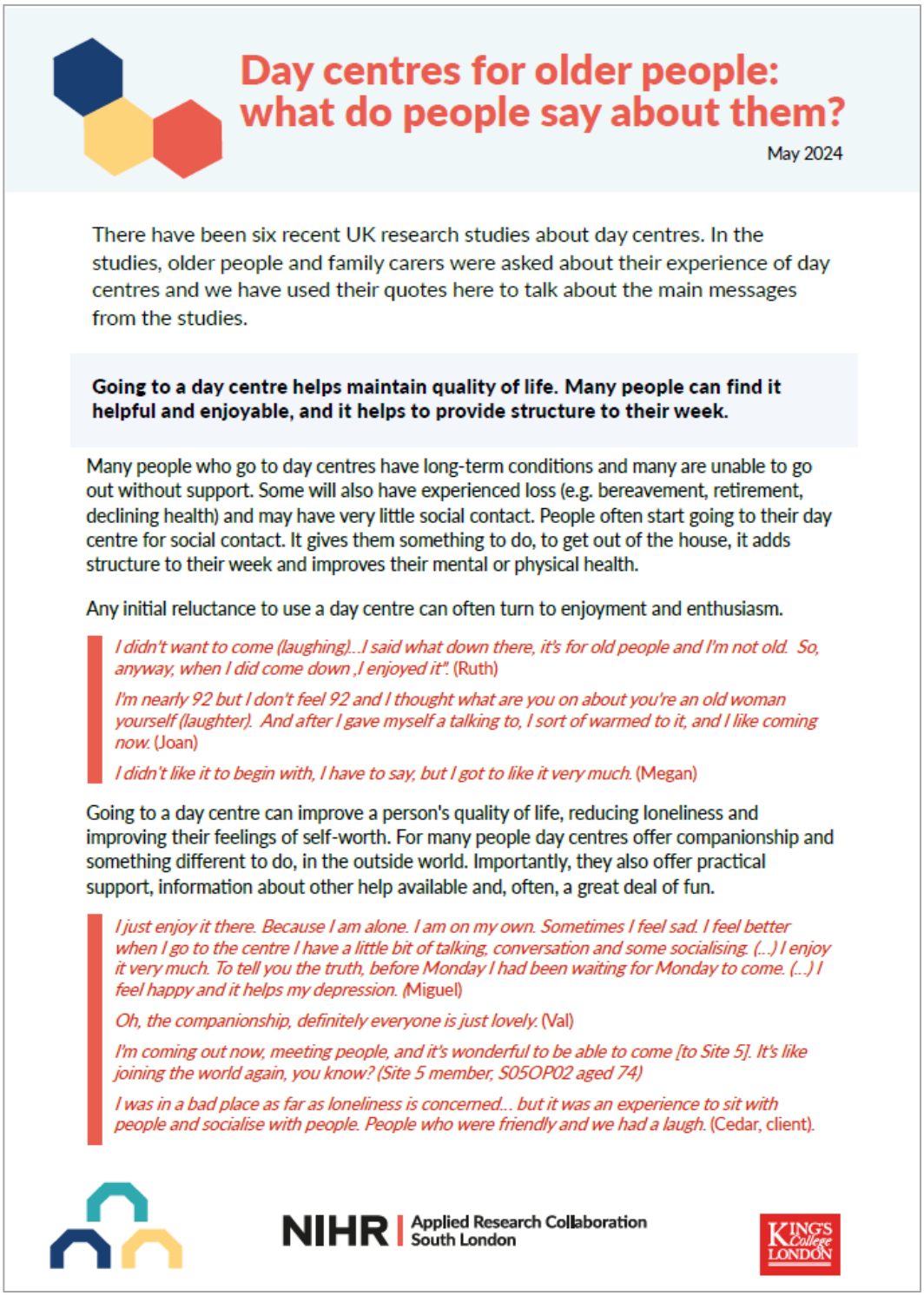
- An evidence-informed, tailored group exercise and walking programme for older attenders without severe cognitive impairment led to them eating more solid food. Walking with poles at day centres led to significant improvements to health-related quality of life associated with activity and function and to some aspects of posture and

maintained mobility. However, fitness and physical function (except mobility - measured by Timed Up and Go (TUG) test did not change. Pole walking is like Nordic walking but without the need for licensed instructor training. See reference details for further information about TUG. (Japan) [72]

- A programme of education-focused falls prevention improved mobility. (Japan) [73].
- Blood pressure monitoring by trained volunteers reduced blood pressure in people with or without diagnosed hypertension. (US) [74]
- Blood pressure monitoring by nurses via telehealth kiosks reduced blood pressure in people with hypertension. (US) [75]
- Self-management education sessions over 4 weeks significantly improved knowledge of heart failure, management and maintenance among people diagnosed with heart failure. (US) [76]
- A 12-week self-management education programme significantly improved self-rated ability to take preventive actions, manage symptoms, find and use appropriate medical care and make care decisions with health professionals. Participants' physical activity and performance and their mental health-related quality of life also improved. (US) [77]
- A behavioural intervention to increase walking and reduce urinary incontinence (UI) decreased incidence of UI in sedentary older people who improved their balance, gait strength and endurance by walking more and improved their physical activity and performance. (US) [78]
- Pelvic floor muscle training (Kegel exercises) to reduce UI with supportive coaching by a GP significantly decreased urinary incontinence (UI) in women. (Spain) [79]
- Medication reviews by pharmacy students led to the resolution of many medication-related problems and better medication use. (US) [80]
- A lifestyle modification programme delivered by trained lay people led to clinically significant weight loss in obese people. (US) [81]
- A programme of low-impact exercise, nutrition education and weight management for people with multiple chronic conditions led to significant improvements to fitness, daily walking distance and hours of weekly exercise, and body measurements, as well as significant reductions in depression. (US) [82]
- Taiwan has introduced reablement-focused integrated care for day centre attenders and carers. Carer satisfaction was significantly higher after the intervention when compared with the control group of similar people. This suggests that reablement – if used as a means of person-centred therapeutic training for attenders - can help carers cope and feel satisfied with caring and improve how they view their caring abilities. There were no differences in physical and mental function between the attender intervention and the control group of similar people. (Taiwan) [83]

3.6 Two-page information sheet about UK research: Day centres for older people: what do people say about them?

(downloadable in pdf format)



Day centres for older people: what do people say about them?

May 2024

There have been six recent UK research studies about day centres. In the studies, older people and family carers were asked about their experience of day centres and we have used their quotes here to talk about the main messages from the studies.

Going to a day centre helps maintain quality of life. Many people can find it helpful and enjoyable, and it helps to provide structure to their week.

Many people who go to day centres have long-term conditions and many are unable to go out without support. Some will also have experienced loss (e.g. bereavement, retirement, declining health) and may have very little social contact. People often start going to their day centre for social contact. It gives them something to do, to get out of the house, it adds structure to their week and improves their mental or physical health.

Any initial reluctance to use a day centre can often turn to enjoyment and enthusiasm.

> *I didn't want to come (laughing)...I said what down there, it's for old people and I'm not old. So, anyway, when I did come down ,I enjoyed it".* (Ruth)
>
> *I'm nearly 92 but I don't feel 92 and I thought what are you on about you're an old woman yourself (laughter). And after I gave myself a talking to, I sort of warmed to it, and I like coming now.* (Joan)
>
> *I didn't like it to begin with, I have to say, but I got to like it very much.* (Megan)

Going to a day centre can improve a person's quality of life, reducing loneliness and improving their feelings of self-worth. For many people day centres offer companionship and something different to do, in the outside world. Importantly, they also offer practical support, information about other help available and, often, a great deal of fun.

> *I just enjoy it there. Because I am alone. I am on my own. Sometimes I feel sad. I feel better when I go to the centre I have a little bit of talking, conversation and some socialising. (...) I enjoy it very much. To tell you the truth, before Monday I had been waiting for Monday to come. (...) I feel happy and it helps my depression.* (Miguel)
>
> *Oh, the companionship, definitely everyone is just lovely.* (Val)
>
> *I'm coming out now, meeting people, and it's wonderful to be able to come [to Site 5]. It's like joining the world again, you know? (Site 5 member, S05OP02 aged 74)*
>
> *I was in a bad place as far as loneliness is concerned... but it was an experience to sit with people and socialise with people. People who were friendly and we had a laugh.* (Cedar, client).

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The welcoming, safe and supportive atmosphere and the opportunity to build genuine relationships are important.

> *Well, it is the fact that everybody says, hello and you are welcomed; when you arrive, you see familiar faces even if you don't talk to everybody.* (Ruth)
>
> *I find the whole atmosphere here is very comforting, you sense it as you walk through the door.* (Anne)
>
> *If they're doing well-er than you, they seem to come and help you. They don't have to. But they did come and help.* (William)

Most people have good experiences. Older people's overall feelings about their day centres:

> *All I can say is that anyone who doesn't go there is missing out on something.* (Kathleen)
>
> *It changes your life.* (Wilma)
>
> *Oh, I love going. Oh yes. Yes.* (Kenneth).
>
> *Yes, it's good value for money.* (Miguel)

People running the service are supportive.

> *They care, and they understand why I am here ...* (Mariana)
>
> *They come around asking "Are you alright? What's the matter?"*(Thomasina).
>
> *Everything is done for you, you know. It's great to think now you can be looked after like this, you know.* (SAM).
>
> *I don't know what I'd do without them.* (Site 3, S03OP01 aged 73)

Day centres provide reassurance and a break for family carers.

Having a regular extended break is beneficial for carers' mental and physical health and helps them to sustain their caring role. Knowing their family member is enjoying themselves enables them to have a relaxing break.

> *"That amount of time [husband] is at [Site 4] is my little core of being normal [...] I know he's safe and he's enjoying himself"*(Site 4 Carer, S04C02)
>
> *She gets a lunch and she gets a social engagement. It gets her out of her flat and (...) that's money well spent (...) it is good value for her, because it does all those things about keeping her mentally and socially active.* (Family carer Evelyn)
>
> *I can sit in my living room on my own. It's one thing I really like doing (...) It relaxes me. Otherwise I'm just highly stressed. I'm like, you know when you're highly strung, you're ready to burn (...) Just to be alone in my own house is just the best feeling.* (Family carer Linda)
>
> *It gives him a break from me and it gives me a break from him. Then when he comes home I'm saying, have you had a good day? It gives you something else to talk about to each other.* (SCF)

Download this document from the Day Centre Resources Hub https://arc-sl.nihr.ac.uk/day-centre-resources-hub.

Research quoted here: Bennett et al (2023), Hagan & Manktelow (2021), Lunt (2018); Lunt et al (2021); Noone (2023); Orellana et al (2020), Orellana et al (2021) Rokstad et al (2019). Names are not participants' real names.

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4. Understanding outcomes and measuring impact

This section explains what is meant by 'outcomes', or 'impact', and discusses the collection of data in English day centres. It sets out how and for whom day centre related outcomes data may useful and introduces different types of outcomes data. It summarises some challenges involved in gathering and making use of outcomes data, and things to bear in mind when doing so. Finally, it lists some ways to gather different kinds of data and gives examples.

4.1 A brief introduction to 'outcomes data'

Outcomes data show the impact of an activity (e.g. impact of attending a day centre on wellbeing). The terms "outcome(s) data" and "impact" are sometimes used interchangeably. Outcomes are not the same as outputs which refer to measurable results (e.g. numbers of day centre places filled).

Outcomes, or impact, data are any data (information) that evidence what happens (benefits and changes) as a result of a particular input, service or intervention – in this case the day centre. Outcomes/impact may include changes and benefits for individuals, changes for organisations or systems (e.g. NHS, social care), communities, or financial changes, for example. These changes may be positive (good), negative (unwanted), inconsequential (neutral) or may be completely unexpected. Outcomes data may reflect potential, slow and small progress, or maintenance (i.e. delaying deterioration). Or they can focus on the 'here and now', for example, people being happy and having a good day rather than on achieving set goals. They may aim to discover whether people got what they hoped for from attending the day centre that day and what was missing if they didn't.

Data can be quantitative (involving numbers) or qualitative (rich, informative text). Both are useful in different ways. Sections 4.4 and 4.5 explain these types of data further.

Data may be collected by regular monitoring or in evaluations. Monitoring may be undertaken at set times, for example, before starting to attend a day centre, one month after starting to attend, 3 months later, 6 months later and after a year. Regular monitoring shows long-term impact on individuals. Evaluations may take place during a project that is unfolding to inform

its future and further development. Or they may take place after an event to discover what has been learnt. One-off measurement of outcomes for individuals can also take place.

> **Outcomes can be:**
>
> 'hard' - obvious and very likely quantifiable, for example, number of GP appointments attended
>
> 'soft' - for example, feelings of wellbeing, quality of life or safety
>
> 'maintenance' - aiming to *retain* a certain level of quality of life, for example, rather than *changing* it
>
> 'process' - about the way a service is delivered and experienced
>
> 'change' – about any changes experienced due to the service.

4.2 Are outcomes data routinely gathered in English day centres?

No standardised ways of gathering outcomes data about day centres are in place in England. This is the case even in other countries where there are day service umbrella bodies, for example the United States of America.

Experts in the United States (US) have called for the development of a uniform set of outcomes measures for use in US day services [84]. One reason for this is to help the leverage of additional funding streams. As in England, US day services are varied, having developed in a piecemeal and inconsistent way, and they may lack resources. Unlike English day centres, US day services are part of the health care system's home and community services, they cater for larger numbers (average 58 per day) [85] and, as some are social and some address their attenders' medical or physical needs, staff bodies often include social workers, nurses and physiotherapists. Measures proposed, therefore, may not all necessarily be suitable for English day centres, although some have been included here.

In England, some commissioners want a better, more systematic way of gathering data across directly commissioned services (for example, a framework). However, because of the lack of systematised outcomes data collection, individual commissioners and providers need to develop their own local approach. Without a strong, systemised evidence base, local authority (LA) and NHS commissioners struggle to justify continuing to fund or to expand services.

Challenges involved in gathering and making use of outcomes data are discussed **in section 4.6.**

4.3 What are outcomes data useful for?

Within a day centre context, outcomes data can serve various purposes and may be of interest to many people in different roles, including people who take decisions related to day centres.

They may be useful for:

- Tracking individual progress
- Showing (evidencing) usefulness/impact for funding-related decision-makers
- Informing staff who are new or new in their role within LA or NHS services
- Making links between services and policy goals
- Evidencing impact for people who make referrals or who signpost to day centres
- Raising awareness of how day centres can support people
- For service improvement
- Supporting recruitment and retention of staff and volunteers
- Informing topic-based local initiatives
- Demonstrating value for money
- Supporting care plan reviews and enabling people to know more about the service.

Tracking individual progress

Outcomes data can track the progress of individuals who attend the day centre. People may wish to see how they've progressed since starting to attend their day centre (especially if feeling tired or having 'a wobble' about going). Carers may appreciate knowing how their relative/friend is doing, too.

Showing (evidencing) usefulness/impact for funding-related decision-makers

Outcomes data can show (evidence) the usefulness (or impact) of the day centre to its users for funders, commissioners and others who make service-related decisions. Outcomes data can be helpful for funding applications/tender bids and service monitoring. They can inform service reviews. They can also contribute to economic evaluations or social value/social return on investment exercises. Business analysts who can help construct strong justification for commissioning decisions are less common in LAs now, and, therefore, easy-to-use data/evidence is appreciated.

Informing staff who are new or new in their role within LA or NHS services

Outcomes data inform new staff and staff moving roles within LA and NHS services where there is high turnover, reorganisations and resulting changing roles are common. Background information will be necessary for new or re-assigned staff and is particularly important within an environment that encourages joint commissioning.

Making links between services and policy goals

Outcomes data can also help map service impact across to current policy goals, thus furthering the understanding of day centres' relevance to policy. Policy goals include ensuring good quality of life for people with care and support needs, delaying or reducing the need for care and support, ensuring people have a positive experience of care and support, safeguarding adults whose circumstances make them vulnerable and protecting them from avoidable harm. Some contracts may specify policy-related outcomes for service providers to aim for.

Evidencing impact for people who make referrals or who signpost to day centres

Outcomes data can evidence the usefulness (impact) of the day centre to social care and NHS professionals and others who may consider making referrals, or signposting, to day centres (e.g. social workers, occupational therapists, social prescribing link workers, information and advice services). Any referrals made should be appropriate, and outcomes data may help with this.

Raising awareness of *how* day centres can support people

Demonstrating how day centres make a difference to those who attend them supports marketing of the service to potential service users and to the general public. This is especially important because day centres will increasingly need to make their services attractive (marketable) to people who will pay for services themselves or their families. These 'self-funders' include people who do not meet a local authority's criteria for services but who have other needs which could be met by a day centre (e.g. functional mental health needs such as depression). These people and their carers will need to understand exactly what they would get for their money. This will be even more important for services not subsidised by contracts and which, therefore, may make higher charges to users. **Section 5 covers marketing communications**.

For service improvement

Outcomes data can support day centre providers to self-audit and undertake service improvement.

Supporting recruitment and retention of staff and volunteers

Monitoring staff and volunteers' feelings/role satisfaction/views may improve staff/volunteer retention as it helps identify where changes need to be made. Publicising satisfaction data may also help market a day centre as a good place to work or volunteer.

Recruitment and retention in social care are often problematic [86]. Volunteering at a day centre is not only an opportunity to help others and can also be beneficial to volunteers' health and wellbeing, especially if they are older themselves [87].

Informing topic-based local initiatives

Localities may wish to address particular problems that have been identified, such as high levels of loneliness. Outcomes data can inform themed briefings for staff or local strategies – such as how to reduce loneliness locally.

Demonstrating value for money

Outcomes data may also help demonstrate value for money (economic evaluation).

Supporting care plan reviews and enabling people to know more about the service

A participant in this research explained how central registration of outcomes data for individuals on statutory databases used by other professionals, for example, can support reviews of an individual's overall care and support package. At the same time, data support other staff within a directorate to better understand the service and raise the profile of the day centre.

4.4 What are qualitative data (rich information)?

Qualitative data are ‘rich’ information. They help to gain a better understanding of people’s perspectives, views, experiences or emotions, the ‘whys’ and ‘hows’. They are detailed feedback (or descriptions). They are usually provided in response to open questions (i.e. ones that do not require yes/no or a 1-5 scaled response answer). They may also be provided not on request (e.g. compliments or complaints). Qualitative data are individual and, therefore, subjective.

Gaining such insights and understanding can help a provider better understand their users (or staff/volunteers) which can help improve service provision (and recruitment and retention). Data can be practically useful for:

- informing, for example, development or direction of services, for understanding what goes well and what goes less well, or for understanding satisfaction with various aspects of service provision or working/volunteering at a day centre
- helping (potential) funders, commissioners, decision-makers and other supporters (e.g. local businesses, ‘Friends of’ groups) to understand the service offer better and its value
- helping the wider public and potential future users know more about what a ‘day centre’ is
- providing evidence that service users have been consulted about, for example, organised activities, meals, service developments.

Qualitative data can be collected in various ways - in surveys, in conversation, by email, or in group discussions, for example. They may be collected alongside quantitative data, for example in a survey that asks people to rate how happy they were with x, and which also asks what they particularly liked about x.

It is crucial to record and process the data collected so that they are of practical use. They can be collated and reported in different ways – narratively (in text), as case studies, or a mix that includes descriptive statistics (e.g. percentages). Short reports can be useful for internal purposes, as records, and for funders or marketing (e.g. on a website). Short reports can also be circulated to service users, carers or 'Friends of', and to motivate staff/volunteers.

Individual case studies (e.g. short overview of the person and the benefits they have experienced as a result of using the service, a 'story') can also be written up and used for this purpose. Information about ways to do this appear in section 4.7 of this document. The **Most Significant Change approach** uses a person's own words to explain the most important change they have experienced as a result of using a service and why this change is important to them, and **Twelve principles for effective personal outcomes-focused recording** are suggested by Social Care Wales.

Some examples of how qualitative data can be presented are shown below.

Examples of ways to present qualitative data

People reported enjoying the meals and valued eating in company. It was important to them that the meals were served to everybody at one table at the same time. Their suggestions for improvement included….

Most people reported enjoying the organised activities. Although most attenders enjoyed bingo – saying it was fun, engaging and mentally taxing – a small number did not.

Most carers reported that their relative seemed happier after attending the day centre, which also helps their own wellbeing. Some carers made some suggestions about x.

Staff satisfaction was influenced by x.

The volunteering survey found that an important factor contributing to people choosing to stay was x. This was because y. All volunteers said volunteering at the day centre improved their wellbeing and was satisfying.

Case study of an individual that demonstrates the value of a service to that person.

Case study demonstrating the 'added value' of a service (what is provided in addition to what is expected or contracted for), for example:

- staff making a GP appointment for someone they suspect may have a urinary tract infection, or liaising with the District Nurse so that someone can have their insulin injection/bandages changed at the day centre instead of waiting at home and missing the companionship they enjoy at the day centre
- how the provider promotes staff wellbeing
- someone taking some flowers from their garden into the day centre for others to enjoy gave the person purpose in life and made them feel like they have actively contributed to this community.

Some things to bear in mind when planning to gather qualitative data:

- Permission may need to be gained to report individual 'stories' (case studies) on websites, social media or in funding bids.
- Although it may be time-consuming to organise, collate and summarise qualitative data, this is usually time well-spent.

The **Institute for Research and Innovation in Social Services (IRISS) developed a guide for individuals and organisations collecting and using, or planning to collect and use, personal outcomes data** (i.e. information gathered from people supported by health and social services and their unpaid carers about what's important to them in their lives and the ways in which they would like to be supported).

It has three sections. Part one discusses why qualitative data is important and what it can help achieve. Part two covers the practical steps involved in the process (collecting, recording and analysing data, ensuring credibility, and reporting findings). This section contains key messages, reflections from case studies and exercises that can be used with groups to encourage discussion, consideration and debate. Part three presents case study examples developed by people using qualitative data about outcomes for the first time.

Miller, M and Daly, E (2013) *Understanding and measuring outcomes: the role of qualitative data*. Institute for Research and Innovation in Social Services (IRISS).

The National Institute for Health and Care Research (NIHR) Applied Research Collaboration, Kent, Surrey and Sussex (ARC KSS) developed CAVEAT (The Community And Voluntary Organisation EvaluAtion Toolkit) which is a free resource designed to help Voluntary, Community and Social Enterprise (VCSE) organisations demonstrate their impact by helping organisations to describe, measure and report key information. The toolkit can be used by charities, community, voluntary and social enterprise organisations, and faith groups. Funding bodies or service commissioners may find the toolkit useful for identifying outcomes for quality monitoring. The Knowledge Base contains useful information, guidance, video clips, documents and webpage links for users to access. Users must register their details (free of charge) before being able to access CAVEAT.

4.5 What are quantitative data and standardised questionnaires / scales / tools?

Quantitative data relate to numbers; they are countable and measurable. These data help us to understand matters concerning quantity (how much, many or often?) or people's characteristics. Data can be objective (e.g. how many days someone attends the day centre, how many times has someone been absent) or subjective (e.g. how much did you enjoy x on a scale of 1-5?). People often refer to this type of evidence as 'hard' (rather than 'soft' which is a term often used to describe qualitative data).

Some examples of objective data include overall attendance levels; how often people attend; do people return after their first attendance; how many people do not return; numbers of carers staying in paid work; the personal or demographic details of those who attend collected in a standardised way (ethnicity, date of birth, health conditions etc).

Such data may be presented statistically (using descriptive statistics). For example, x% of people reported enjoying Y; x% of carers reported that Y; x% of volunteers said Z; x% of people reported improved quality of life since starting to attend their day centre. Presenting them alongside qualitative data gives a broader picture of the service and its outcomes/impact.

Quantitative data can also be gathered about individuals' experiences (subjective data). '**Standardised' questionnaires (i.e. validated scales, tools or measures)** may be used to do this. These are questionnaires developed to measure a certain thing in a specific group of people. If a questionnaire (tool, scale or measure) has been 'validated', it has been tested to check how well it measures what it is intended to measure. This will have involved using it with a representative group of people and checking that the results did actually represent what they are supposed to measure (i.e. were valid) and if the results could be reproduced when used again (i.e. were reliable). Because standardised questionnaires have been carefully tested, they usually have questions with pre-determined wording and structured answer options. Some questionnaires are objective (e.g. health status) and some are subjective (e.g. perspective on feelings of wellbeing or how/if a service has helped someone). Some questionnaires are very short (e.g. five questions) and some are longer (e.g. 20 questions). Their length does not necessarily indicate how long they may take to use; some are quick, and some are not. Many standardised questionnaires are free to use. Some require registration (i.e. informing their issuer that they are being used, with whom and in what context). Some require payment. Many tools that are likely to be useful in day centres are available free of charge. Some of these appear in section 4.7.

Collecting data in a standardised, systematic way like this can be helpful for reporting - both about individuals and about the whole service user group – because it means that the resulting scores are comparable and standard across the group.

As with qualitative data, **it is crucial to record and process the data collected so that it is of practical use**. Standardised questionnaires are usually accompanied by guidance on their use, scoring and interpreting the results. You do not necessarily need to be 'an expert' to use these questionnaires.

Traditionally, 'hard' data, like those resulting from standardised questionnaires, have not been collected by day centres about their clients. In the current environment, in which evidence-based commissioning is encouraged, it may become increasingly important to consider this option. Gathering such standardised evidential data may contribute towards day centres beginning to be considered more as health and wellbeing 'interventions' and be taken more seriously. This is particularly important as LAs are continuously under pressure to save money and justify spending, and social prescribing is becoming increasingly widespread in primary care.

In summary, standardised questionnaires can be useful for:

- monitoring individual outcomes and experiences – at one point or at several points over time (e.g. when starting to attend a day centre, one month later, 3 months later, 6 months later and after a year). Scores may indicate individual improvement (i.e. the service has made a positive impact) or maintenance (i.e. that deterioration has been delayed).

- feeding into care plan reviews - as evidence of outcomes/impact for older people attending day centre (and their carers, if also using tools with them).

- enabling a person to see how far they've progressed since starting to attend their day centre. This may be useful for people who may be feeling tired and need encouragement to go to a day centre or are having 'a wobble' about going.

- carers may also appreciate knowing how the person they care for is progressing.

- reporting about whole groups (e.g. all the older people attending a day centre) – as averages, for example. Such data may be reported to funders (and other decision-makers) or included in funding applications. 'Hard' evidence, like the scores resulting from standardised questionnaires (validated tools), are often very appealing to people working in the NHS.

4.6 Challenges involved in gathering and making use of outcomes data, and things to bear in mind

Background knowledge, expertise and time are significant barriers to gathering and using outcomes data. Measuring outcomes can be complex and involves time and resources.

Individual outcomes can cover a very broad span. For example, safety is an outcome (feeling safe, lack of falls, being out of a risky situation), as is improved wellbeing; feeling significant as a person is an outcome; and enjoying companionship is an outcome.

It is important to remember that service or organisational outcomes, are the sum of the individual outcomes as a group, but these outcomes may also be linked with use of other services, such as additional home care, respite, GP appointments, hospital bed use or care home placements.

Many questions need consideration and decisions must be made *before* gathering outcomes data. For instance:

- What is the purpose of gathering these data?
- Is there in-house expertise on how to measure outcomes?
- Which outcomes should be measured and how should this be undertaken?
- How difficult/easy and time-consuming will it be to gather these data?
- Is staff training necessary?
- When should data be gathered – how often, after what period and during which part of a day centre day?
- Are there staffing implications?
- Should the exercise be undertaken in a private area?
- Is the person willing to provide data about their own outcomes?
- How will data be interpreted and presented?
- Will data be reported on an individual basis or for groups of people? How should data be stored?

When gathering outcomes data (whether qualitative or quantitative), it is also important to bear in mind that:

- brevity is key: the method should not be burdensome for any party involved, but some people are happy to fill in longer forms. People can be asked if they are happy to do so.

- frailty can also be a barrier to collecting data: people may have too much going on in their lives and may not wish to add another exercise.

- some conditions, for example dementia, are progressive and can mean that collecting reliable outcomes data is challenging. Carers may need to be involved in a respectful way. The best way to gain consent to complete surveys will need to be considered.

- sensory loss may mean considering additional things. **Tips on administering questionnaires with people with sensory loss appear on pages 30-31 of Campaign to End Loneliness' Measuring your impact on loneliness in later life** (also see section 4.7).

- the process should be stress and anxiety free, especially for people living with dementia, and undertaken in a way that minimises discomfort about what's going on for them and realisation of their loss of skills etc.

- timing is important:
  i) getting to know a person, building a rapport and letting them settle before asking lots of questions can lead to fuller responses
  ii) some people do not mind being asked questions at first contact, but others may not wish to share personal feelings before having developed a relationship with staff/volunteers
  iii) some people function better at certain times of day
  iv) outcomes for people with cognitive limitations (e.g. memory loss) may need to be measured 'in the moment' rather than a long while after an event.

- carers' responsibilities may mean some are reluctant to respond to requests.

- when surveying staff/volunteers or older people attending a day centre across an organisation that provides various services, surveys may like to include some separate questions for each service to enable reporting of findings by service.

- if data are collected across several day centres, it is useful to be able to separate data for each centre.

- if any standardised questionnaires are being used, guidance on their use and interpretation is available (see below).

- outcomes data gathered should be put to use somehow: it is counterproductive to collect data from individuals (using any method) and then file it away in its original form without processing it somehow.

- becoming more digitally literate is a target for some (e.g. local authorities), so being stretched by the use of digital outcomes monitoring data can be a good thing.
- permission may need to be gained to report individual 'stories' (case studies) on websites, social media or in funding bids.
- although it may be time-consuming to organise, collate and summarise qualitative data, this is usually time well-spent.

Some advice is provided in Campaign to End Loneliness' Measuring your impact on loneliness in later life (pages 22-29). This covers how to introduce a questionnaire (useful more generally although specifically about loneliness), encouraging staff and volunteers to use a questionnaire, at what points and how regularly a questionnaire might be used, how to choose people to use a questionnaire with ('the sample'), getting consent, asking open questions and making sure enough information is gathered about the people it is used with.

4.7 Some ‘tools’ (questionnaires) or approaches to gathering data that could be used by day centres

This section gives an overview and links to further information about tools, questionnaires or approaches that may be useful for day centres to consider using when monitoring or gathering evidence about outcomes.

Introducing tools, questionnaires and approaches

This section introduces and gives some background to tools, questionnaires or approaches that may be useful for day centres to consider using when monitoring or gathering evidence about outcomes. Clicking on links will take readers directly to further information in the next sub-section. All tools are free of charge to use unless otherwise stated.

Practical suggestions are made for recording individual outcomes in Social Care Wales’ **12 principles for effective outcomes-focused recording**.

Thinking about giving examples of how involvement with a day centre (attending, volunteering, being a carer) has improved people’s lives, **how to write ‘stories’ to communicate outcomes** that have resulted in change is explained, building on the Most Significant Change technique.

Social care service-related quality of life can be measured by the **Adult Social Care Outcomes Toolkit (ASCOT)**. ASCOT is a set of questionnaires specifically designed to measure aspects of quality of life that specific social care services may impact upon. They cover a broad range of aspects of quality of life that are relevant and important to people who use social care and their carers (e.g. social relationships, control over daily life, feeling significant, feeling safe, time to yourself, feeling supported). As well as helping service providers understand client experiences, these questionnaires support care planning and quality monitoring and are useful for demonstrating service impact. Other tools to measure outcomes include:

- **ICECAP-O (ICEpop CAPability measure for Older people)** which is free of charge and measures older people’s capability-wellbeing in 5 areas (attachment, security, role, enjoyment and control)
- **Outcomes Stars**, a popular but charged-for tool that is more suited to support key work with individuals
- Health Improvement Network’s (HIN) straightforward **tools to measure outcomes for people with dementia** in a range of support settings (including community groups).

ASCOT and ICECAP-O have been recommended for use in economic evaluations [5].

Measuring staff time needed to support older people attending a day centre is another useful approach to evidencing individual changing needs and for organisational planning purposes. A day centre manager developed a 'time tool' to do this.

Social care is expected to be person-centred. Different understandings of what 'person-centredness' means make monitoring and reporting it difficult. A review of definitions concluded that understanding the person, engagement in decision-making and promoting the care relationship are central to service person-centredness [6]. To 'measure' how person-centred a day centre service is from the perspective of the older people who attend it, two tools may be useful:

- **PERCCI – the Person-centred Community Care Inventory** – a questionnaire with 12 questions about how people feel they are treated, to what extent they are involved in decisions about their care and how well the service addresses individual needs and preferences.

- **Making it Real** includes a set of "I" statements covering various aspects of a person's experiences, designed for broader use within and outside social care.

Loneliness is one aspect of wellbeing that day services may help to reduce. Measuring loneliness is important because feeling lonely can be accompanied by worsening physical and mental health[7]. Recognising that persistent loneliness can harm health, the **Government published a strategy for tackling loneliness in 2018 and has continued its work in this area**. Loneliness can be measured (at different points in time) to discover whether attending a day centre has reduced feelings of loneliness. Several questionnaires do this. They are short and useful for different purposes:

- The **Campaign To End Loneliness Measurement Tool** aims to measure the change that happens as a result of an intervention (e.g. day centre attendance), with a focus on how people's scores change over time. This questionnaire is based on the idea that loneliness is felt when there is a mismatch between the social contact a person has and the social contact they want. Because it was co-designed with older people and service providers, it uses language that is non-intrusive and unlikely to cause any embarrassment or distress and, therefore, may be the most appropriate questionnaire for use in day centres.

- The **loneliness measure recommended in the Government's Loneliness Strategy** is a 4 question scale (including 3 questions from UCLA scale and an additional question) that is widely used and suitable for gathering data that may be compared with data about other services or service user groups.

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[7] See a) Campaign To End Loneliness' page about research https://www.campaigntoendloneliness.org/the-facts-on-loneliness/; b) What Works Centre for Wellbeing in its report A brief guide to measuring loneliness (2019); c) Hol Holt-Lunstad J, Smith TB, Baker M, Harris T, Stephenson D. Loneliness and social isolation as risk factors for mortality: a meta-analytic review. Perspectives on Psychological Science. 2015 Mar;10(2):227-37. https:/doi.org/10.1177/1745691614568352.

- The **de Jong-Gierveld scale** is also widely used.

- Further information about these three tools can be found in Campaign to End Loneliness' guide **Measuring your impact on loneliness in later life** (2015) and What Works Centre for Wellbeing's **A brief guide to measuring loneliness**.

Certain health measures may be of particular interest to people working in health, for example commissioners, occupational therapists, physiotherapists, or GPs.

- The **Timed Up and Go Test (TUG)** is a good indicator of balance and, therefore, **falls risk**, and may be helpful in determining levels of staff support needed in day centres.

- Changes in individual wellbeing could be measured as an indicator of service impact and may be helpful for monitoring purposes. The **Short Warwick Edinburgh Mental Wellbeing Scale (SWEMWBS) (or the Warwick Edinburgh Mental Wellbeing Scale (WEMWBS))** are recommended by the What Works Centre for Wellbeing.

- The **SF-12 or SF-36 health outcomes questionnaires** measure quality of life and functional health and wellbeing from a person's own perspective. They may be better for providing an overall profile of a day centre's service users. However, the latest versions (SF-12v2 or SF36v2) are subject to licence.

- The **Assessment of Quality of Life (AQoL)** measures health-related quality of life in four domains: Independent Living, Relationships, Mental Health and Senses. It may be helpful for profiling older people attending a day centre, as a group, and for evidencing impact (even in a single domain, such as Relationships).

Making records of healthcare service use, suggested by US day service experts [1], may also form part of an approach to evidencing day centre attendance outcomes.

Matters concerning staffing may also form part of a day centre's impact. Staff recruitment and retention are known to be challenging in social care. Day centres may wish to **monitor their staff's job satisfaction**.

While this resource does not cover **Social Return on Investment (SROI)**, readers may wish to read an example of an exercise undertaken on a Peer Support Network for people with dementia signposted here.

Tools, questionnaires or approaches: further information

In this section, further information is given about tools, questionnaires and approaches introduced in the previous section. Hyperlinks to these and further supporting information are provided, and information about use outlined.

Twelve principles for effective personal outcomes-focused recording.

Social Care Wales suggests principles for meaningful and effective outcomes monitoring and provides guidance and practice examples of personal outcomes-focused recording for each of the principles (e.g. case records, reflections).

Friend not foe: supporting meaningful outcomes focused recording in social care in Wales (36 pages) (2022) (see page 10).

Using 'stories' to convey change outcomes

The 'Most Significant Change' technique involves a person (e.g. day centre attender, volunteer) reporting, in their own words, the most significant change that has happened to them as a result of something (e.g. attending or volunteering at the day centre). The 'story' covers the most significant change they have experienced, what happened/where/what or who was involved/when, why it is significant for you/what difference it has made to the person's life, and why this difference it has made for the person is so important.

Detailed guidance and examples: **The 'Most Significant Change' (MSC) Technique. A Guide to Its Use** (2005) by Rick Davies and Jess Dart

Examples appear in ***Magic Moments in adult service provision*** **(numbers 1,6, 7, 20, 33 and 40 are about day services)** developed by Swansea University and Swansea Council in 2016.

More detailed examples of stories that have been written are available in section 4.8 (see **Evidencing impact using individual stories written using the Most Significant Change approach: Knit one, purl one, see my confidence grow My wife – big difference)**. See also **Joan's story** in section 7.7 (Case studies and inspiration).

Social care-related quality of life questionnaire: Adult Social Care Outcomes Toolkit (ASCOT) – for older people attending day centres and their carers

The **Adult Social Care Outcomes Toolkit** is a set of standardised questionnaires specifically designed to measure aspects of quality of life affected by social care services – to understand client experiences, for care planning and quality monitoring. Instead of focusing only on physical or psychological health, ASCOT includes broader aspects of quality of life (e.g. social relationships, control over daily life, feeling significant, feeling safe) that are relevant and important to people who use social care and their carers. These are called 'domains'. Questionnaires can be used to monitor individual progress, demonstrate the impact of a service across a group of people, and for economic evaluations of services (i.e. cost

effectiveness) if unit cost data are available. Scores/results can be shown visually using a spider chart. There are several versions which include questionnaires to be read out to older people/carers (i.e. 'administered in an interview') and questionnaires to be completed by older people attending a day centre or carers themselves:

- **ASCOT INT4** (23 questions for service users), **ASCOT Carer INT4** (21 questions) and **ASCOT-ER (OP)** are designed to be read out in an 'interview'. **ASCOT-ER (OP) is a revised version of ASCOT INT4 which is aimed specifically at older people with or without memory problems.** These versions discover how much the service has impacted on someone. As well as overall benefit, they are helpful for identifying which are the areas (domains) in which people feel they have benefited the most and the least, so can also inform service improvement initiatives. Questionnaires include explanatory notes for the person reading them out and prompts they can use. These versions measure the *current* quality of life and '*expected'* quality of life (i.e. how the person perceives their quality of life would be in the absence of the service). The difference between these scores is the "gain", or the impact of the service on that person's quality of life (expressed numerically). Because of this structure, service users/carers must be able to imagine hypothetical situations. A benefit is that it only needs to be used once to measure service impact. ('ASCOT INT4 four-level interview tool', 'Carer INT4 four-level interview tool or family/friend (unpaid) carers', 'ASCOT Easy Read (Older People)')

- **ASCOT SCT4** (8 questions for service users) and **ASCOT Carer SCT4** (7 questions) can be completed by older people attending a day centre or carers themselves. It can be used once or repeated to monitor change. These versions are currently used in local authority service user surveys. ('ASCOT SCT4 four-level self-completion tool', 'Carer SCT4 four-level self-completion tool or family/friend (unpaid) carers')

ASCOT questionnaires are free of charge by not-for-profit organisations or if to be used for the benefit of the public (e.g. a LA using these for quality monitoring or service improvement). For-profit organisations are required to pay a fee. All will need to complete a registration form (explaining planned use) and agree to Terms and Conditions of use before a license is granted and the questionnaire and guidance for its used provided. Guidance documents include how to calculate scores manually. Data entry tools (i.e. Excel spreadsheets set up to do automatic calculations of scores and graphs – one for each questionnaire) cost £50 and can be downloaded from the website (cost at May 2024).

A 13 minute **video explains how providers can use the ASCOT tools in a 'circle of care' interview.**

Katharine Orellana shared her experiences of using ASCOT (INT4 and INT4 Carers) in day centres for older people in a talk at an ASCOT 10th Anniversary webinar series (October 2022). See **https://www.youtube.com/watch?v=SUDgp1q16Tw** (from minute 21).

An ASCOT care work-related quality-of-life questionnaire is under development (at the time of writing). Day centre staff wellbeing is likely to impact on the quality of service provided, and on outcomes for service users. Therefore, understanding the aspects of quality of life most affected by their work is important. See **www.pssru.ac.uk/ascotforstaff/homepage**.

ICECAP-O (ICEpop CAPability measure for Older people)

The ICECAP-O measures older people's wellbeing in 5 dimensions: Attachment (love and friendship), Security (thinking about the future without concern), Role (doing things that make you feel valued), Enjoyment (enjoyment and pleasure), Control (being independent). The questionnaire is short and easy to complete. Registration is straightforward.

Using ICECAP-O is free for non-commercial users, but users must sign a licensing agreement with the University of Bristol in which they agree not to change the wording of the measure. Scoring coding is provided on the website using STATA and SPSS statistical software. An Excel scoring spreadsheet is available upon request after registration.

The **registration form, questionnaire and scoring system codes** are downloadable from the ICECAP-O web page.

Outcomes Star

The **Outcomes Star** is a charged-for standardised tool in the shape of a star, each leg of which represents different levels of progress towards an outcome area. It is a keywork tool that increases awareness and informs action planning/interventions. Many versions are available including the Older Person's Star (covering Staying as well as you can, Keeping in touch, Feeling positive, Being treated with dignity, Looking after yourself, Feeling safe, and Managing money and personal administration) and the Carers Star (covering Health, The caring role, Managing at home, Time for yourself, How you feel, Finances, and Work). Paper or online versions are available.

An annual licence and training for each staff member using an Outcomes Star is required. Supportive resources are available (action plans, guidance, flashcards etc). Costs start at £250 per annual licence for all published versions, the online version and supportive resources; additional licences cost £40 per person. Training starts at £960 (costs at May 2024).

Measuring outcomes for people with dementia

The Health Improvement Network (HIN) developed a set of easy **tools to measure outcomes for people with dementia** in a range of support settings (including community groups) which may be useful in demonstrating the value of day services to people with dementia (see page 15).

Time Tool spreadsheet to monitor staff time needed to support older people attending a day centre

The Time Tool is a spreadsheet used by a day centre to monitor the frequency of certain occurrences and staff time needed to intervene. This has enabled better understandings of changing needs and was also valuable for self-audit as staff could learn from each other about how best or most efficiently to support clients. It is straightforward and calculations are made automatically behind the scenes. Detailed information about the areas of support monitored, how to use it and its benefits appears **in section 4.8**. The tool is downloadable from the Resources Hub in the **Understanding outcomes and impact section**.

Person-centred related quality of life experience questionnaire: Person-Centred Community Care Inventory (PERCCI)

PERCCI (pronounced 'percy') a short (12 questions), straightforward standardised questionnaire that measures quality of care experiences (e.g. if people feel they are treated with kindness, respect and compassion, are involved in decisions about their care, if care is personalised and responsive to their needs and preferences). It was co-designed with people with lived experience of care services and is based on evidence.

It can also help to demonstrate whether the service/provider is well-led (how it promotes a person-centred culture, if it has a process for continuous quality improvement, if it gathers and acts upon people's experiences of care or if it uses evidence-based processes within the service).

The questionnaire can be downloaded from the website; people wishing to download the questionnaire are asked for their details, how they heard about it and if they are willing to be contacted about their experience of using PERCCI.

Scoring is explained on the PERCCI website. An Excel spreadsheet for entering and storing scores is available on request. Each response is scored 0, 1, 2 or 3 (0 for 'rarely or never' and 3 for 'always') and scores for all 12 questions are added together. Individual scores range from 0-36. Scores can be compared between people (e.g. to identify those with particularly low scores) or for the same people over time (e.g. to see if care experiences are improving).

An **infographic summarises PERCCI**.

Read more about how it was developed in a **presentation given to the Day Centre Research Forum in June 2020**.

Making it Real

Making it Real is a framework built around 6 themes that reflect important parts of personalised care and support. It is for use in and beyond social care services (i.e. in housing, residential care, hospitals, public services) therefore, not all themes may be relevant to day centres. It was co-produced by Think Local Act Personal with input from a range of organisations and individuals.

Each theme has a set of "I" statements about how support is experienced by an individual (e.g. I have considerate support delivered by competent people; I am supported to make decisions by people who see things from my point of view, with concern for what matters to me, my wellbeing and health) and related "We" statements that cover the provider's perspective of what needs to be in place for the "I" statements to happen (e.g. We don't make assumptions about what people can or cannot do and don't limit or restrict people's options).

Campaign to End Loneliness Measurement Tool

A three-question standardised questionnaire that is useful for service providers wanting a short questionnaire that uses positive and sensitively worded language (i.e. written in language which is non-intrusive and unlikely to cause any embarrassment or distress) and is easy to use. It was co-designed with older people and service providers. It is based on the idea that loneliness is felt when there is a mismatch between the social contact a person has and the social contact they want. **Guidance** covers the questionnaire itself and scoring system (pages 11-13), how to introduce it, encouraging staff and volunteers to use it, at what points and how regularly a questionnaire to measure loneliness might be used, how to choose people to use it with (sample), getting consent, asking the questions themselves and making sure enough information is gathered about the people it is used with (see pages 22-29).

National Loneliness Measure (UCLA Loneliness Scale)

The UCLA is the standardised loneliness questionnaire recommended in the Government strategy. It has three questions and is helpful for service providers wanting a short tool that uses a simple scoring system. Although these questions do not mention 'loneliness', they are worded negatively. The Government strategy recommends adding a fourth question that uses the word 'loneliness'. This approach is widely used and, therefore, enables the comparison of data between different types of services or service user groups.

Details and scoring information can be found in **Campaign to End Loneliness' Measuring Your Impact on Loneliness in Later Life** (see page 17-19), in **What Works for Wellbeing's Brief Guide to Measuring Loneliness** (see page 10-11), on the **ONS web page**, and on **What Works for Wellbeing's pages on National Loneliness Measures on its 'Measure Bank'**.

De Jong Giervald Loneliness Scale

A six-question standardised questionnaire developed for researchers. It distinguishes social loneliness (when the number of friendships or relationships someone has is smaller than desired) and emotional loneliness (when someone is missing intimacy from their relationships, friendships or acquaintances) and gives an overall measure of loneliness. Although it does not mention 'loneliness', questions are worded negatively. Details and scoring information can be found in **Campaign to End Loneliness' Measuring Your Impact on Loneliness in Later Life** (see page 14-16), and on **What Works for Wellbeing's pages on National Loneliness Measures on its 'Measure Bank'**.

Timed Up and Go (TUG) Test

The Timed Up and Go Test [7] is a standardised test that assesses mobility, balance, walking ability and falls risk. If repeated at intervals, this test can monitor change; it may be useful, for example, before and after specific programmes of exercise, for example. It may also indicate levels of staff support that a person may need at their day centre (e.g. going to the toilet or moving between activities). The test is simple, quick and requires no special equipment or training; a person is asked to rise from a standard chair, walk to a marker 3 metres (10 feet) away, turn, walk back, and sit down again. They do this while wearing their usual footwear and using their usual mobility equipment, if any (e.g. walking stick, walking frame).

Different approaches are taken to scoring (i.e. being at risk of falling starts at 12 seconds for some, 13.5 seconds for some, or 20 seconds for others). The UK Chartered Institute for Physiotherapy defines a person being at risk of falls if the test takes 15 seconds or more.

The Chartered Institute for Physiotherapy has produced a **video that demonstrates the test**.

Short Warwick Edinburgh Mental Wellbeing Scale (SWEMWBS) and Warwick Edinburgh Mental Wellbeing Scale (WEMWBS)

The Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) is a standardised self-completion questionnaire developed to measure mental wellbeing in the general population and evaluate projects, programmes and policies which aim to improve mental wellbeing. Both ask positively worded questions about feelings and thoughts over the previous 2 weeks. Each has a choice of 5 response categories. The WEMBWS has 14 questions and the SWEMWBS has 7 questions.

Both scales are recommended by the What Works Centre for Wellbeing, with further details in its 'Measures Bank': **WEMWBS** and **SWEMWBS**. **Scoring and interpretation guidance is provided**. The full (and rather complex) **user guide** covers both questionnaires. **Frequently Asked Questions** provide additional useful information about its use. The only drawback to this questionnaire is that it has not been validated for use with people aged 75 and older.

Both scales are free to use (non-commercial use) but users must register for a license.

SF-12 or SF-36 health outcomes

The SF-12 and SF-36 are standardised questionnaires that measure quality of life and functional health and wellbeing from a person's own perspective. They cover physical functioning, bodily pain, limitations due to physical health problems and personal/emotional problems, emotional wellbeing, social functioning, energy/fatigue, general health perceptions, and a perceived change in health. They have 12 and 36 questions respectively.

These questionnaires may help day centres to present information about the health and wellbeing characteristics of older people using their service (as a group of service users) rather than to evidence outcomes and impact (i.e. background information to outcomes/impact data gathered in another way).

Use of the original (outdated) version of SF-36 is subject to a few **Terms & Conditions**, including crediting its development at RAND as part of the Medical Outcomes Study. The **questionnaire (blank printable form; can also be completed online and printed) and scoring instructions (see Table 1-steps 1&2) are downloadable** from RAND's website.

Use of the most up-to-date versions (SF-12v2 or SF36v2) require a license (3-page form more suited to academic research than local monitoring of service users' characteristics). See **further information about these and the licences required.**

AQoL (Assessment of Quality of Life)

Several versions of the AQoL standardised questionnaire measure health-related quality of life. The shortest is **AQoL-4D** which has 12 questions covering four domains: Independent Living (self-care, household tasks, mobility), Relationships (friendships, isolation, family role), Mental Health (sleeping, worrying, pain) and Senses (seeing, hearing, communication).

The AQoL may be useful for presenting health information about older people attending a day centre (as a group of service users as background information to outcomes/impact data gathered in another way) as well as a means of evidencing outcomes and impact. A single score is calculated, or the score for each domain may be reported separately (e.g. Relationships) and the measure repeated at intervals to evidence any change.

Scoring assigned to each question differs according to whether the questionnaire is being used as a 'psychometric' measure (i.e. to get scores on health-related quality of life that can be used as a single score or separately by domain) or as a 'utility' measure (i.e. to be used in economic evaluations). Psychometric scores are more straightforward (e.g. 1-5 for each of 5 answer options). Utility scores are 'preference weighted' (i.e. reflect preferences more accurately than unweighted scores).

The **analysis spreadsheet to calculate Psychometric (unweighted) scores** is downloadable (see Step 1). A **Zip Folder of SPSS and STATA documents to calculate Utility scores is downloadable from the web**. Use is free, but users must **register**. Registration means that technical support can be provided.

Healthcare use records

In their call for the development of a set of uniform set of outcomes measures to be used in US day services, Anderson and colleagues [1] reported that simple records of healthcare use have been recommended as useful for evidencing impact. For example, records may include numbers of hospital admissions, numbers of Accident and Emergency visits, numbers of prescribed medications, or numbers of GP consultations or NHS professional home visits.

Monitoring job satisfaction

What Works Centre for Wellbeing has developed a Workplace wellbeing question bank. One measure is of job satisfaction in terms of worker wellbeing. Seven response options range from 'Completely dissatisfied' to 'Completely satisfied'. The **question and response options** can be found on the Measures Bank.

As a single question, it is easy to interpret.

A longer, 10-question version, the **Worker wellbeing snapshot survey** is also available.

Social Return on Investment (SROI)

SROI aims to measure the wider (social and environmental as well as economic) value of a service (or organisation). It uses financial calculations to indicate the ratio of input cost to wider value created (e.g. for every pound spent, the service achieved a return of £x in social value). The scope of this resource for day centres and their stakeholders does not include SROI, but readers may wish to read an example of an **SROI study undertaken by the Health Improvement Network on Peer Support for People with Dementia**

4.8 Some local examples

Study participants have shared some examples developed locally and given permission for these to be downloaded and edited to suit local circumstances.

- A short event evaluation form that uses smiley faces and open questions
- A short evaluation form of a project, event or workshop
- A telephone survey carried out by keyworkers at Central Hill Day Service (London Borough of Lambeth) with carers of older people using the service to collect their opinions and preferences (includes instructions for keyworkers)
- Evidencing impact: Two examples of individual stories written using the Most Significant Change approach: Knit one, purl one, see my confidence grow and My wife – big difference.
- Introduction of an Excel 'Time Tool' to monitor time needed by staff to support people and to prompt reflection about support techniques

Short event evaluation form that uses smiley faces

[downloadable in Word format]

[Name of organisation]
[Event e.g. workshops]

ADDRESS

	NAME		OVER 50	
	DATE		SEX	

1. MARK HOW THE PARTICIPANT FEELS ABOUT THE [EVENT] 1=LOW, 10=HIGH:



D


1	2	3	4	5	6	7	8	9	10

2. Did the workshops improve your health and wellbeing?

3. If yes how?

4. BENEFIT OF WORKSHOP IN GENERAL?

Short event/project/workshop evaluation form

[downloadable in Word format]

[Name of organisation and project/event]

LOCATION:

NAME: SEX: DATE: OVER 50

please tick one box - yes, no, or not sure		YES	NO	NOT SURE
Was this workshop an enjoyable experience?				
Did the workshop help you overcome lockdown?				
Did coming to the workshop reduce isolation?				
Did you find people in the workshop friendly?				
Did the workshop make you feel part of the community?				
Did you feel included in the activities?				

Did workshop improve your health and wellbeing?			

If yes, how did is improve your health and wellbeing

DID YOU EXPERIENCE ANY OF THE 5 STEPS TO WELLBEING? Please tick: A. Connect B. Being active C. Learning D. Give to others E. Mindfulness

Any particular benefits that the workshop provided for you?

Telephone survey carried out by day centre keyworkers with carers of older people using the service (Central Hill Day Service, London Borough of Lambeth)

[downloadable in Word format]

Collecting carers opinions and preferences

INSTRUCTIONS FOR KEYWORKERS

Please call the carers of the people you keywork. All the information needs to be returned to [manager] by [date].

Have a quick friendly chat to put the person at ease. Ask them if this is a good time to have a quick chat with them – **you will tell them you need about 15 minutes of their time and have 5 key questions for them. Tell them this is in confidence and totally anonymous, so please do be frank.**

There are 2 questions about their preferences which obviously we do need to identify them for.

Tell them You may have responded to our last survey. (The questions are the same). If you did, I will take you straight to your preferences

If **no**, they are too busy with something else, ask them when a good time is to call them and try to keep this time.

If **yes,** they are free, go on to say the following:

Thank you. Your input is important to us.

As you know we have been able to open in August 2020 and remain open throughout this last lock down.

We want to make sure we are getting things right and need your opinions and preferences.

Q1. Before Covid-19: Please rate the quality of contact you received from [name of day centre].

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Disappointing Exceptional

If disappointing, please ask them for a comment

Q2. During Covid-19 lockdowns: Please rate the quality of contact you are receiving from Central Hill.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Disappointing Exceptional

If disappointing, please ask them for a comment

Q3. Please rate the quality of contact you receive from [name of day centre].

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Disappointing Exceptional

If disappointing, please ask them for a comment

Q4. Please rate how confident you are in your loved one coming to [name of day centre]

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Feel unsure OK Happy Totally happy More than happy

If unsure, please ask them for a comment

Q5. Please rate your overall satisfaction with the service we offer.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Disappointing Exceptional

If disappointing, please ask them for a comment

Preference 1. How often do you wish to be contacted about (Name of their loved one here)

Just delete the ones they do not choose before you send it to me

1. At the end of the day
2. Once a week
3. Once a fortnight
4. Only if there is an issue

Preference 2

We want to set up a way to pay for lunches which does not include collecting cash.

We want to start a TOKEN system where you pay for a set number of lunches up front. Your tokens will only be used if your loved one attends and has lunch.

We cannot accept cash for the tokens, and we cannot take a credit card.

Are you able to pay be cheque?

Y N

If you do not have a cheque book, can you order one from your bank?

Y N

Can someone send a cheque in on your behalf, and you pay them?

Y N

Evidencing impact using individual stories written using the Most Significant Change approach: Knit one, purl one, see my confidence grow My wife – big difference

The 'Most Significant Change' technique involves a person (e.g. day centre attender, volunteer) reporting, in their own words, the most significant change that has happened to them as a result of something (e.g. attending or volunteering at the day centre). The 'story' covers the most significant change they have experienced, what happened/where/what or who was involved/when, why it is significant for you/what difference it has made to the person's life, and why this difference it has made for the person is so important.

Detailed guidance and examples can be found in **The 'Most Significant Change' (MSC) Technique. A Guide to Its Use** (2005) by Rick Davies and Jess Dart

Examples appear in **Magic Moments in adult service provision (numbers 1,6, 7, 20, 33 and 40 are about day services)** developed by Swansea University and Swansea Council in 2016.

Below are two detailed examples of stories. Permission has been given for these to be used to training and development purposes.

(See also **Joan's Story** in section 7.7)

Knit one, purl one, see my confidence grow

Background to my story

I am an older person who attend a 'knit and natter' group in a local library in South Pembrokeshire every Tuesday

What changes have happened

- My confidence has increased
- I walk to the library instead of taking the car
- I really look forward to the weekly sessions, the chatter, tea and biscuits
- I love to share patterns, ideas and skills
- My knitting has improved
- I am helping others by knitting '**chip shop baby**' sweaters and hats

Which of these changes are most significant to me?

Regaining my confidence and courage. It took a lot of courage for me to join the group. I felt I may be seen as stupid if I couldn't knit what the group were all knitting. I hadn't knitted for 15 years as my children and grandchildren didn't need anything knitted. I was nervous – could I fit in?

What it was like before

I have always relied on my husband's company since we retired. I think I was getting to feel that I couldn't do things on my own anymore. I was apprehensive about going out on my own. I didn't think people would have anything to say to me.

What it is like now

The 'knit and natter' sessions allow me time for myself. They have increased my confidence and I love knitting once more. I have something to look forward to! I am also looking out for ideas to share with the group. I also share what I have been doing with my family. Last weekend, when my son called, we were watching a TV programme on Africa and as he moved closer to the TV, I asked him why? He said "I am looking for the 'chip shop baby' jumper you knitted" We all laughed!

What happened to make the changes come about

The volunteer who leads the knitting sessions allows us to be ourselves and the sessions are very much about enjoying our time together. She suggests things for us to knit, so we can choose what to do. I have found my long-lost knitting skills and now really look forward to our Tuesday morning get-togethers over a cup of tea and a biscuit.

I have also shared my concerns about my recent bout of pneumonia. Before, I was worried that the doctor had said that my lungs had been affected by the condition, but my fellow knitters have reassured me. I am not so worried now.

My wife - big difference

Background

Arthur and his family are involved in the work of ACE Ely Caerau, an asset-based community development organisation based in Cardiff. They co-ordinate a range of projects, one of which is a community shop. Arthur's wife became involved in the shop.

What changed

"My life has completely changed. For 25 years I've been by myself even though I was in a partnership. My wife wouldn't go out. I was like a carer. I cooked and did the shopping, now she is able to come with me."

What it was like before

"We used to go out at 2.00 in the morning, down to the Knap or to Porthcawl. She would run along the beach and into the sea. She would then get out, get dried and dressed and we would go home. If there was nobody around, then she was fine. We would go shopping at 2.00 in the morning, as soon as it started filling up she was gone. We went to Tesco one day at 1.00 in the morning, she sent me off for something, when I came back she had left the trolley and had gone. She had the money and everything. I had to get the assistant to help look for her, but she wasn't there. I headed home and found her there with my two daughters. I then had to go back to the shop and pay for the shopping. She couldn't even answer the door."

What caused the change

"My daughter had the idea of the community shop and took mum along to see the room. It was a really small room. She needed someone to run it. Mum took to the idea straight away, she was in her element because it was like being in a cupboard. She wanted pictures up on the wall. One day a lady came in and asked to buy the pictures but she said "You can't, that's my window". She now runs the shop 4 days a week."

What it was like after

"For me the most significant change was my wife, big difference, it's been hard. I'm from a big family, my niece got married but she couldn't come. My family were asking why. Fantastic, unbelievable, she is a different person. They run a knitting club now, they run the Retreat group on a Thursday, she goes out with the women, gets on a mini bus and goes, goes out for meals. It's unbelievable, I've got time for my garden and my dogs. I don't worry now. I still cook and shop but she can come with me now and we can go during the day, she isn't stuck in the house anymore. We get on like a house on fire. She is phenomenal."

Why this is the most significant change:

> "I got my relationship with my wife back."

Introduction of an Excel 'Time Tool' to monitor time needed by staff to support people and to prompt reflection about support techniques

An Excel 'Time Tool' to monitor time requirements for individuals' and whole-group support needs was developed by the manager of a local authority (LA) day centre for people with dementia.

The manager of a local authority day centre for people with dementia, Esther Wiskerke, developed a spreadsheet to monitor the frequency of certain occurrences (e.g. individual behavioural, mobility or personal care related support needs), and the staff time needed to support people at these times. The Time Tool aimed to help monitor a person's changing needs for support and overall group needs. It was also useful for sharing expertise between staff and for self-audit. The tool was intended as a positive monitoring exercise - to support staff, improve personalised support and support care plan reviews.

Rough timings were entered into the tool retrospectively in whole group staff meetings. Each client was discussed in turn. How long was spent supporting them (to do different things)? Was the day centre still appropriate for them? The staff team then reflected on support timing differences and learnt from each other how best and most efficiently to support clients in certain situations. For example: if one staff member said it took them five minutes to support a certain person to use the toilet, and another commented that it took them 20 minutes, discussion would follow about what method each had used. Care plans were sometimes amended accordingly.

Background

Although day centre clients are part of a group, they can expect a certain level of individual input from staff during their day at the centre. Some people will need exclusive individual support with some tasks to ensure that they are not at risk of harming themselves or others. The Time Tool addresses this.

The following were measured: time taken by certain 'events', the number of times these would happen (frequency), staff time taken in intervening (minutes) and numbers of staff needed to intervene. These would lead to a number and time that could be logged to review progress. Support needs were divided into categories, such as mobility and nutrition. Frequency and length of staff intervention time for certain 'events' were noted based on clients' behaviours and needs, and the number of intervention minutes totalled. This enabled progress monitoring /intervention needed at individual level.

Examples

Behaviour: If, in the beginning, before a client had settled in, they needed help to feel calm, measures of this would be recorded on the behaviour category. For instance, 10 times, 2 and a half minutes each time, two staff (25 minutes per staff member, 50 minutes in total). Over time, once they had settled in, this might reduce significantly.

Personal care*:* Somebody not needing help to use the toilet would have no measure recorded on the tool. With time, they might need to be signposted to the toilets or need prompting or help with handwashing. Later, they may need to be discouraged from putting inappropriate things into the toilet. Eventually, full personal care assistance may be necessary (e.g. incontinence pad changes).

Mobility: A client may ask where they need to go and be able to go there without assistance. If they are at risk of falls, or require supervision or assistance to move around, then these would be examples of increased staff intervention.

Nutrition: If a client can eat and drink independently, even with modified diet or equipment such as a non-spill cup, they would not have any measures recorded on the Tool. If clients need prompting to drink enough, assistance with eating, or supervision to ensure they do not take food from others, then time measurements reflecting the need to provide one to one support would be included in the Tool.

Outcomes of using the Time Tool

- **Benefits for clients:** Better understanding of changing needs and the time and methods necessary to support them. Staff sharing tips may lead to improved personalised support. Regular reviews of needs, sometimes leading to care plan changes, would ensure their needs are recognised, met and accounted for. More focus on actual practical support time needed means that clients would not be excluded from the service on specific individual criteria, such as whether they are able to weight-bear.
- **Benefits for relatives**: Provides non-judgemental evidence supporting decisions about whether the service continues to be appropriate for individual clients. Providing non-emotive descriptions of time intensity required to support their relative can be less painful for carers to hear than details of 'inappropriate' behaviours (e.g. undressing, faeces-smearing). It may be helpful for carers to be given clear explanations of Time Tool evidence, and how it was arrived at. This could help illustrate how their family member has been treated as an individual and not compared with other clients and may alleviate any concerns they may have.
- **Benefits for staff**: Staff felt that identifying specific individual support challenges helped them feel validated because the challenges they faced on a daily basis were evidenced. The tool was also useful for service self-audit – e.g. team meetings identified how much time staff spent supporting people with the same tasks – shared tips etc. Reflective discussions at meetings were reportedly experienced as refreshing.
- **Benefits for manager/service**: Gaining clarity on the complex behavioural and psychological symptoms as clients' dementia progresses and the effect this has on pressure felt by staff and on staffing levels. Additional way to review care plans and monitor clients' needs.

Notes on use of the Time Tool

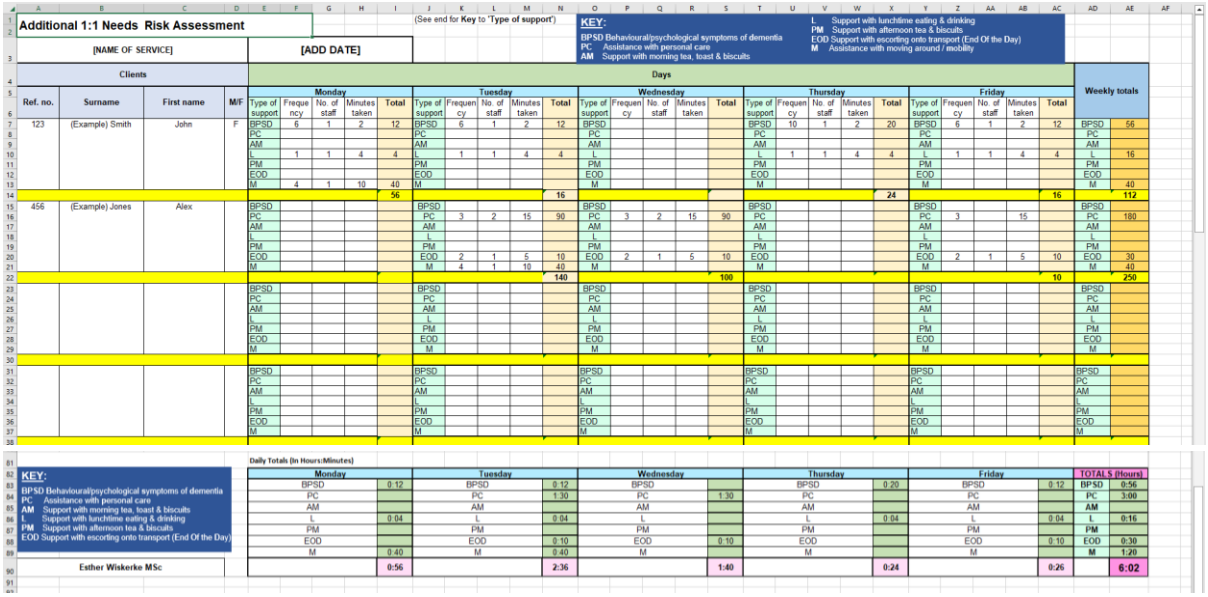
The Time Tool is intended to be used at intervals, to monitor a person's support needs. For example, every month or 6 weeks. Staff groups would then discuss individual support needs and any differences across time.

Two example lines have been completed to demonstrate how to input. A screenshot appears at the foot of this page.

- Spreadsheet users input to white cells only (name, m/f, frequency of support, number of staff needed and minutes taken).
- Figures in coloured cells are calculated automatically.
- Figures in the final daily totals section are calculated automatically (minutes of support in each category and in total).
- One row is provided for each area of support required.
- The key to areas being monitored appears at the top and bottom:

BPSD	**B**ehavioural/**p**sychological **s**ymptoms of **d**ementia
PC	Assistance with **p**ersonal **c**are
AM	Support with morning (**am**) tea, toast & biscuits
L	Support with **l**unchtime eating & drinking
PM	Support with afternoon (**pm**) tea & biscuits
EOD	Support with escorting onto transport (**E**nd **O**f the **D**ay)
M	Assistance with **m**oving around / **m**obility

Below is a screenshot of the Time Tool which can be downloaded as an Excel spreadsheet from the **Understanding outcomes and impact section of the Resources Hub**.



5. A guide to marketing communications

This section explains marketing communications, why it is important for day centres to carry out marketing communications and who their potential audiences might be. It suggests ways that day centres can communicate and share information about themselves and the communication routes that might help them to do that.

Case studies and examples are given throughout, some of which are downloadable as separate documents.

Further resources are signposted to.

5.1 A brief introduction to the importance of marketing communications

Marketing includes a broad range of activities, including communicating and building and maintaining relationships. These all contribute to securing the sustainability of your organisation. Marketing does not only mean selling. It is also about communicating value (i.e. quality of service), establishing credibility and nurturing relationships. Marketing communications involves making conscious efforts to share information and keep in touch.

Aims include increasing awareness of your day centre, what it has to offer and to spark interest in it. Ensuring your service is known about is key for sustainability. Awareness-raising aims to result in new relationships, often broadly directed at the general public or, more directly, at others who work in a similar field. This awareness raising tells people that the day centre exists and about the services provided.

A further aim is to build relationships with groups of people or organisations who are already in touch with your organisation by keeping them informed. It may be volunteers, unpaid carers of people who attend the day centre, commissioners and other funders, or local organisations with whom you have worked (e.g. community groups or companies involved in corporate volunteering schemes).

Madeline Powell and Stephen Osborne have studied day centres for adults with disabilities that are run as social enterprise[a] organisations. They asked day centres about their views of "marketing", how marketing was undertaken and how successful efforts were. They discovered that "building long term relationships rather than focusing on short term transactions is important for public services and is critical for fundraising." [91]

Marketing communications is not only about formal communication routes. Informal communication outside a service is part of marketing communications. This means that staff and volunteers who make phone calls to carers or speak with a visiting professional, for example, are involved in marketing communications.

5.2 Who are potential audiences for day centres' marketing communications?

Knowing your audience is crucial for marketing communications work and the potential audience for day centres is very varied. Audiences are also important "stakeholders" in your organisation.

Day centres will want to make efforts to engage with:

- Older people who are looking for some support, care or social contact and activities during the day
- Family members or carers who might be considering the use of a day centre for the person they support
- Students or trainees looking for a placement in a day centre to broaden their work experience (e.g. social work, occupational therapy or medical university students, or health and social care college students)
- Job seekers
- Potential volunteers
- Donors, grant-making and other funders, or organisations who can help with funding, or where a contract is already in place
- People putting together or updating directories about local services (e.g. organisations contracted by a local authority (LA) to do this as part of the LA duty to make information available)

- Local community and other organisations that want to work with the day centre somehow (e.g. organising employee volunteering, donating money, gifts or items as prizes, local schools interested in intergenerational working, organising information visits)

- People working in roles who might make referrals or signpost to day centres (e.g. carer support organisations, Admiral Nurses, community nurses, occupational therapy, social services, social prescribers/link workers/care coordinators[b] or others based in GP surgeries or in community organisations)

- Local councillors with influential decision-making roles about funding or choosing or reviewing committee members (e.g. Overview and Scrutiny Committee,[c] Healthwatch[d]).

> **Certain groups may need more of an introduction to day centres. They might have preconceived ideas about what a day centre is and does. Others might have had previous experience (good and bad) which influences their views of day centres. Hearsay may have informed some people's views.**

Good marketing communications can help inform the GPs, link workers and other health and social care professionals who are "social prescribers". Social prescribing is a new profession and not all workers will be familiar with day centres. They can refer people who have non-clinical needs to services (e.g. day centres) to support the person's health and wellbeing but they should be properly informed, and your marketing communications are an important part of this.

Some people may know of people who attended a day centre and who did not have a good experience. Some people assume that a day centre involves sitting on chairs around the edges of a room all day with the television on. Others may know day centre volunteers or have heard of people who have benefited from a family member going to a day centre.

A widespread old-fashioned view of day centres makes it important for your communications to be informative and to illustrate that attending a day centre can be interesting and attractive, with activities that are appropriate for a range of people.

5.3 Where and how can day centres undertake marketing communications?

Places and formats for undertaking marketing communications are many and varied. They include websites, social media, printed materials, local radio stations and newsletters. They can also include face to face events, meetings, videos, photos and sharing individual stories. A short piece about each of these now follows. Some examples are included, and more are signposted to.

Marketing communications can also be undertaken through blogs, podcasts, exhibitions and networks.

More about these (and the formats covered in this section of our resources) can be found in can be found in **King's Improvement Science's publication 'Communication: a practical resource'**.[e]

> **Websites are an increasingly important source of information for many individuals and professionals. For some, websites are a first point of call.**

However, online information about day centres [92] and information for carers on local authority websites [93, 94] is very variable in detail and quality. It is important to ensure that information is available online, and that information is accessible and inclusive. This contributes to respecting and protecting the rights of people with disabilities, including people living with dementia and their carers [95]. Although many older people do not use the internet, the Covid-19 pandemic has improved digital access for many older people [96].

Day centre providers may have their own website, or pages on an organisational website. Day centre providers may choose to make information available on other websites hosting directories of services; these may cover whole areas, selected, boroughs, smaller areas, or may be themed by groups of people (e.g. carers, people living with dementia, minority ethnic groups). Often, the service provider will be responsible for providing information and for updating this from time to time. Keeping the information reliable and up to date can be challenging but it is important, and it is worth checking how this will be done. There may be an online form to submit this information.

Example: Social prescribing websites (directories of services and activities)

Lewisham Wellbeing Map and **Lambeth's MYcommunityDirectory** are part of these boroughs' social prescribing initiative.

Social Prescribing London was created in 2021 to support the Mayor of London's vision for every Londoner to have access to a social prescription. From the **signposting home page**, there are searching options for **'activities & services'** or **'organisations'**. Although a searchable service category is 'day centres', few are listed.

Example: CarePlace London-wide service directory

CarePlace is commissioned by Commissioning Alliance (which supports LAs). It aims to be London's centralised source for care and community services, information and guidance. Service providers can advertise their services and include links to their own websites free of charge.

> **Social media is any online service or website that allows content to be created and shared, and connections and interactions made within virtual communities or networks.**

These include X (formerly known as Twitter), Facebook, Instagram, TikTok and WhatsApp (which is a more restricted platform for messaging). Some of these are linked (e.g. Instagram and Facebook). Some allow static content, such as news, announcements, or photos. Some also allow "stories"; these are short videos or a series of images with text.

Social media is a cost-effective way to build relationships with multiple stakeholders. Using social media helps give a "personality" to a day centre and can help foster relationships. It can be used for awareness-raising, highlighting events or notable achievements. It is effective for telling stories and it helps generate positive word of mouth messages. It can be used to support and engage people in the community, such as for virtual support groups or lunch sessions.

Although many service users do not use social media, it is a key tool for marketing communications. It accepts text, links to other materials, and photos or videos can be uploaded. Users can 'follow' an account so that they are alerted when new material is posted.

Public-facing social media (e.g. X - formerly known as Twitter, Facebook, Instagram, TikTok) is useful for providing general information, showcasing recent and upcoming events, and highlighting notable achievements. This raises awareness of a service for service users, their carers and the broader community. It enables funders and donors to have an idea of general

activity and progress, or to find out more before investing. Accounts on these platforms may be made publicly accessible for all; this is useful for public-facing marketing communications. Alternatively, an account can select its membership, with requests to join a group needing approval; this may be useful for communicating with existing networks of people, such as relatives of service users.

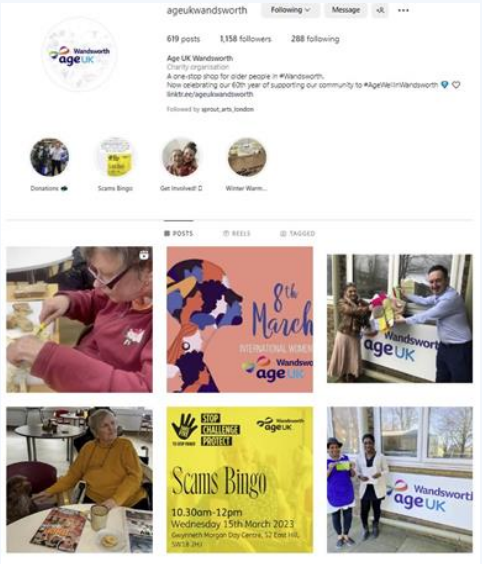
Restricted access social media (e.g. WhatsApp), whereby people need to receive an invitation to join a group, may be used for smaller and more defined groups. A group may be used for supporting and managing volunteers, or for keeping groups of people in contact virtually when meeting may be difficult, for example.

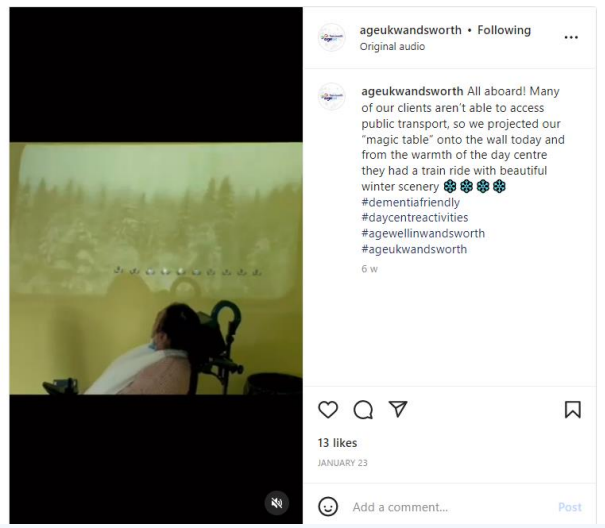
Read about how Bring Me Sunshine uses social media.

This case study example also covers challenges around using social media (e.g. boundaries, security, expertise, moderation procedures, data protection) and shares details of its own public-facing Facebook and Twitter accounts.

Example: Age UK Wandsworth's Instagram

Age UK Wandsworth also makes good use of Instagram to bring alive day centre experiences. Many of the photos and video clips showcased are of activities – manicures, dancing, fairground games, balloon tennis, static bikes and use of a magic table to project moving scenery (showcased in a video – below right).





A **presentation to the Day Centre Research Forum by Madeline Powell** in June 2020 covered the following social media tips:

Boosting your Social Media Presence

Identify what the objectives of your social media strategy are

- Engaging and creating awareness in the local community?
- Boost donations?
- Volunteer recruitment?

50% adults with disabilities have used social media in the last 4 months (ONS, 2019).

- Opportunity to penetrate service user networks.
- Helps to create a safe online forum for service users.

Speak with your volunteers

- Why do they volunteer with you?
- Will help you establish how your day service is viewed externally.
- Is this how you want to be viewed? i.e. your "personality"?

Remember

- You don't need to be on every single social media platform.
- Instagram and Facebook are linked.
- You need to try to post at least once a day.
- Be creative with hashtags to further your reach.

Creating a personality on social media

Create a story narrative

- Post pictures/YouTube videos which portray a story of your service users.
- Engage parents of service users.
- How have your service users flourished since being at your day centre?
- Be as visual as you can.

Post daily updates

- What have your service users done?
- Have you engaged in any activities which have benefited the local community?
- Any positive reviews you could post?

Spotlights on your volunteers

- Helps reaffirm internal marketing
- Potential to act as part-time marketers.
- Makes volunteers feel valued.
- Contributes to the personality you are portraying on social media.

Engage the local community

- Join or follow local community groups and post in them.
- Establish as a community asset.
- Helps to foster a sense of community ownership.
- Political support.

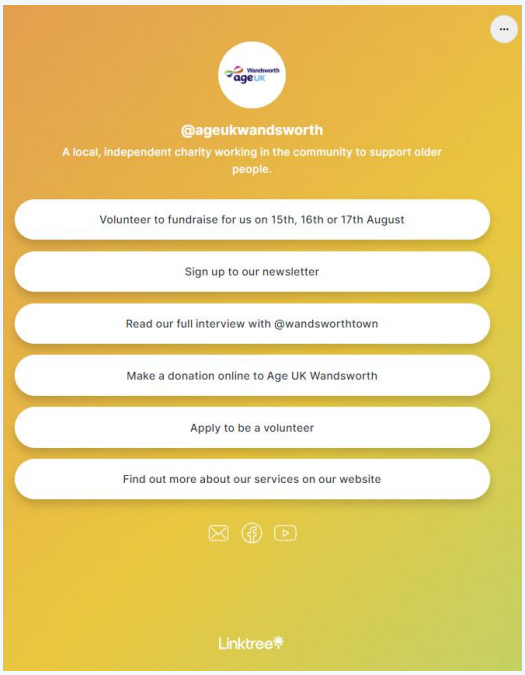
Engage and follow local business:

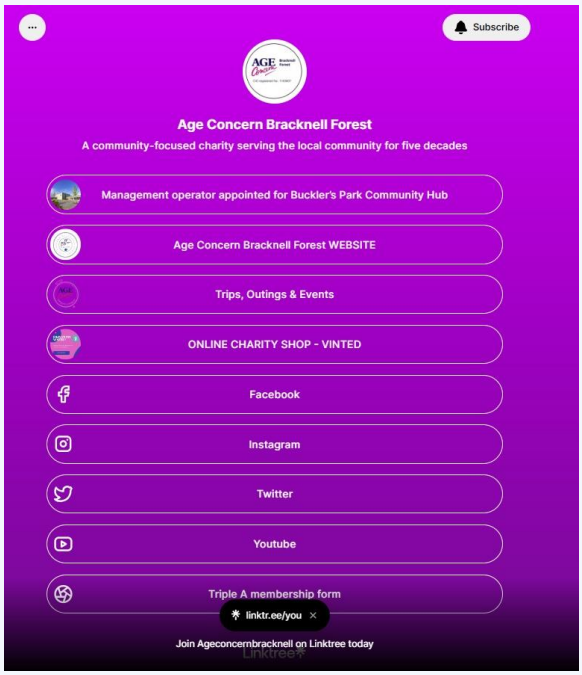
- Potential donors if you run an appeal.

> **Linktree is a simple social media "landing page". It allows users to create a personalised/customisable page of links they wish to share with their audience and descriptive text for these.**

Its basic version is free of charge. A link to the page (the url) can be included in various places to guide visitors to other materials (e.g. in the descriptive text in Instagram or organisational details in Facebook). Visitors can "subscribe" to receive notifications of new content – such as publicity about upcoming events (e.g. open days).

Example: Age UK Wandsworth's and Age Concern Bracknell Forest's Linktree





> **Radio publicity and articles in free newspapers may reach people who are difficult to make contact with inperson, for example people who do not often leave their homes.**

Example: Day centre advert on local radio

The Devonshire Dementia Day Centre built a relationship with a local radio station and recorded a short advert that is regularly played. It is very simple and states that there is a care home and a day centre that specialises in caring for people available for carers who need a break.

> **Leaflets have long-since been used to reach people visiting places such as libraries, GP surgeries, supermarkets, or public buildings.**

They are useful for people who do not use technology. Leaflets can showcase highlights of a service and include individual testimonials and photos as well providing important details about times, location and a contact telephone number.

Some people feel that printed information is more trustworthy than verbal recommendations. A day centre attender we spoke with during the development of these resources said:

My sister already came to the club and was telling me all about it. (...) I think a leaflet would have been more helpful, and I might have come sooner. Because it's sort of like saying things on paper, and by word of mouth, they might say things that are not happening. And if you have a leaflet that you know exactly what's going on.

See Devonshire Dementia Day Centre's printed leaflet

Its front cover states clearly that the leaflet is about that day centre, shows a photograph of someone being helped to do an activity underneath which is the text 'every day is special, come and see why...'. Various of the available activities and what is available feature on a colourful border. The rest of the leaflet includes brief information about the day centre's facilities, contact information, 'what we do', 'our dementia model', 'our services', the daily programme, hours of operation, fees and 'why choose us?'

Leaflets summarising research about day centres may reassure older people and carers and encourage them to try a day centre.

See the two-page information sheet developed for the Resources Hub: *Day centres for older people: what do people say about them?* in section 3.6

It summarises some of the main messages coming from six recent UK research studies and illustrates these with quotes from some of the older people and family carers interviewed for these studies. It can be **downloaded from the website**.

Newsletters keep your contacts informed and are a good way to reach new people and organisations.

Newsletters help keep people you are already in contact with (e.g. regular clients, their family members or volunteers) informed about the organisation, events, news and announcements.

Newsletters are also a good way to reach new people who may be interested in using the service or who would like to introduce a family member to it.

Local community organisations and funders may also be interested in keeping up to date via a newsletter. Some day centres produce monthly or quarterly newsletters.

Some newsletters are printed, while others are electronic (email or website-based). An advantage to making newsletters available on a website is that any interested person or organisation who has searched and found the service website can read about the service, important news and have contact details. It is a good idea to include an option on the website to "subscribe" or "sign up" to the newsletter, so that someone can choose to receive it by email when issued. Some older people may prefer to receive paper copies.

Example: Devonshire Dementia Day Centre's monthly newsletter

This four-page newsletter covers news from the day centre and adjoining care home. Short summaries of events (sometimes just one sentence) and news are in a large font size. Plenty of photographs of people are accompanied by quotations about these. The newsletter is an excellent opportunity to advertise the service and its benefits by using testimonials. Extracts here are from November 2022 and January 2024.

EVERY DAY IS SPECIAL, COME AND SEE WHY

Why families choose us...

- Day Guests can enjoy a fun day out with music, exercise, hot lunch, reminiscing, activities & afternoon tea and experience moments of joy throughout the day
- Loved one comes back home calmer & settled
- Family carer has a well-deserved, guilt free day off
- We offer this exclusive service 5-7 days a week, from 9am to 5pm daily for a minimum of four hours; an 8am drop off can be arranged.

Share the care with a brand new chapter.
FREE Helpline: 0208 949 0818.

What one of our Day Guests said:

Dear Devonshire Dementia Day Centre, I am writing to you as I would like you to know that since Mum has been attending your day centre, her mood and behaviour have improved greatly. She seems to be a lot happier and calmer when she returns home. Even her sense of humour seems to be returning and it is nice to see her smile again. If she is having a bad day at home, it does not last long and it's made both mine and my husband's role as carers a lot easier. It also gives us some respite time to recharge our batteries so we can continue with our carers' roles. Thank you and kind regards Mrs. Christine McGoldryck

WE'RE HERE TO SHARE THE CARE

To family carers: we appreciate how difficult things can get & our concerns are just as much about you as they are about the person living with dementia. It is imperative (long term) for at home family carers to build your team with the best interests of everyone's wellbeing. This is sometimes difficult to do. Start slow, come to our free singing group, get to know us, enjoy the relaxed joy and snacks and attend a day out at the Day Centre. From our compassionate care staff & carefully designed vintage-themed rooms to music therapy, afternoon tea & tranquil gardens, we hope to share the care in 2024 as we provide moments of magic & spark reminiscence. Our Day Centre offers a safe & secure environment that promotes independence & social interaction during dementia friendly and purposeful specialist activities. We provide pick up & drop off and are open Mon-Fri 9am-5pm. We are here to chat, explore, consider & suggest alternatives as we continue to share the care.

Call Smith or Donna on 0208 949 0818 to register your interest.

***"It was a pleasure to see the new dementia care facility. Very well designed & thought out, which made the visitors very happy"* – Kim Bailley.**

Some electronic newsletters are Adobe Acrobat (pdfs) and some on e-libraries, such as **Scribd**, as well as being downloadable as a pdf.

Example: Staywell's monthly newsletter on Scribd

Readers can scroll through the newsletter on Scribd or download a pdf. **Staywell's Scribd page** includes Annual Reports (impact reports) as well as its various different types of newsletters.

Tip:

Including links to online newsletters and social media sites in automatic email footers can broaden awareness of a service.

In-person events and in-person input.

In-person events may include having a stall at a local community summer fayre or holding an open day.

In-person input (to external bodies) may include attending a local social services or NHS staff meeting or community group to speak briefly about the service (i.e. being actively engaged with the local community and social care and NHS communities). It can also be a good way to recruit volunteers whilst raising awareness of the service.

A staff member of a provider we spoke to about the development of these resources felt that an open day is a secure way of helping the public to have a better understanding of what goes on in a service and who uses it. It also helps members of the public to feel it is a friendly space and a community asset. She felt this is necessary because *'most day centres that I've seen, they are friendly inside, but it is kind of a fortress, you know, with big walls around it.'*

Example: Annual open day on forecourt

Merton and Morden Guild, a voluntary activity day centre in the London Borough of Merton, organises an annual open day on the building's forecourt to raise awareness of its existence. The day, which is attended by the Mayor, includes demonstrations (tap dancing, music, exercise, line dancing), a buffet lunch and other fun activities. People – who may be passing by on their way to do shopping - stop and see what is happening.

The organiser told us: "*Not everybody has a forecourt. I do make it sound terribly grand. It's just a bit of tarmac out the front, but it's our bit of tarmac.*"

Example: Annual International Day for Older Persons activities and partnership with supermarkets

Merton and Morden Guild, in partnership with the LA and the NHS is involved in celebrations for the International Day of Older Persons – usually known as 'Older People's Day' – which is on 1st October every year. Celebrations take place in the nearby Sainsbury's Savacentre Superstore. M&MG organises demonstrations by people who attend its exercise classes. Music is played. Other organisations are also involved (e.g. Age UK). The NHS provides blood pressure testing amongst other things.

Photos and videos can help people to visualise a service and build confidence and trust. It is often said that a picture is worth a thousand words.

Photos and videos will be useful for people considering starting to attend a day centre, their relatives and any professionals speaking to someone about starting to attend a day centre as an option.

Photos might be of people engaged in activities or chatting, of outings or of day centre rooms. A day centre manager we spoke with during the development of these resources said that photos are good "*to show people are engaged, and that it's not a big, scary, cold day centre*".

A short video can also be a good introduction to a day centre. Day centres may wish to make a brief video that explains what to expect. It might show groups of people, or one or two people talking about what it's like to go there. A manager might explain the benefits, or a social worker (for example) can explain why it's useful to be able to refer someone to a day centre and the difference attending can make to people's lives.

'What to expect when you come here' may cover transport arrangements, how long the day lasts, lunch and refreshments, some of the group activities that are organised, but that people can also do their own thing if they prefer, and who will be supporting them when they are there.

A slightly longer video may also cover other benefits such as safety, safeguarding, health monitoring, signposting and emotional support. Family carers will be interested in this, as will social prescribers, social workers, occupational therapists and others who work with older people and their family members. A professional, doing assessments and referrals, is likely to want to know if a service would meet their cognition, mobility and health needs, whether the location is convenient and what the transport time and arrangements are.

A video need not be "fancy" or "all-singing, all-dancing". For example, a day centre attender/volunteer we spoke to during the development of these resources (in a joint interview with the day centre organiser) explained how happy she was to be back at the centre once it re-opened after its Covid-19 pandemic closure period and how important the centre was for her. The day centre organiser commented that it would have been good to film her saying these things.

It is a good idea to make sure that a video is accompanied by its transcript, if this is possible.

The Centre for Ageing Better has a library of photos that are freely downloadable. See **https://ageing-better.org.uk/resources/age-positive-images-guide-and-terms-using-our-image-library**

Example: Photos used in a newsletter

Devonshire Dementia Day Centre's newsletters make good use of well-captioned photos that demonstrate purposeful activity, singing, coffee and dancing.

See a selection of photos in the case study example about how Bring Me Sunshine uses social media

Example: Informational video – Devonshire Dementia Day Centre

'A look inside the Devonshire Dementia Day Centre" is a 41 second (YouTube) video embedded into the day centre web page. The opening picture shows text "Join us for a fun day out at our Dementia Day centre". Music backs photos and films of people at the day centre. It includes photos of the rooms, garden and greenhouse, older people and a staff member chatting in the tea room while enjoying afternoon tea, examples of activities (flower arranging, art, balloon/parachute game, with text "Meaningful activities", someone using the shop/market stall with the text "Multi-sensory room", hairdressing, "Specialised care", people being supported to do gardening and walking in the garden ("Outdoor activities"). It finishes with contact details.

The video is on the **day centre web page** and also on Devonshire Dementia Care Home and Day Centre's **You Tube channel**.

Example: Informational video – Age Concern Bracknell Forest

Age Concern Bracknell Forest shares information about its day centre in a 3 minute 55 second video. The organisation manager, Lead Care Supervisor and Assistant Care Supervisor and a Care Support Worker speak about their work and what happens at the centre. The video provides a tour of the facilities available. They invite people to visit the day centre and provide contact details.

Social workers, occupational therapists, social prescribers and other suggesting day centre attendance may wish to show a video like this to potential users and their family members.

> **Individual stories (case studies) can convey how and why people find the service valuable and enjoy it.**

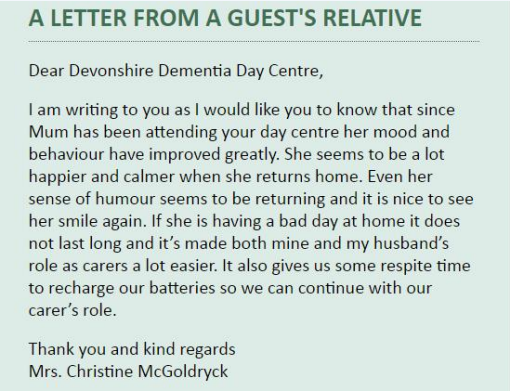
These stories are often called “case studies” (e.g. short overview of the person and the benefits they have experienced as a result of using the service).

Stories can be powerful when they are shared alongside other data about the day centre, for example in reports to funders.

One way to do this is to share letters written by relatives of day centre attenders. These can be shown as letters or "a review from an attender’s relative".

Example: Letter from relative and video of attender’s daughter

Devonshire Dementia Day Centre’s website is dynamic, changing regularly. At one time, it featured a letter written by an attender’s daughter and a two-minute video of another attender’s daughter speaking about her mother’s use of the centre. These appeared alongside each other **on the web page with information about the centre.**



A LETTER FROM A GUEST'S RELATIVE

Dear Devonshire Dementia Day Centre,

I am writing to you as I would like you to know that since Mum has been attending your day centre her mood and behaviour have improved greatly. She seems to be a lot happier and calmer when she returns home. Even her sense of humour seems to be returning and it is nice to see her smile again. If she is having a bad day at home it does not last long and it’s made both mine and my husband’s role as carers a lot easier. It also gives us some respite time to recharge our batteries so we can continue with our carer’s role.

Thank you and kind regards
Mrs. Christine McGoldryck

Quotations, taken from a completed satisfaction survey for example, can also be used.

Example: A day centre attender’s words used on the provider’s website

Michael Whicher is a member of Raleigh House day centre.

> **'I felt very low spirited following the death of my wife as we were very close. It must happen to lots of people when they lose someone. I couldn’t believe I could be so lonely. As soon as I walk through the door of Raleigh House I blossom and feel great. It makes a huge difference to my life and my health. The staff are fantastic.'**

Example: Videos of a day centre attender, activities and a volunteer

A **day centre attender talks for 49 seconds** about the difference that going to Staywell's Raleigh House day centre in Kingston borough has made to his wellbeing.

The Bradbury's programme of activities web page opens with a video of an exercise class. A second video, which follows automatically, is an 'interview' with Stewart, who is the centre's volunteer photographer. He talks for almost 5 minutes, answering questions about himself and his association with the day centre.

A volunteer, **Hilary, talks about how she has benefited from volunteering** at The Bradbury (3 mins 15 seconds).

These, and other, videos are available on **Staywell's You Tube channel**.

Individual stories can also be written up (as more "formal" case studies) using the Most Significant Change approach. This involves using a person's own words in a structured way to explain the most important change they have experienced as a result of using a service and why this change is important to them.

See some **examples of using the Most Significant Change approach to write individual stories as testimonials** and links to guidance on how to write these.

During the development of these resources, we spoke to Joan who shared how going to a day centre has changed her life. **See Joan's story** here.

5.4 Marketing communications content ideas

Appropriate information can provide the reassurance and information that builds trust and prompts people to make contact. Different audiences have different informational needs. So, what should marketing communications cover?

> **Knowing what happens at a day centre is important for all stakeholders.**

We have heard from **older people** that the idea of going to a day centre for the first time can sometimes feel a bit daunting, even for people who are keen to start attending one, because it involves going into a new environment with a group of strangers.

Family members are more likely to consider a day centre as a realistic option and feel happier about a relative they support starting to attend if they have reasonably detailed information about it beforehand. This may be the case particularly when an older person may not be able to tell their family about their time at a day centre.

A professional assessing someone's support needs or suggesting suitable local services is likely to be interested in whether a service would meet that person's cognitive, mobility and health needs. They would also consider practical issues like the day centre's location and travelling time as well as arrangements for transport.

Perceptions and knowledge of services can vary. An occupational therapist participating in this research said *"a lot of people's objection is that they don't just want to go and be dumped in a room once a week with a load of other people who are in their eighties and nineties. We don't know any different from that, as OTs. It almost feels like there's not really much information out there at all about them."*

Knowing how people *feel* about their day centres is also important for all stakeholders.

See the **two-page information sheet *Day centres for older people: what do people say about them?*** (section 3.6) that summarises some of the main messages coming from six recent UK research studies and illustrates these with quotes from some of the older people and family carers interviewed for these studies. **Download it from the website**.

So, what might be covered in marketing communications?

The basics to cover in most formats are:

What is available at the day centre (e.g. activities, additional services such as footcare), the building's facilities and accessibility.

Important practicalities such as operational hours, lunch, transport, parking availability), which geographical areas are covered by the service and costs and payment arrangements.

Cost is key information for social workers; being able to find it saves them time. The absence of cost information may put older people and carers off taking the next step of contacting the centre.

Contact details for someone who can offer more information or discuss the service.

Explaining how service quality is monitored may be reassuring for older people, carers and professional referrers.

Any particular selling points you are proud of or insights into the service will be useful or will attract people's interest.

These may include free 'taster' days, coffee mornings for current members and others who are interested, extra services available (e.g. toenail cutting or hairdressing), links to newsletters and photos, videos or individual testimonials that add a human element or enable readers to gain further insight into the service, what the day centre offers and how people benefit from it.

Example: Taster days

A day centre provider we spoke to during the development of these resources said:

We offer taster days, but sometimes it can take quite a lot of persuading for someone to come along. And it is a big thing to do, to step across that threshold into quite a big space with complete strangers.

Example: Reiterating important information and low hourly cost in the referral form

Age Concern Bracknell Forest's professional referral form (halfway down the page) (Microsoft Forms) reiterates important information that could have been missed and uses the opportunity to emphasise the low hourly cost of the service and signpost to an informational video about the day centre.

The form includes the following text:

"Our centre opens at 9 am and closes at 4 pm, Monday - Friday. We charge a single flat fee of £45 per day, per person (less than £6.50 per hour). Our centre is fitted and furnished with our members (and dementia) in mind. We have immersive high street artwork throughout our corridors, a unique small cinema screening room, and a stylish dining room area. Our lounge is where we deliver exciting, stimulating activities designed to offer something for everyone. We champion friendship, fun and relationship building. We serve a two-course meal everyday. Plus unlimited refreshments and snacks across the day. FULLY DEMENTIA FRIENDLY. All our staff are experienced trained care professionals. Meet the team & see the centre in this video https://youtu.be/8d9qBwKk4dk.

No age restrictions, no postcode restrictions, can accommodate people out of borough.

We can provide emergency "one off" short term / emergency placements additionally."

> **Clarity and detail are helpful and will contribute to referrals or enquiries being appropriate.**

Consider what social care or NHS professionals may wish to know. For example, is the exercise class run weekly an Extend exercise class led by a qualified person? Are some activities designed around a particular therapeutic programme (such as Cognitive Stimulation Therapy)? An occupational therapist would welcome knowing this information before making a referral. Mentioning specific activities designed to be dementia-friendly is helpful for professionals and reassuring for carers. Including a referral form for professionals to use will make the process easier for them. Cost information is key.

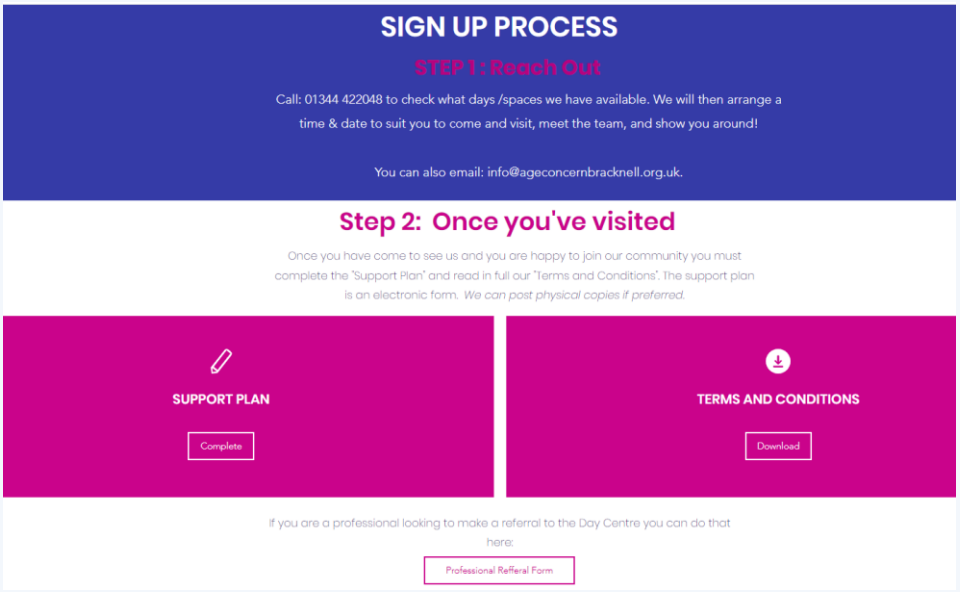
Day centres may like to extend an invitation to social workers or social prescribing link workers to visit. These people and others in social care and NHS roles, may value visiting the day centre as part of an induction when they are new in post.

Example: Cognitive Stimulation Therapy newly offered

When two of Staywell's Raleigh House staff were trained to provide Cognitive Stimulation Therapy (CST), **a blog was published** about this on the website, which featured a video introducing what CST is beneath it. Within the '**dementia support' web page, this was also advertised** (with a link to the blog for readers to find out more). Including this information offered the opportunity to inform readers that provision of CST is recommended by the National Institute of Health and Care Excellence (NICE), something that professional referrers may be interested in knowing.

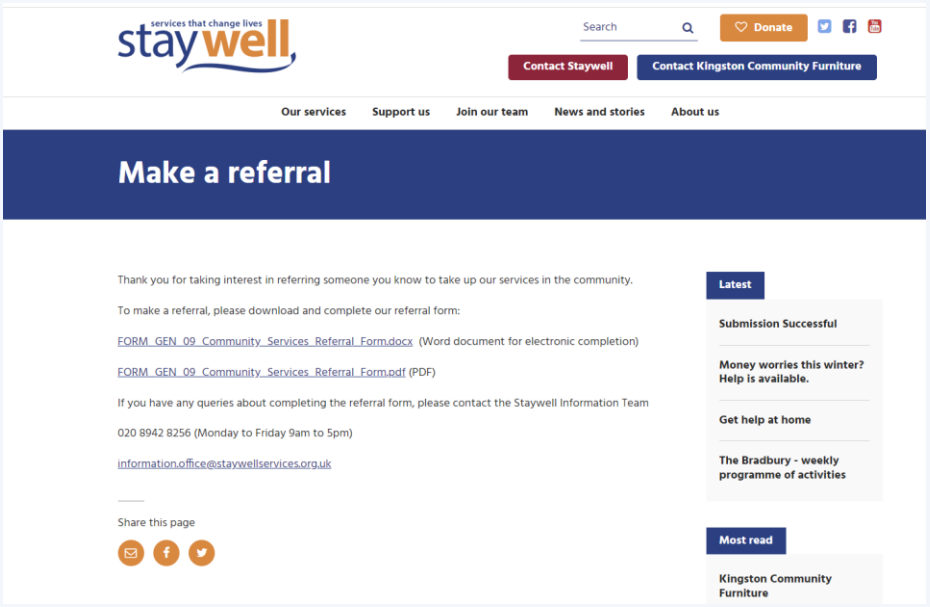
Age Concern Bracknell Forest explains how to access its day centre on its webpage

Terms and conditions, a support plan and a referral form for professionals are **provided**.



Example: Staywell's website's 'Make a referral' page

This **page is specifically for people making referrals**. The referral form (in Word or pdf format) is downloadable and contact details are provided for any queries.



> **Providing further information can be helpful, too, whether about the day centre or other resources.**

Example: Programme of activities

Staywell's website dedicates a page to its **weekly programme of activities** (activities, times, booking details and price) at The Bradbury.

Example: 'Resources' page

Devonshire Dementia Day Centre (and care home) website features a "**Resources" page** which includes contact details for sources of elderly care and family support, financial and legal advice, as well as government and regulatory bodies, local adult social care and some articles of potential interest.

Websites need not be fancy and complicated.

Below are two very different but good examples of straightforward day centre web pages. (i.e. one single page)

Example: Age UK Wandsworth: one page

The web page about **Age UK Wandsworth's Gwynneth Morgan Day Centre** is simple and also explains the process of accessing the service, including the option of a free 'taster' day. It is accompanied by a **colourful pdf leaflet with photos**.

Example: Age Concern Bracknell's website: all the information!

As well as including photos and text about what it offers, the **day centre page on Age Concern Bracknell Forest's website** states that its care team is trained and experienced, and also includes downloadable Terms and Conditions (with complete information about using the day centre – definitions, introduction, journey into their care, the service, trial periods/monitoring, illness/medication/meals, fees, closures, a Covid-19 disclaimer, cancellation policy, additional information, billing and invoicing information and a service agreement the T&Cs), a downloadable support plan to fill in (also available through a direct link on its Linktree page), a professional referral form, and it highlights information about current availability.

5.5 Things to consider or bear in mind, and further resources

Certain practicalities must be considered when planning marketing communications. These include expertise, need, cost and time.

Digital skills.

Providers will need to improve their skills to make adequate information about day centres available online. However, staff and volunteers do not necessarily have the skills or equipment to make video clips or create and update web pages.

Below is an example of a day centre that secured volunteer IT help. Volunteer support might also come from young people wanting to gain some work experience.

Example: Social media presence with the support of a volunteer

A voluntary sector day centre receives IT support from a volunteer once a week (2.5 hours). This has enabled the organisation, which was lacking in IT expertise, to have social media presence (X - formerly known as Twitter, Facebook, Instagram) and an improved website. Staff provide materials (photos, text) for the volunteer to use. The volunteer loves computers and technology and was introduced to the organisation by their LA support worker, who accompanies them during volunteering time. The volunteer has been in this role for four years.

The National Council for Voluntary Organisations (NCVO) is a membership organisation for charities, voluntary organisations and community groups in England. A section of **NCVO's website is dedicated to providing help and guidance on digital technology**.

Within it, advice is given on **planning a website** – which also **discusses why a new website may not be necessary** (**before you start a new website project**). Proper consideration should be given to the problems you are trying to solve and why before paying to create or redesign something. Cost-effectiveness comes from identifying problems that need solving (through user feedback). If you do decide you need to make changes to your website design and build, **start with this comparison of DIY website building tools**.

The Digital Inclusion Toolkit is an independent and comprehensive source of digital inclusion (DI) advice and information for local councils. It provides very straightforwardly written **guidance on setting up a website and email for small business and organisations** and an **introduction to GDPR** (General Data Protection Regulation) and protecting people's personal data. It provides "how to" guides and case studies covering starting, delivering and evaluating digital inclusion projects.

It has a section about **free software (including for working with photos and videos)**. **Resources and case study examples** are also available.

Searchability.

Ensuring that your web pages appear when people search online is important. This is possible by including key words (e.g. older people, day centre, day care, club, elderly) behind what is visible. Doing this is called 'Search Engine Optimisation'. This is **explained simply in Wikipedia** and more about this can be found in this **free guide to online marketing**. People feeling brave might like to read **more detailed information on the gov.uk pages**.

Permission

Permission should be sought to share materials that identify people or share personal stories (e.g. photos, individual stories, films, recordings). A template seeking such permissions that can be adapted for local use can be downloaded in Word format from the Resources Hub website; it is based on NIHR ARC South London's release form.

See editable photo/film/recording/story release form template

This template based on NIHR ARC South London's release form can be edited as necessary. It can be downloaded from the Resources Hub website (A guide to marketing communications).

In gaining permissions, it is important to remember the Mental Capacity Act principles around consent.[f] Many older day centre attenders will have mental capacity to give consent for the use of their photos/film etc, but some may not. Some people's capacity fluctuates. Some people have capacity to make some decisions but not others. Complying with the MCA will mean discovering whether a person has capacity to give the necessary permission at the time it is being requested. If they do not, a proxy will need to be approached for permission (e.g. a family member).

Discovering a person's capacity to give permission can be relatively straightforward and can be done by someone at the day centre who would explain they would like the person's permission to use photos etc. They should explain what the photos might be used for, that they may be

used for some time, and that the person can withdraw their permission in the future. The individual 'assessing' the person's capacity to make this decision would then use the 4-stage test of capacity, during which further questions about understanding/decisions are asked. The person may be asked to explain their understanding of the situation:

1) can they understand what is being asked of them and any consequences?

2) can they weigh up this information?

3) can they make a decision about it?

4) can they communicate their decision?

Example: Diamond Club's forms for gaining consent for use of photos, film and recordings

For its Holiday at Home project, the Diamond Club developed three documents used alongside each other to gain consent. These can be downloaded from the Resources Hub website.

5.6 Examples of marketing communications and materials

This section has already included several examples of marketing communications. Further case study examples are also available:

- **Bring Me Sunshine** explains how the group uses social media, some challenges faced (e.g. boundaries, security, expertise, moderation procedures, data protection) and shares details of its own public-facing Facebook and X (formerly known as Twitter) accounts.
- Two examples of printed leaflets: **Devonshire Dementia Day Centre** and **Staywell's Raleigh House.**
- **An editable template to gain permission to use photos, films, audio recordings or stories** that can be edited as necessary and a **local example of forms used**.

See also **Joan's story** (in 7.7) written using the **Most Significant Change (MSC) approach**.

Use of social media by Bring Me Sunshine

Bring Me Sunshine (BMS) provides dementia-friendly activities and events for older people in the community. It aims to help combat isolation and loneliness and promote health and wellbeing to older people in Catford, Lewisham.

Although most of Bring Me Sunshine's service users are not on social media in any way, social media is a key tool for marketing to relatives/carers of service users and the broader community, and for internal management. BMS mainly uses various social media platforms to:

- inform about upcoming events (marketing communications)
- report on events with photos and videos (most popular especially using tagging and hashtags) and improve engagement (marketing communications)
- raise awareness of related issues and events - that would mainly appeal to those in touch with older people in the community (marketing communications)
- support and manage volunteers (internal management).

Facebook https://www.facebook.com/BringMeSunshineSE6 is openly accessible and aims to:

- keep volunteers updated and reminded about upcoming and past events
- keep the wider community informed about activities that are going on in their community (engaged and interested as a 'liked' page)
- enable referrals to the service through awareness raising and information provision.

Often local groups will share BMS content, especially if they are fun pictures and videos. People like to see happy real-life content of people enjoying themselves - especially the entertainment! When people meet the priest or one of the in-house entertainers and volunteers who sings and leads movement and music sessions in the community, they often comment on their latest notorious costume or performance. (e.g. the priest in his captain outfit or an entertainer volunteer who performed using personas during Covid visits.)

X (formerly known as Twitter) https://twitter.com/lesleyaallenbt1

BMS uses the organiser's personal account. This has worked well as she is a local community leader and has key followers who re-tweet content about BMS. Photos and videos of events are extremely popular (see below). However, the line between personal and work can sometimes be grey (see Challenges below).

What'sApp (closed group, accessible by invitation only)

Group chats are a key tool for engaging the volunteer team and works better than emails which tend to get fewer responses because people receive too many. What'sApp is instant and tends to get more instant attention. Status updates on What'sApp are also useful.

There are 43 older service users ("we use the term elders") on the What's App group which keeps them informed of updates. It is also a great way of connecting and sharing positivity. Occasional reminders of the group's purpose are needed, for example after out of scope messages are shared and discussions become political.

Social media challenges

As for any organisation dependent on volunteers, social media content can be patchy and sometimes inconsistent. It tends to be reactive rather than proactive.

> **To have one person who has social media experience and is dedicated to posting regular content is important.**

Engagement is key to a wider exposure of content (through algorithms). This means that the more a post is "liked" or "commented on" or "shared", the greater that post's reach. Writing posts that are engaging is key, but time-consuming, and emphasises the need for someone who is dedicated and responsible for this social media content.

Organisations may wish to draft some social media related policies and procedures that look to the future. Matters for consideration will include boundaries and monitoring, security, the impact of successful social media and information governance.

Boundaries and overlap between work and the personal need to be carefully considered for future-proofing, to allow separation between parts of people's lives and to protect privacy.

While current organisers, staff or volunteers may be comfortable taking on a social media role from their personal accounts (e.g. X - formerly known as Twitter), others who come to the organisation in the future may not wish to continue with the same arrangement. Some staff or volunteers may choose not to be constantly accessible, and this is to be respected. An organisational account (X handle) that is accessible by named people will enable continuity at times of change or unavailability and will protect individual privacy.

As well as aiming to raise awareness and attract people to events, social media involves substantial interaction. Security and the impact of successful social media work need consideration.

Monitoring is important.

Organisations may wish to consider putting in place procedures for moderating (i.e. vetting) posts before these are posted online and make arrangements for someone to do this. Open groups or larger organisations, in particular, may experience trolling, cyber security breaches, negative or inappropriate posts, or inappropriate promotion of services that your organisation does not endorse, but these challenges can also happen in closed groups. BMS' had experience of inappropriate posts and addressed matters by providing a reminder of the purpose of the What's App group (sharing information relevant to activities and sharing hope and positivity), by contacting perpetrators separately to discuss how their post(s) could have been received by other group members, by not engaging in dialogue on certain posts or restricting comments.

Organisations will also need to be mindful of information governance regulations (GDPR) (**General Data Protection Regulations**). Exchange of 'personal information' may take place over, for example, an organisational What's App group, and organisations may wish to consider the implications of this from a GDPR perspective.

It is also important to remember that a person who is living with dementia and who does not have mental capacity to give consent to have their information shared must, by law, be respected.

According to the **Mental Capacity Act 2005**, the following principles should apply concerning decisions around capacity:

1. A person must be assumed to have capacity unless it is established that he lacks capacity.

2. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.

3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.

4. An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.

5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

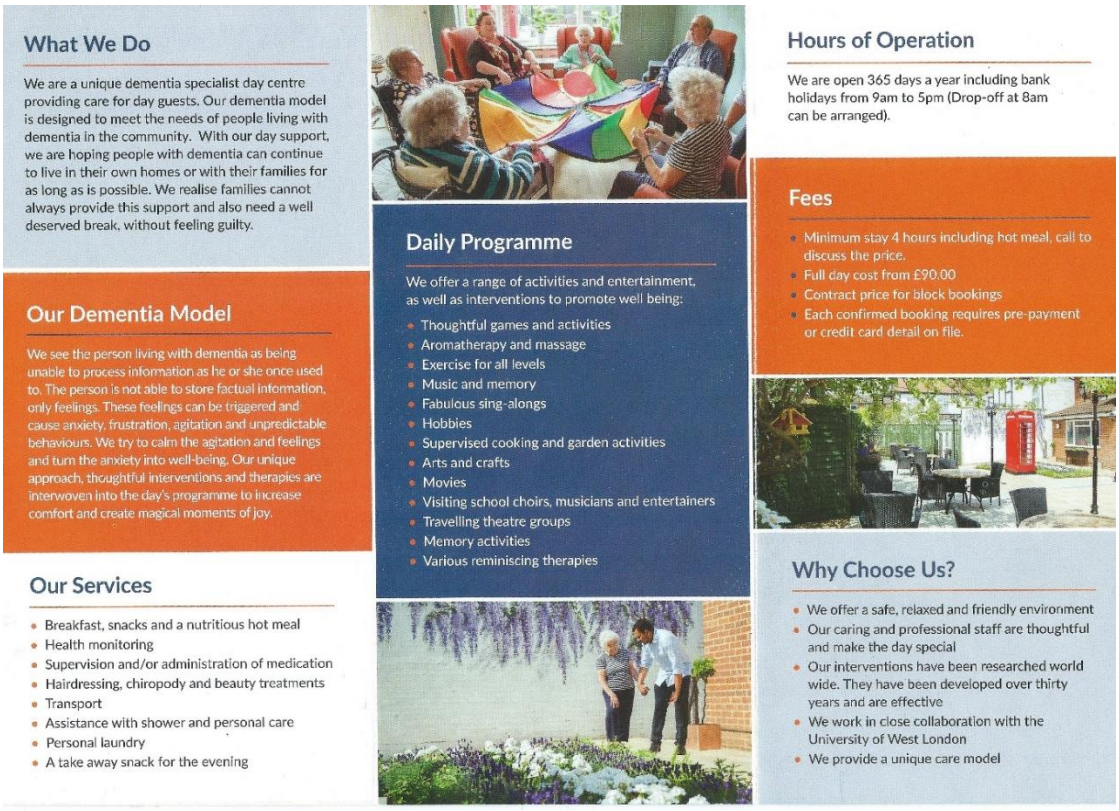
Contact details: https://bringmesunshinese6.co.uk/

See next page for examples photos used on social media.

Photos used on social media by Bring Me Sunshine

Devonshire Dementia Day Centre printed leaflet

This leaflet is printed on heavy paper and is A4 folded into three.



Staywell's Raleigh House printed leaflet

This leaflet folds into an A5 booklet.

How to contact us

If you would like to join, to look around, try a taster day or to find out more, please get in touch.

Phone: 020 8942 8256
Email: hello@staywellservices.org.uk
Web: staywellservices.org.uk

Raleigh House,
14 Nelson Road
New Malden
KT3 5EA

Opening times
Monday to Friday 9.30am to 3.30pm.

Who we are

- An independent local charity
- Over 75 years' experience
- Award-winning and innovative
- Working in partnership
- Supported by volunteers

Support us

We love to hear from volunteers who can bring their talents and enthusiasm to enhance our members' experiences.

Rooms at Raleigh House can be hired for meetings and events. Contact us for more information.

services that change lives staywell

Raleigh House

Supporting wellbeing
Supporting independence
Supporting carers

Staywell is the working name for Age Concern Kingston upon Thames
Registered charity no. 299988 Company no. 2272550

Care and support for older people

Welcome to Raleigh House

Would you, or someone you care for, benefit from joining our friendly day centre community?

Raleigh House offers a welcoming, safe environment in which to spend the day, meet people and engage in a variety of activities of your choice.

- Spend time in our bright, spacious facilities with all your access needs catered for.
- Meet new people and be looked after by our trained and friendly staff.
- Enjoy a cooked, two-course lunch and refreshments as well as occasional treats.
- Make use of our facilities, entertainment and activities including a pool table, arts and crafts, live music, games area, nail bar, computer suite, sheltered courtyard and quiet terrace.
- Get around easily, whether or not you have access needs, with our fully accessible step-free facilities, specially trained personal care assistants and accessible transport options.

'The best thing is the company. I've made friends and the whole team working here are lovely.'

Support and respite

Our staff are trained to assist people living with dementia and we can provide respite for carers and families.

Find out more

Call or email us to arrange a viewing or taster day, or to become a regular member.

'I moved to be near my family when my husband died and here I've met a great group of friends.'

Link up to our other services

At Raleigh House our members' needs come first. If we can link you up to our other services, supporting you to live as independently as possible, please speak to one of our friendly team.

We can offer help with:

- Hairdressing
- Podiatry
- Accessible shower facilities
- Specialist information and advice
- Handyperson
- Help at home services, including meal preparation, cleaning, shopping and companionship

020 8942 8256

Photo, film, audio recording or story release form

(TEMPLATE downloadable in Word format)

Instructions for users of this suggested template [delete before use]:
Please add your organisation details and amend the purposes the photos/film/recording/story will be used for where prompted.
See also notes at the end about capacity.

The **[ORGANISATION NAME]** would like to [**EXPLAIN REASON FOR WANTING TO USE PHOTOS, FILMS, AUDIO RECORDINGS OR INDIVIDUAL STORIES** – for example: promote stories about the impact of day centres from the perspective of service users and carers; or promote a better understanding of our day centre service].

I (add full name here) _____ hereby give permission to be photographed/filmed/interviewed/recorded/provide my story to the **[ORGANISATION NAME]** to be used for the following purpose(s):

- Internal and external communications, publications and online.

☐ I consent to use of material captured involving me/my research story in media outlets and **[ORGANISATION NAME]'s** promotional material and publications, and for general use, where appropriate.

☐ I am aware that the materials will be held indefinitely, that resources may be in circulation for a number of years and that I retain the right to withdraw my consent for use of materials at any time.

☐ I understand that, if I withdraw my consent for their use, all appropriate steps will be taken to remove the materials, but that it may not be possible to stop their use completely as they will already be in circulation.

☐ I consent to my photo being used.

Signature:

Date:

Email:

Tel:

(Must be signed by parent/guardian if individual is under 18 years of age)

Consent collected:

by: **[PRINT NAME]**

_____

of the **[ORGANISATION NAME]**.

Notes for users of this template [delete before use].

In gaining permissions, it is important to remember the Mental Capacity Act principles around consent (see below this note). Many older day centre attenders will have mental capacity to give consent for the use of their photos/film etc, but some may not. Some people's capacity fluctuates. Some people have capacity to make some decisions but not others. Complying with the MCA will mean discovering whether a person has capacity to give the necessary permission at the time it is being requested. If they do not, a proxy will need to be approached for permission (e.g. a family member). Discovering a person's capacity to give permission can be relatively straightforward and can be done by someone at the day centre who would explain they would like the person's permission to use photos etc. They should explain what the photos might be used for, that they may be used for some time, and that the person can withdraw their permission in the future. The individual 'assessing' the person's capacity to make this decision would then use the 4-stage test of capacity, during which further questions about understanding/decisions are asked. The person may be asked to explain their understanding of the situation:
1) can they understand what is being asked of them and any consequences?
2) can they weigh up this information?
3) can they make a decision about it?
4) can they communicate their decision?

***Mental Capacity Act 2005** principles concerning decisions around capacity: (1) A person must be assumed to have capacity unless it is established that he lacks capacity. (2) A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success. (3) A person is not to be treated as unable to make a decision merely because he makes an unwise decision. (4) An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests. (5) Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.*

Local example: Diamond Club's forms for gaining consent for use of photos, film and recordings

Holiday at Home Photographic and Film Consent

▪ Holiday at Home relies on donations and small grants to fund its activities, by purchasing refreshments, equipment and venue

▪ Films, photographs and voice recordings may be used to promote or report on Holiday at Home sessions to our funders or local media

▪ Images and/or voice recordings may be used in leaflets, posters, reports and internet publications

▪ You will not be identified by name in any use of your image/voice recording

▪ Permission for your image to be used may be withdrawn at any time by contacting Lesley Allen, Chair, Holiday at Home organiser in person or by e mail [email address] , although images that have already been made public cannot be withdrawn

Holiday at Home Statement: Your Personal Information

▪ On your first visit, we ask you to complete a registration form with name, address, contact numbers and the name and contact of a family member/friend. You may also choose to let us know if you have any specific needs

▪ This information may be helpful for us to respond to any enquiries from you, give you information about activities or if you need extra support. If we are required to share your information with emergency services or safeguarding office we will inform you and gain your consent if possible. Your information will never be given to any other third party without your explicit consent

▪ Information is kept in a locked box or password/PIN protected device accessible only to the organisers, who have DBS clearance and have attended Safeguarding awareness training

▪ You are free to withdraw consent for us to hold your information at any time by contacting Lesley Allen, Chair, Holiday at Home organiser in person or by e mail [email address]

Registration form

Name: Address:	Contact e mail/telephone (if you are happy for us to contact you):
How would you describe your ethnic background?	How old are you? (Please tick) 60-69 70 -79 80-89 90 or older
Name/contact for carer/friend/family member:	
Do you have any particular needs? e.g care needs, dietary requirements:	
Do you have any symptoms of COVID-19? (If you do, you will not be able to attend today's activity)	
I agree to my personal information being kept by Holiday at Home organisers in a locked box or on password or PIN protected devices for: the duration of the events/ for a period of one year, to inform about other events of interest. Signed: Date:	
If photographs are taken, I agree to my image being used in reports and publicity about the Holiday at Home scheme. I understand I may withdraw my consent at any time, although it will not be possible to remove images already circulated. Signed: Date:	

Holiday at Home/Bring Me Sunshine Event Date:

Name (please print)	Please sign if you agree to your photograph being used in our publicity/newsletter locally	Time in	Time out

6. Workforce: staff and volunteer recruitment

This section outlines staff and volunteer roles in day centres, shares recruitment and retention tips, signposts to useful resources about values-based recruitment, share tips about role descriptions and adverts and highlights the value of sharing testimonials. It then suggests ideas for bringing young people and people who have support workers and specific skills-sets into day centres.

6.1 Introduction to day centre staff and volunteer roles

Day centres may be operated by paid staff, a combination of paid staff and volunteers, or by volunteers. As day centres vary hugely, so do the roles of their staff and volunteers.

Day centre staff have described their roles as a mixed care and social role. Their work is likely to involve personal care; planning, running and supporting activities, playing games with people attending the centre, organising occasional events; providing emotional support; monitoring attenders' wellbeing and health, often by chatting on arrival or during the day, and acting on information given where necessary; making/serving refreshments; practical support; attending to logistical requirements, acting as a key worker for named attenders and maintaining paperwork.

Both staff and volunteers might set and clear tables and serve meals, and perhaps even wash up or load a dishwasher.

Volunteers tend not to undertake personal care. Instead, their roles are likely to involve taking initiative in supporting attenders to enjoy themselves, thinking of stimulating activities, supporting attenders during activities, reassuring anxious attenders, making and serving refreshments, serving lunch, helping people walk to the toilet, moving furniture, chatting with attenders, collecting money and "troubleshooting" (e.g. sewing on a button, popping out to buy something locally).

It could be considered as an 'assisting/filling gaps' role when volunteers work alongside paid care workers; but, sometimes, day centres are reliant on them to open - even day centres employing staff. [97]

Training (or qualifications) may have already been undertaken or may be undertaken in-house, externally delivered and online once in their roles.

To find out more about typical day centre staff and volunteers, see King's College London's 2023 report ***What happens in English generalist day centres for older people? Findings from case study research* (see Chapter 6: Formal and informal care and support)** and **Making My Day. Volunteering or Working at a Day Centre for Older People: Findings of Exploratory Research in English Day Centres**, an article in the Journal of Long-Term Care.

6.2 What helps recruitment and retention?

Skills for Care [98] asked social care employers with low turnover rates what they did that they felt helped recruitment and retention. They said the following:

Recruiting the right people

- Finding staff with the right values and behaviours is more important than finding staff who are already qualified; skills can be taught but personal attributes cannot (e.g. kindness, compassion, reliability, honesty, etc.)
- Life experience and a willingness to learn can be more desirable than previous work experience (reflecting the principles of values-based recruitment)
- "*Openly invite all applicants to a 'meet and greet' before any shortlisting as we found some younger and older people do not have the skills to complete the application and were excellent workers being missed. We also had excellent applications where people proved they were not right for the role at interview.*" (Day care provider)
- Inviting candidates for 'taster shifts' and involving people who need care and support and their families (or friends and advocates) in the recruitment process helps you to establish whether candidates 'walk the talk.'
- Asking candidate to complete a pre-interview assessment is very useful.

Once employed

- Respecting and valuing staff, investing in learning and development, embedding the organisation's values and celebrating achievements all go a long way to improving staff retention. Continuity of staff is crucial in delivering high quality care to people who need care and support.
- Involving staff in decision making and paying above the local minimum (paying competitively) also ensure that staff feel valued for the work that they do which can have a positive impact on retention rates.

- Monitoring staff satisfaction can be useful in identifying ways to further develop the culture of the organisation but whether this is done formally or informally, the crucial part is to be seen to listen to and act upon what staff tell you (see section 4.7 'Monitoring job satisfaction' for more about this.)

- The importance of good leadership and management cannot be underestimated. "*We have focused a lot on leadership and management with a programme running to support the managers at all levels to enhance their skill set to lead their local teams*." (Independence Matters, Day care provider)

- Monitoring reasons for leaving can feed into the business planning process and inform how the organisation responds to staff concerns.

6.3 Resources to support recruitment

This section covers values-based recruitment, role descriptions and advertisements, and the value of testimonials.

Values-based recruitment

Values-based recruitment is an approach that contrasts with the traditional approach that focuses more on qualifications and experience. It aims to attract people whose values, attitudes and aspirations are suitable for working in a certain care environment, in this case, a day centre.

Skills for Care's evaluations of a values-based recruitment toolkit (VBRT), suggests that values-based approaches might lead to lower recruitment costs, positive return on investment, lower staff turnover and better staff performance.

IMPACT (IMProving Adult Care Together) separates using a values-based approach to recruitment into stages. After identifying the organisation's values, the recruitment stage includes attracting the right people, the process of application and selection. After recruitment, things that matter are feeling welcome, an induction that sets out expectations, goals and aims, consistency, regular managerial contact and supervision and ongoing support and development. See the **2 minute 19 second video explaining values-based recruitment** (top of page).

Helen Sanderson used a values-based approach to recruitment

The process they went through to start using a values-based approach to recruit the right people for new wellbeing teams is explained in the report **Using values-based recruitment to recruit the right people for new wellbeing team.**

Values-based recruitment toolkit (Curious about Care)

The University of York and Skills for Care have developed a free, evidence-based tool to help employers make a decision about candidates. It puts applicants in the shoes of care workers facing dilemmas (based on real life scenarios) that stretch people's values. In addition to three pre-selected scenarios, employers choose at least two or three others from the range available to create a bespoke quiz for applicants. Candidates take the quiz, and a short report is automatically generated based on their responses. It uses a traffic light system for making recommendations (red, yellow and green). Applicants' answers may lead to discussion in the interview and to support early training/induction, if selected.

Person-centred evidence underpins the scoring system and the values are around person-centred care. Scoring was set by people with lived experience, not service providers.

Curious about Care is available at https://curiousaboutcare.org.uk.
See the **two-page infographic introduction, 'how to' guide and overview of the scenarios** and the **video introduces the tool (for homecare providers)**.

Skills for Care's web pages offers guides and tips for attracting different types of people with the right values and behaviours.

The **'Attracting people' webpage** covers:

Effective ways to target specific groups of people covers channels / routes to use, suggested key messages each group may be most interested in and top tips. It is 7 pages long. Channels, messages and tips are given separately for the following demographic groups: young people, graduates, older workers, under-represented groups including male workers, disadvantaged groups such as care leavers, long-term unemployed people and people who have a criminal record, people with disabilities and women returning to work. Further resources are signposted to.

Using social media for recruitment suggests tips and platforms to use.

The **'Widen your talent pool' webpage** focuses on how to remove unfair and unnecessary barriers that could unintentionally prevent certain people applying for roles. Guides cover ***Employing men, Employing people with criminal records*** (Safe and fair recruitment guide, Did you know – see the person value the difference) and ***Employing people with disabilities*** (A guide for employers, Busting the myths), and ***Employing young people*** (Employing workers aged 16 and 17, What Gen Z need to know about working in social care, Attracting a diverse workforce – generational differences).

Role descriptions and advertisements

Social care employers with low turnover rates (see Skills for Care report [98]) offered the following tips with respect to role descriptions and advertising.

Role descriptions and person specifications should be checked to ensure they:

- use neutral language and do not discriminate against any group of (potential) staff/volunteers
- promote a values and behaviours based approach
- do not include jargon
- are clear about key elements of the role
- are clear, concise and easily accessible
- do not include criteria that aren't relevant to the role (are minimum skill or knowledge requirements necessary?).

The most successful methods of advertising job vacancies are:

- via existing employees referring a friend (49%)
- adverts posted on the organisation's website (29%)
- adverts printed in the local newspaper (20%)
- posters in the local community (20%)
- adverts posted on social media (17%) or elsewhere online (25%).
- word of mouth 'advertising' can be a valuable avenue to pursue because as well as being low or no cost there is a greater potential of attracting people with the right values and behaviours because the existing staff/volunteers know the organisation's core values and can share these with the people they know.

Department for Health and Social Care's Every Day is Different campaign

This **campaign aims to highlight the benefits and positives of social care**. The website includes role descriptions (activity support worker and care worker), various videos and resource materials for advertisements about social care careers (e.g. pictures to use on social media).

The value of testimonials

Given that word of mouth and individual stories are said to be effective recruitment strategies, there is value in featuring volunteers and staff in short videos that feature on websites.

Example: Staywell's videos of volunteers

Staywell's You Tube channel features a film in which **Hilary talks about how she has benefited from volunteering** at The Bradbury Centre (3 mins 15 seconds).

Another film shows an **'interview' with Stewart'**, who is the centre's volunteer photographer. He talks for almost 5 minutes, answering questions about himself and his association with the day centre.

6.4 Bringing younger people into day centres

Intergenerational activities and relationships can be very beneficial for both older people and younger people. Developing links can lead to low-cost activities for day centre attenders.

Day centres can make formal links with local **universities, further education colleges and sixth forms** so that students can undertake course-related and other activities (e.g. Duke of Edinburgh Award, volunteering, placements) in a planned way for a fixed period. Students may be following courses in health and social care, social work, allied health professions or medicine. Day centres participating in this study suggest doing this at the beginning of the academic year, or at the start of courses, to maximise time for engagement with individuals.

Day centres may also wish to make links with **nurseries** so that they think of the day centre as a local resource for them and their children. Research has shown that sharing activities with pre-school children (e.g. reading with them, talking to or playing with them, watching dancing/singing) improves wellbeing and physical activity levels among older people. Those choosing not to actively join in benefit from the children presence. Some said it helps them feel connected or needed.[99, 100]

Making links with **schools and youth clubs** could lead to the development of, for example, occasional days (e.g. one visit per term) during which younger 'buddies' visit the day centre to support older people with using tablets, facilitate WhatsApp video calls with family or simply chat to learn empathy.

The following case studies highlight relationships with schools: (see section 7):

Bringing the community into day centres: performances by local theatre groups and a secondary school

Introducing cycling for day centre clients. Young people from a Pupil Referral Unit support older people living with dementia during bike-riding sessions.

Example: University student placements and the benefits of these

(An abridged extract from the case study entitled 'Redesigning for survival': an in-depth case study of re-designing a day centre for people with dementia' in section 7.7)

Braid Health and Wellbeing Day Centre hosts placements for allied health professional students at two universities – occupational therapists, paramedics, physiotherapists, podiatrists and nutritional therapists. Links with universities (via students' supervisors) have led to the introduction of a rolling programme of therapies and interventions which has counteracted lack of payment for student placements. Positive feedback on these placements have led to placements for nursing students.

Students have been surprised at the level of complexity faced and the range of experiences they have gained. They bring in new knowledge, skills transference and a new workforce experiencing day services for the first time. An unexpected benefit of these placements the new referral pathways they have generated. Students sharing their new understanding of the day services provided with a workforce among which there was low awareness of day services has led to extra referrals.

Example: University student volunteers

A day centre participating in this research was near a university campus. Students often approached the centre about volunteering, or when they needed to do a research project or an exercise (or 'intervention') with day centre attenders. While useful, it found this not consistently sustainable due to term times, essay pressures and suchlike.

Example: Secondary school sixth form volunteers

A day centre participating in this research provided a Saturday Club for people with dementia and their carers. The club benefited from school and sixth form volunteers who may have been considering medicine or an allied health profession as a career and wanted to gain work experience. This was possible because the club was out of school hours.

6.5 Bringing in people with Support Workers and specific skills-sets as volunteers

Meaningful activity is good for wellbeing. People who have Support Workers and who are without paid work could be introduced to day centre volunteering if their skills match those needed. For example, someone may become a 'conversation volunteer' and simply chat with older attenders; some day centre staff are too busy to be able to chat for as long as they would like to. The example below shows how a day centre benefited from much-needed computer skills; the volunteer benefited from being able to share their skills.

Example: Social media presence with the support of a volunteer

A voluntary sector day centre receives IT support from a volunteer once a week (2.5 hours). The volunteer loves computers and technology and was introduced to the organisation by their local authority support worker, who accompanies them during volunteering time. The volunteer has been in this role for four years. This has enabled the organisation, which was lacking in IT expertise, to have social media presence (Twitter, Facebook, Instagram) and an improved website.

7. Case studies and inspiration

This section presents some case study examples grouped by topic area and signposts to external examples or resources relevant to these topics.

7.1 Introduction

One consequence of the lack of opportunity to exchange knowledge, expertise and experiences in day care can be 'wheel reinvention' and missed opportunities for partnership and development. Case study examples usefully capture knowledge and experiences, enable learning from other organisations' efforts and broaden understandings of day centres' work and how they might be involved in mutually beneficial initiatives, for example. Day centre providers and their professional and community stakeholders can benefit from reading such examples.

This section presents some case study examples, external examples or resources and further examples. They are grouped into five headings:

- Day centres supporting the NHS and social care
- Enhancing service quality
- Activities in day centres
- Outreach, partnership working and bringing the community into day centres
- Service expansion or re-design.

Sections 7.2-7.6 briefly introduce case studies under each heading. Full case studies appear in section 7.7.

People with little background in day centres may wish to start by reading a report published by King's College London's NIHR Policy Research Unit on Health and Social Care Workforce. **What happens in English generalist day centres for older people? Findings from case study research** aims to further the understanding of these diverse, multi-faceted settings among potential collaborators and social care and health professionals. It reports a pre-Covid pandemic descriptive picture of four day centres. It covers aims, funding models, location, internal environments, staffing, day structure, charges and a typical day. Additional 'extras' made available to attenders of these four day centres through local organisational links appear in its Section 7 of *What's in a 'day'?*

7.2 Day centres supporting the NHS and social care

A day centre for people with advanced dementia in south London identified why a service user with dementia and diabetes frequently became unresponsive, leading to **a reduction in ambulance call-outs, thus saving NHS expenditure.**

A local authority **day centre opened up its building to social workers, Occupational Therapists and a falls clinic, during its temporary closure due to Covid**. Teams have continued to use the building after it re-opened.

A voluntary sector activity centre, that was in contact with many carers, **supported the local authority to consult with carers about an update to its local Carers Strategy**.

A day centre **worked with the NHS adult mental health service on a project to transform a storage room at the day centre into a reminiscence room**. As well as creating a place for day centre clients, this project also benefits users of SLAM adult mental health services who were employed to work on it as part of their recovery programme.

One day centre explained how **day centres contribute to safeguarding, and safety in terms of not being alone and by supporting carers**.

Individual testimonials also provide valuable evidence and a useful perspective for understanding the impact of day centres. During the development of these resources, we spoke to **Joan who shared how going to a day centre has changed her life.** Her story/testimonial is written using the **Most Significant Change approach which is covered in section 4.7**, which provides information and links to tools that can be used to gather data about day centres' impact.

7.3 Enhancing service quality

A **positive risk management strategy** was developed to ensure that people with early dementia were not excluded from, but were enabled to attend, an exercise programme without a carer.

An **Excel 'time tool' to monitor time requirements for individual and whole-group support** needs was developed by the manager of a local authority day centre for people with dementia. It monitors time needed by staff to support people and prompts reflection about support techniques.

In a day centre that is linked with a care home, **handheld mobile devices used for handovers between shifts in the care home are used for gathering information about attenders' days and to guide reflective conversations with staff**.

The Scottish Care Inspectorate has published a guide to self-evaluation for continuous improvement. It introduces the concept of self-evaluation and provides suggestions for how care settings might reflect on what they are doing so they can get to know what they do well and identify what they need to do better.

> **The importance of a good welcome**
>
> During the development of these resources, an older person, a day centre attender's daughter and a social worker emphasised how important it is for people to feel welcomed and at home as soon as they arrive. This contributes to a person feeling comfortable, demonstrates caring and allays worries they may have had about where to go and suchlike. Feeling that a day centre is responsive and the warmth of the manager and staff/volunteers – to older people, relatives and professionals - helps social workers feel comfortable making referrals. Having a good relationship with a manager, leading to a sense of trust, is also important to social workers.

Tools for measuring how person-centred services are appear in **section 4.7 (Understanding outcomes and impact)**, for example, PERCCI and TLAP's "I" statements.

Templates or games help provide person-centred care and support. They are also useful for new staff and volunteers who need to get to know their day centre's clients.

One-page profiles capture the most important information about a person, including what is important to them, what people appreciate about them, and how they want to be supported. **Read more about them here**.

'This is me', produced by Alzheimer's Society, is longer and includes background information about the person, important people/places/events in their lives and their preferences and routines.

'**Insights into me'**, produced by My Home Life, is an online or printable booklet aiming to generate conversations about a person. It includes a one-page overview, a family and friends tree, personal history, what makes a good day and other areas more relevant to a residential setting.

My Home Life has made available two online, interactive games that, if played as a group (using a tablet, for example), may help attenders, staff and volunteers to get to know each other and build relationships. Guidance is provided for both.

- '**Picture Knowing Me'** is a light-hearted, interactive way for people to share something about themselves and learn something about others. It involves clicking on a wheel to spin it. The wheel stops on a topic (e.g. small things that annoy me, something small that makes a big difference to me, something about me that may surprise you) and people can choose to share something about the topic or to spin again for a different one. Guidance is provided.

- '**Key Cards**' aims to get people chatting and finding out new, surprising or moving insights about each other. It is a set of 55 downloadable questions. In the interactive version, you press the button to generate a question, answer it or press again to generate a new question. (Example questions: is there something that you know how to do that you would like to show others? What, for you, is the most beautiful sound in the world? What has been the best change in the world over the last 50 years?)

7.4 Activities in day centres

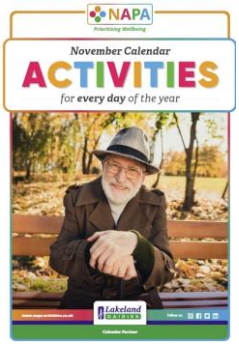
A dementia day centre **introduced cycling for day centre clients**. Use of adapted bikes, bike storage and intergenerational support were all made possible through local collaborations with Wheels for Wellbeing and a local Pupil Referral Unit.

One day centre for people living with dementia improved its offer by **introducing technology in the form of iPads and static cycling with virtual scenery**.

Two south London day centres **brought music in** through local collaborations.

Two local theatre groups and a secondary school perform for attenders of a voluntary sector activity centre, giving them access to the arts and fresh conversation material to take home.

The National Activity Providers Association (NAPA) publishes a series of free resources and **low-cost topical resource ideas**. Free resources vary e.g. monthly calendar of activities, guide to promoting mobility and preventing falls (covers factual information and activity suggestions) and guidance on planning a community disco. A creative quizzes booklet previously featured.



Health Innovation Network has published a guide to Maintaining Activities for Older Adults During COVID19 - A guide to online resources for staff in older adult mental health wards and care homes and any other relevant settings (April 2020)

It provides brief information about and links to activities on tablets, access to newspapers and magazines, physical activity and exercise, films, music and television, livestreamed concerts, nature and museums, and links to other useful activity resources.

My Home Life has made available two online, interactive games that, if played as a group (using a tablet, for example), may help attenders, staff and volunteers to get to know each other and build relationships. (See previous page for details.)

7.5 Outreach, involving and bringing in the community, and local partnership working

Developing local links has brought music and theatre into several day centres. Through local collaborations**, two day centres brought music into their centres** in different ways**.** Two **local theatre groups and a secondary school perform for attenders of a voluntary sector activity centre**, giving them access to the arts and fresh conversation material to take home.

A day centre undertook **outreach with its local Mosque that aimed to support and include its older female members**.

One day centre for people with moderate to advanced dementia developed one-off partnership working opportunities. It **partnered with The National Citizen Service, resulting in the transformation of an unused locker room into a sensory room**, fundraising for this and storytelling workshops. This formed part of the young people's social action (volunteering and campaigning) programme. It also **worked with the NHS adult mental health service on a project to transform a storage room at the day centre into a reminiscence room**. This created a place for day centre clients and benefited users of SLAM adult mental health services who were employed to work on it as part of their recovery programme.

A voluntary sector activity centre **worked with the local authority, the NHS and a local supermarket to put on celebrations for the annual International Day of Older Persons.**

Some day centres have opened up their buildings for use by others:

- A large day centre in south London developed a partnership with a social enterprise that employs and trains adults with learning disabilities; this led to the **day centre's kitchen being used as the training setting.**
- A dementia day centre introduced cycling for day centre clients. **Use of adapted bikes, bike storage and intergenerational support were all made possible through local collaborations with Wheels for Wellbeing and a local Pupil Referral Unit.**
- A local authority day centre **opened up its building to social workers, occupational therapists and a falls clinic, during its temporary closure due to Covid. Teams have continued to use the building after it re-opened**.

7.6 Day centre service expansion or re-design

An in-depth case study shares **experiences of providing a day centre for mixed service user groups**. Age UK Wandsworth's Gwynneth Morgan Day Centre supports older people, with and without dementia, and adults with physical disabilities, some of whom also have learning disabilities. As well as covering background, the case study details impact (including some individual case studies), day-to-day experiences of providing care for mixed groups, what helped and what was a hindrance and tips for others.

A second in-depth case study recounts the **experiences of redesigning and modernising a traditional day service into an innovative, creative centre for wellbeing for older people**. It covers challenges (internal and external) and details of developments and new partnerships (and includes an apology for having misrepresented day centres in previous roles!).

Devonshire Dementia Day Centre, which adjoins a care home, offers 1950s themed reminiscence experiences. It is a 1950s themed reminiscence day centre with a tea room (based on Lyons Tea Rooms), a pop-up market and a hairdresser. Equipment and paraphernalia were selected to match this theme. The screenshots below were taken from the website.

ENJOY A CUP OF TEA

A 1950s Devonshire Lyons tea experience

The Lyons photo, credited to Royal Pavilion & Museums, Brighton & Hove

A TRIM OR A PAMPERING

A hairdressing salon and barber's shop

A TRIP DOWN MEMORY LANE

A reminiscent shopping experience at the pop-up market

7.7 Examples

Reducing ambulance call outs for a diabetic day centre service user

Use of day centre building by local health and social care professionals

Annual International Day for Older Persons activities and partnership with supermarkets

Supporting the local authority to consult with carers during an update of the local Carer Strategy

Partnership with NHS adult mental health service to transform a storage room into a reminiscence room for day centre clients

Day centres for safety and safeguarding: the role of day centres as consistent factors in people's lives

Joan's story (written using the Most Significant Change approach)

Using a positive risk management strategy to ensure inclusion of people with early dementia in an exercise programme

Introduction of an Excel 'Time Tool' to monitor time needed by staff to support people and to prompt reflection about support techniques

Handovers and reflective conversations guided by daily wellbeing conversations and using handheld mobile devices

Local collaborations bringing music into day centres

Bringing the community into day centres: local theatre group and secondary school performances as entertainment

Partnership working with the National Citizen Service leading to transformation of an unused locker room in a day centre into a sensory rp0m, fundraising for this and storytelling workshops

Introducing cycling for day centre clients. Adapted bikes, storage and intergenerational support all made possible through local collaborations

Outreach to support and include older women members of a local Mosque

Introducing technology in a day centre (iPads and static cycling)

A local partnership led to the use of a day centre kitchen for training adults with learning disabilities

Providing a day centre for mixed service user groups: older people, people with dementia and adults with disabilities

'Redesigning for survival': an in-depth case study of re-designing a day centre for people with dementia

Reducing ambulance call outs for a diabetic day centre service user

The situation

A service user with diabetes became unresponsive several times (slumped, eyes rolled back), the ambulance needed to be called and took her to hospital. From a management perspective, this disrupted activities and had staffing ratio implications. One staff member needed to accompany the service user, another phone the ambulance, and another prepare paperwork. Meanwhile, staff needed to move other service users (with high needs) away from the area.

Background

Staff at this day centre actively monitored what this service user ate and drank with her diabetic needs in mind. Although none of the day centre staff are medically trained, they know their service users well, with time, knowing 'what is normal' for each one. When something is 'not right' with a service user, staff do not always know the reasons for this. A service user with advanced dementia arriving at a day centre is unable to explain what they have done that week or the day/night before. Not all family/carers are able to inform the day centre to let them know that a service user may not be too well on that day, or the service user has only seen their home care worker that morning.

Action taken

The service focused on discovering the cause of these episodes to understand whether they might be avoidable. Staff worked closely with the service user's family and identified the cause as hypoglycaemia. Together, they devised a plan to avoid hypoglycaemic episodes which included ensuring the service user ate regular small snacks.

Impact

- Better understanding the service user's medical needs led to fewer episodes of hypoglycaemia, fewer unresponsive episodes, and, consequently, a reduction in ambulance call-outs.

- NHS expenditure was avoided: ambulance call-outs (unit cost £213) and accident and emergency attendances (unit cost £117)[8].

- Service user: experienced fewer hypoglycaemic incidents, falls, hospital visits, and uninterrupted day service.
  - Hypoglycaemic episodes in people with dementia can worsen cognitive impairment or cause delirium (abnormal metabolism - e.g. low salt or blood sugar levels – that can have a lasting impact)

[8] **National Cost Collection: National Schedule of NHS costs - Year 2019-20**, NHS trust and NHS foundation trusts

- - Hospital admissions can be very disorientating for people with dementia, and can also contribute to delirium.
  (see **https://www.alzheimers.org.uk/get-support/daily-living/delirium)**

- Family carer: uninterrupted respite periods, worry, avoidable hospital visits, and disruption to plans.

- Service and other service users: reduced disruption to the service, operating with planned staff (service user ratios).

Use of day centre building by local health and social care professionals

A large local authority (LA) operated Dementia Day Centre in south London was being underused because of its mandatory closure to clients during the earlier part of the Covid pandemic. The LA closed its offices and introduced hybrid, or flexible, working. During this period, various LA employed social care staff started to use the day centre building. Opening up the use of the building has introduced health and social care professionals and borough residents to the existence of the day centre.

Some staff started to collect their PPE supplies from the building (and continue to do so) which heightened awareness of the day centre among these professionals.

The enablement service was relocated from the hospital to the day centre. Later, the 'discharge to assess' social workers[9] were also relocated there as they needed to be connected with the enablement team. These teams are based in the main office and main dining hall. The day centre's training room is used by LA occupational therapists (OTs), who are part of the enablement team, to run moving and handling training sessions.

The Falls Clinic, run by the falls OTs, now takes place at the day centre. This started during the pandemic when falls OTs delivered all their virtual training sessions from the day centre. Since the building has re-opened, the team has started to bring older people in to do their exercise programmes in the sports hall.

Social workers on the LA's single-point-of-access gateway use the day centre as a base to interview people from the local area and other parts of Lewisham. This is both for safety and accessibility reasons. There are both good public transport links and car parking.

A continuing, but acknowledged, challenge to extended use of the centre is the building's poor wi-fi connection. Managers hope that the building's broadening usage would lead to approval of an improved internet connection which would, in turn, enable creativity around use of technology with day centre clients.

[9] See Department of Health's hospital discharge service guidance https://www.gov.uk/government/collections/hospital-discharge-service-guidance (also https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance/hospital-discharge-and-community-support-guidance)

Annual International Day for Older Persons activities and partnership with supermarkets

Merton and Morden Guild, in partnership with the local authority and the NHS is involved in celebrations for the International Day of Older Persons – usually known as 'Older People's Day' – which is on 1st October every year. Celebrations take place in the nearby Sainsbury's Savacentre Superstore. M&MG organises demonstrations by people who attend its exercise classes. Music is played. Other organisations are also involved (e.g. Age UK). The NHS provides blood pressure testing amongst other things.

Supporting the local authority to consult with carers during an update of the local Carer Strategy

The London Borough of Merton needed to consult with unpaid carers living in the borough about its Carer Strategy. Merton and Morden Guild, a voluntary sector activity day centre that was in contact with many carers, supported the council to hold a consultation event on its premises. The event was open to carers linked with the organisation and other family carers living in the borough who were not were not.

Partnership with NHS adult mental health service to transform a storage room into a reminiscence room for day centre clients

Background

- Central Hill Day Service is for older adults living with moderate to severe dementia. It is an in-house service run by Lambeth Council.
- We wanted a place where people could sit among furniture and household items and ornaments from past times. We wanted to give people visible links to their younger years to evoke memories and conversation and to give reassurance through familiarity.
- It is a quiet room dressed up like a family living/dining room. The walls have been wallpapered to complete the illusion. The quietness of the room appears to aid anxiety, taking the usual day centre noises away, and is somewhere staff can concentrate on the individual if they are having an episode of anxiety or upset.
- Senior management agreed to offer enough funding to pay South London and Maudsley NHS Foundation (SLAM) for labour and to buy materials such as wallpaper, decorating items and hardware, for the job of transforming the storage space into a living space. All the collectables came out of Central Hill's budget. These were bought at local second-hand shops and on eBay.

Aims

The day centre's target service users had recently changed from older people to older people with moderate to severe dementia. The storage room was being used inefficiently and had potential to be a further, peaceful room that service users could enjoy as part of their day to provide them with a better day centre experience or to unwind and relax.

What was done

The day centre worked with **South London and Maudsley NHS Foundation** on a project to transform a storage room at the day centre into a reminiscence room. As part of their recovery, users of SLAM adult mental health services were employed, (i.e. paid) through SLAM, to work at Central Hill to put up wallpaper, a picture rail, treat damp above windows, paint above the windows and picture rails and fix ceiling kites to the walls to create a false ceiling.

We had to clear the storage area by placing needed items around the centre and having unwanted items taken away. There was also a huge amount of archiving to do before we got the space empty.

As the room was being prepared to be decorated, I (the day centre manager) asked my facilities officer (with a fleet van) to take me round all the local second-hand shops. We chose wallpaper and bought all the items needed to put it up. I was constantly thinking of how the

pieces I bought would fit together to create a living room of enough interesting detail for people. A false fireplace was fitted with fairy lights for effect. There was an unused piano in the room which became part of the living room. It was tuned and is ready for any piano players to 'have a tinkle'. People enjoy the live piano playing.

The work took place between November 2019 to December 2019 varying in days each week and people working on the day.

Resources needed

- Staffing: SLAM workers from Re-Cover, a man with a van, manager (project planner).
- Training: People came from SLAM with their own work experience and knowledge. They were stretched as the project was unusual and presented a few posers such as how to wallpaper a brick wall and create the *illusion* of a room.
- Space: When two centres became one, two sets of furniture and office items were stored at Central Hill. The only place to put it all, was an unused room at the rear of the building. A lot of work went into clearing the space in a timely manner for the creation of the reminiscence room.
- Decoration costs (involving mental health service users): Labour £1,000 (SLAM costs). Decoration materials £200. (Total £1,200).
- Manager: I was able to use my time within working hours and I did do some purchases outside of my working hours online from sites, such as eBay. I saw this room as part of the development of our service and we had full support from line managers to get the result we did.
- Transport. Our Facilities Officer, who is supervised by me, and who has a fleet van drove us both around several second-hand shops. This was not too time consuming as we found quite a few shops in our local area.
- Payment card. I am the only Lambeth card holder in our service to purchase such items. Other staff would have had to paying out and claim back expenses.
- Staff availability. As a face-to-face service, I and the Facilities Officer were the only ones who were not offering direct support which freed us up to do the above.
- Vision. Overall, it was my vision and ability to mentally tie all the elements in and the support of the Facilities Officer which brought the room together. The team saw all the things we bought as just random items piled up in a chaotic looking room until the room was dressed. It wasn't until they saw the results that they finally understood the vision.
- Out of hours time: Both the Facilities officer and I worked late to dress the room for the reveal to the staff and more importantly the clients who use our service the next day.

- **Reminiscence room furniture and paraphernalia costs**: £350, the biggest purchase was a working 1940s radio (see video – link below).
- **Funding**: Lambeth Council paid for this. A Purchase Order was created to pay SLAM for their labour. Workers were paid in accordance with their financial limitations such as benefits through SLAM.

Impact / outcomes

- We have not yet formally gathered feedback as the room is still very new. However, every family member, social worker etc who visits the room instantly starts identifying and pointing at things they remember from their childhood which sparks conversation.
- Clients attending Central Hill and their families benefit when the space is used for reviews and meetings. It is a pleasant place for a meeting. We offer potential new referrals and their family/carer to join us for lunch in this room.
- It was a cheap space to construct. Labour and gathering items took time.
- Satisfaction for those working on the transformation as demonstrated by an email from the SLAM contact:

> Dear Andy,
> Please find attached the invoice for decorating your reminiscent room. Thank you for giving the team an inspiring project we all enjoyed it, and the chaps look forward to coming to have a look.
> A very happy Christmas to you all at the centre BW Jane, SLAM

- Future plans: We are seriously considering using this space for people on the estate in which the day centre is located. We want to start either a breakfast club or a luncheon club for older adults on the estate who may have become isolated and need some social interaction and can have hot fresh food when they visit.

The process

The process was straightforward once the idea took form. Only clearing the space was laborious. Working in harmony with SLAM workers was important. Communicating clearly what exactly what was being asked of them and making sure they understood meant they could be left to get on with the work with minimum oversight.

Tips for others considering something similar:

- Make the space functional as well as interesting not just a room to visit to look at, like a museum. Furniture and items are to be *used*. Having a functional, useful room is more likely to result in service users feeling like they are a valuable part of the group, not just 'service users' or 'patients'.

- Purchase items from across the decades not just from one era (i.e. not all from the 1950s). People with dementia are at various stages of their regressive memory and will identify with different years. Also, their ages may range from 60 to over 100 meaning these years are likely to cover several decades,
- Carry the theme through the whole room/s.
- Go to local second-hand shops rather than vintage fairs where things are too costly to buy. Look on eBay for items being sold privately; we got some lovely items this way.
- This type of initiative is a great way to put partnership working in to practice, and helps people to learn about other groups of people. Try to link with services, such as SLAM, to do work for you. It is mutually beneficial. I bumped into one of the workers recently (2023) and he said he *'loved the work. It was challenging and he still thinks about it - how they overcame the challenges and the final result'.*

Reflections:

- It might have been a good idea to have the people who would use the service choose wallpaper and furniture as their views may not be the same as a manager's and facilities officer's. However, this would have been very difficult logistically.
- Service users and family members might have items or furniture they would like to contribute to the room. These could be personally relevant to individuals (but not precious) or to an era. Involving service users and family members would be a good opportunity to attempt to co-produce something that they will all use.
- Buying furniture and other items and thinking how to make a room attractive and relevant for service users is time consuming and labour intensive. Not all services will have the time/workforce to be able to do this.

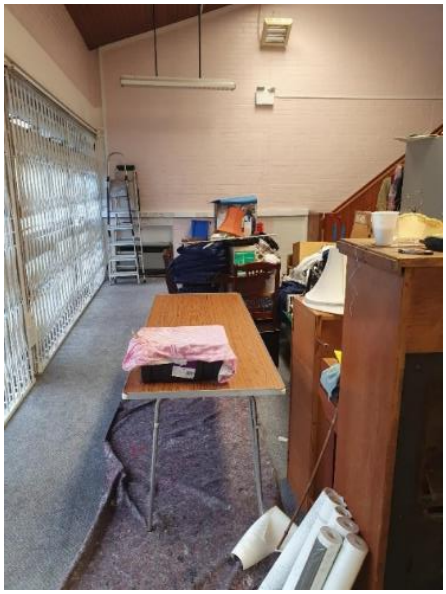
Relevance to policy and/or social care or NHS initiatives:

- Improved quality of life and wellbeing for people who need care and support and carers
- Reduced social isolation and loneliness (future plans)

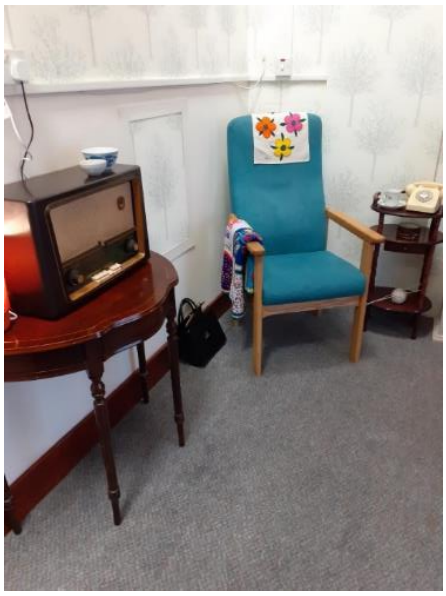
Sustainability

- Future funding plans/ideas: As mentioned we want to open this space to older people on the estate who may feel lonely, isolated. As well as being a lovely space to visit they can possibly create friendships. They can have a hot meal and we can look out for any safeguarding issues we observe/hear and alert our front door service.
- All the items are removable so when we eventually move, money has not been wasted.
- At some point, consideration will need to be given to how the room and resources in it will need to be changed to cater for future members as generational needs change.

Photos of the storage room and reminiscence room (before and after)



The storage room (before)



The reminiscence room (after)

Video of the reminiscence room (VLC media file – double click to open):

20191207_194130.mp4

Andy Lorentson, Manager, Central Hill Day Services, London Borough of Lambeth.
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Day centres for safety and safeguarding: the role of day centres as consistent factor in people's lives

Safety

Common reasons for referral to the day centre might include concerns that the person is not safe at home or cannot be left alone when living with a family member who works – either at or away from home – and is, therefore, unavailable. For some people with greater support needs, attending a day centre, while the family member is at work, is often considered to be more acceptable than a move to a care home. For many carers, the day centre support is an invaluable source of replacement care, often enabling them to care at home for longer.

Safeguarding

Day centres are a regular service run by a group of staff who can get to know their clients very well, their families and their home circumstances. A good rapport is important for relatives of clients to feel safe to speak out and this is possible due to continuity within the service. Family members often speak with day centre members about concerns or difficulties, and staff may signpost to sources of support.

Staff may, for example, notice bruising or that a carer sounds distressed and has commented that they lock their family member in the bedroom. Day centre staff would then discuss this with the carer and liaise with the LA safeguarding team if appropriate. A visit by a social worker could be triggered or matters discussed with the person's GP.

Safety-net for family carers

Some day centre managers argue that day centre staff play the role of "substitute social workers". It is not uncommon for family members who are feeling the pressure of caring to phone their relative's day centre for moral support, on occasions for a long time (half an hour).

Joan’s story (written using the Most Significant Change approach)

Background to my story

I am an older person who attends Merton and Morden Guild (a day centre providing activities and other services), in the London Borough of Merton, about three times a week, taking part in social activities and exercise classes. I also help out a lot now since a colleague died, from simple things like making tea to helping organise activities such as our apparently famous outings to the pub!

What it was like before?

I did feel depressed and there seemed to be no purpose to my everyday life.

What it is like now

I am a lot more active and like keeping myself busy, I am happier now than before joining the Guild.

What changes have happened?

It has helped me quite a lot. It makes me get up and get out and exercise whereas, before, I wasn't. You know, just like if you're not going anywhere, you don't bother getting up and you don't bother washing or dressing, but because you know you're going out, you have to make an effort.

I have formed a small friendship group which does things outside of Merton and Morden Guild activities, such as trips to markets.

Which of these changes is most significant to me?

Getting out, making new friends.

Why was this change significant for you?

I have more social life and something to look forward to.

What happened to make these changes come about?

My sister told me about The Guild as her husband had been collected by them for NHS Falls Prevention Classes in the past. It took me a couple of months before I eventually got here. It was one of the best things I did was to walk through that door. It's just the atmosphere down there. The welcome made a big difference to me. It was very smiley. “We're going to do this. Would you like tea or coffee?” It just sort of makes you feel at home, so to speak. And there’s always somebody there to help. Is absolutely brilliant. Everybody's so happy. Well, everything really good about the Guild. Everybody's so helpful that run the Guild. They're so kind.

Using a positive risk management strategy to ensure inclusion of people with early dementia in an exercise programme

Guidelines for an exercise programme, organised as part of a Local Authority (LA) Public Health programme, stated that people living with a dementia diagnosis (and who have been referred to the programme) wishing to access it must be accompanied by a carer. This excluded people at the early stage of the diagnosis who did not wish, or need, to be accompanied. The approach taken to address risk management and enable people with early dementia to access this programme may be relevant to day centres planning a visit to a local gym or leisure centre.

This exercise programme is accessible only by referral from a GP or health care professional. It forms part of an overarching exercise referral pathway and aims to bridge the gap between health and leisure. The person referring makes the decision as to whether the individual is medically well enough to exercise on the programme. This aims to mitigate the risk of injury to the individual or a staff member. There are no age limits in place.

Through conversation and negotiation, risks were identified (informal risk assessment). Solutions were found for the programme to be accessed and delivered in a safe way, thus opening it up to people with early-stage dementia who wished to attend independently. Alzheimer's Society also delivered a Continuing Professional Development (CPD) session to support LA staff to work with clients living with dementia.

To access this particular program independently (without a carer present), an individual would need to:

- be able to sign a consent form
- be able to remember instructions
- be able to use machines
- have no balance issues
- have no history of falls*****.

The decision about the above is made by the referring professional. If the individual is not able to do all of the above, a carer must accompany and support them.

An individual, client-centred approach is taken to manage risk and address arising concerns. Initial action involves a conversation between the provider and the exercise programme lead to identify risks and practical solutions in order to manage risk in a way that does not unduly limit access to the service.

Other settings or services will need to identify a decision-maker and tailor their own risk assessment and exit/review policy according to the activity, staffing considerations and progression of dementia.

***** Persons (whether or not diagnosed with dementia) with a history of falling will require further triaging to determine whether the exercise programme is suitable for them or if they need onward referral /signposting to another service (i.e. Falls Prevention Service).

Introduction of an Excel 'Time Tool' to monitor time needed by staff to support people and to prompt reflection about support techniques

An Excel 'Time Tool' to monitor time requirements for individuals' and whole-group support needs was developed by the manager of a local authority (LA) day centre for people with dementia.

The manager of a local authority day centre for people with dementia, **Esther Wiskerke,** developed a spreadsheet to monitor the frequency of certain occurrences (e.g. individual behavioural, mobility or personal care related support needs), and the staff time needed to support people at these times. The Time Tool aimed to help monitor a person's changing needs for support and overall group needs. It was also useful for sharing expertise between staff and for self-audit. The tool was intended as a positive monitoring exercise - to support staff, improve personalised support and support care plan reviews.

Rough timings were entered into the tool retrospectively in whole group staff meetings. Each client was discussed in turn. How long was spent supporting them (to do different things)? Was the day centre still appropriate for them? The staff team then reflected on support timing differences and learnt from each other how best and most efficiently to support clients in certain situations. For example: if one staff member said it took them five minutes to support a certain person to use the toilet, and another commented that it took them 20 minutes, discussion would follow about what method each had used. Care plans were sometimes amended accordingly.

Background

Although day centre clients are part of a group, they can expect a certain level of individual input from staff during their day at the centre. Some people will need exclusive individual support with some tasks to ensure that they are not at risk of harming themselves or others. The Time Tool addresses this.

The following were measured: time taken by certain 'events', the number of times these would happen (frequency), staff time taken in intervening (minutes) and numbers of staff needed to intervene. These would lead to a number and time that could be logged to review progress. Support needs were divided into categories, such as mobility and nutrition. Frequency and length of staff intervention time for certain 'events' were noted based on clients' behaviours and needs, and the number of intervention minutes totalled. This enabled progress monitoring /intervention needed at individual level.

Examples:

Behaviour: If, in the beginning, before a client had settled in, they needed help to feel calm, measures of this would be recorded on the behaviour category. For instance, 10 times, 2 and a half minutes each time, two staff (25 minutes per staff member, 50 minutes in total). Over time, once they had settled in, this might reduce significantly.

Personal care*:* Somebody not needing help to use the toilet would have no measure recorded on the tool. With time, they might need to be signposted to the toilets or need prompting or help with handwashing. Later, they may need to be discouraged from putting inappropriate things into the toilet. Eventually, full personal care assistance may be necessary (e.g. incontinence pad changes).

Mobility: A client may ask where they need to go and be able to go there without assistance. If they are at risk of falls, or require supervision or assistance to move around, then these would be examples of increased staff intervention.

Nutrition: If a client can eat and drink independently, even with modified diet or equipment such as a non-spill cup, they would not have any measures recorded on the Tool. If clients need prompting to drink enough, assistance with eating, or supervision to ensure they do not take food from others, then time measurements reflecting the need to provide one to one support would be included in the Tool.

Outcomes of using the Time Tool

- **Benefits for clients:** Better understanding of changing needs and the time and methods necessary to support them. Staff sharing tips may lead to improved personalised support. Regular reviews of needs, sometimes leading to care plan changes, would ensure their needs are recognised, met and accounted for. More focus on actual practical support time needed means that clients would not be excluded from the service on specific individual criteria, such as whether they are able to weight-bear.
- **Benefits for relatives**: Provides non-judgemental evidence supporting decisions about whether the service continues to be appropriate for individual clients. Providing non-emotive descriptions of time intensity required to support their relative can be less painful for carers to hear than details of 'inappropriate' behaviours (e.g. undressing, faeces-smearing). It may be helpful for carers to be given clear explanations of Time Tool evidence, and how it was arrived at. This could help illustrate how their family member has been treated as an individual and not compared with other clients and may alleviate any concerns they may have.
- **Benefits for staff**: Staff felt that identifying specific individual support challenges helped them feel validated because the challenges they faced on a daily basis were evidenced. The tool was also useful for service self-audit – e.g. team meetings identified how much time staff spent supporting people with the same tasks – shared tips etc. Reflective discussions at meetings were reportedly experienced as refreshing.
- **Benefits for manager/service**: Gaining clarity on the complex behavioural and psychological symptoms as clients' dementia progresses and the effect this has on pressure felt by staff and on staffing levels. Additional way to review care plans and monitor clients' needs.

Notes on use of the Time Tool

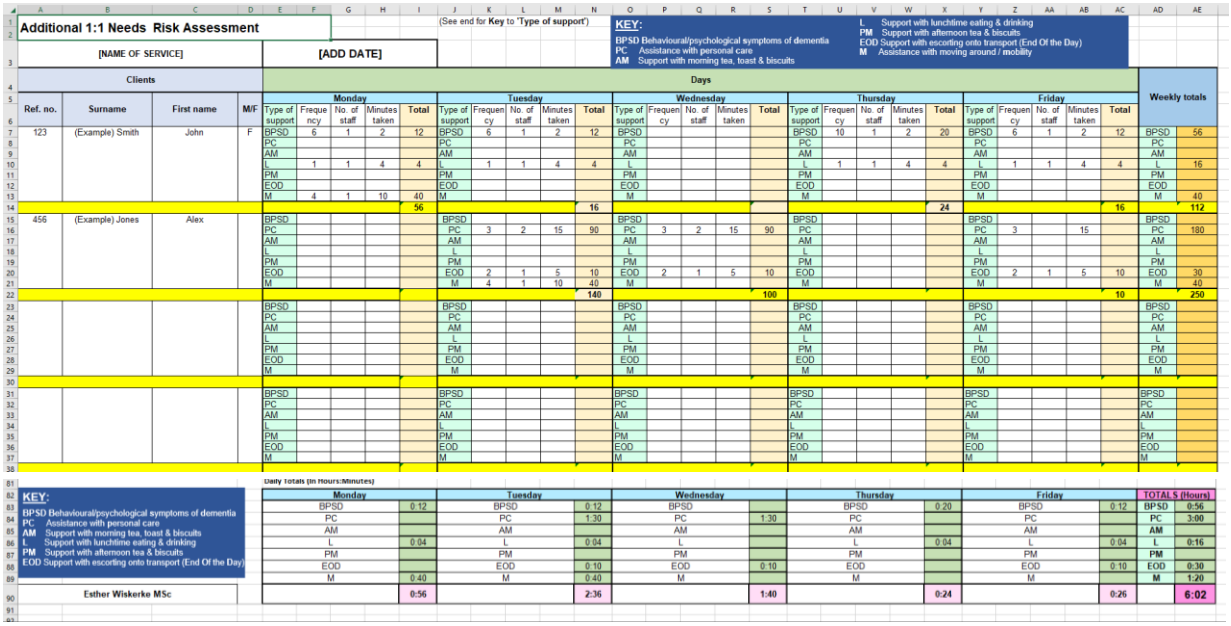
The Time Tool is intended to be used at intervals, to monitor a person's support needs. For example, every month or 6 weeks. Staff groups would then discuss individual support needs and any differences across time.

Two example lines have been completed to demonstrate how to input. A screenshot appears below.

- Spreadsheet users input to white cells only (name, m/f, frequency of support, number of staff needed and minutes taken).
- Figures in coloured cells are calculated automatically.
- Figures in the final daily totals section are calculated automatically (minutes of support in each category and in total).
- One row is provided for each area of support required.
- The key to areas being monitored appears at the top and bottom:

BPSD	**B**ehavioural/**p**sychological **s**ymptoms of **d**ementia
PC	Assistance with **p**ersonal **c**are
AM	Support with morning (**am**) tea, toast & biscuits
L	Support with **l**unchtime eating & drinking
PM	Support with afternoon (**pm**) tea & biscuits
EOD	Support with escorting onto transport (**E**nd **O**f the **D**ay)
M	Assistance with **m**oving around / **m**obility

Below is a screenshot of the Time Tool which can be downloaded from the Case studies and inspiration section of the Resources Hub.



Additional 1:1 Needs Risk Assessment

(See end for Key to 'Type of support')

KEY:
BPSD Behavioural/psychological symptoms of dementia
PC Assistance with personal care
AM Support with morning tea, toast & biscuits
L Support with lunchtime eating & drinking
PM Support with afternoon tea & biscuits
EOD Support with escorting onto transport (End Of the Day)
M Assistance with moving around / mobility

[NAME OF SERVICE] [ADD DATE]

Clients				Days																						Weekly totals	
				Monday					Tuesday					Wednesday					Thursday					Friday					
Ref. no.	Surname	First name	M/F	Type of support	Frequency	No. of staff	Minutes taken	Total	Type of support	Frequency	No. of staff	Minutes taken	Total	Type of support	Frequency	No. of staff	Minutes taken	Total	Type of support	Frequency	No. of staff	Minutes taken	Total	Type of support	Frequency	No. of staff	Minutes taken	Total		
123	(Example) Smith	John	F	BPSD	6	1	2	12	BPSD	6	1	2	12	BPSD					BPSD	10	1	2	20	BPSD	6	1	2	12	BPSD	56
				PC					PC					PC					PC					PC					PC	
				AM					AM					AM					AM					AM					AM	
				L	1	1	4	4	L	1	1	4	4	L					L	1	1	4	4	L	1	1	4	4	L	16
				PM					PM					PM					PM					PM					PM	
				EOD					EOD					EOD					EOD					EOD					EOD	
				M	4	1	10	40	M					M					M					M					M	40
								56					16										24					16		112
456	(Example) Jones	Alex		BPSD					BPSD					BPSD					BPSD					BPSD					BPSD	
				PC					PC	3	2	15	90	PC	3	2	15	90	PC					PC	3		15		PC	180
				AM					AM					AM					AM					AM					AM	
				L					L					L					L					L					L	
				PM					PM					PM					PM					PM					PM	
				EOD					EOD	2	1	5	10	EOD	2	1	5	10	EOD					EOD	2	1	5	10	EOD	30
				M					M	4	1	10	40	M					M					M					M	40
													140					100									10		250
				BPSD					BPSD					BPSD					BPSD					BPSD					BPSD	
				PC					PC					PC					PC					PC					PC	
				AM					AM					AM					AM					AM					AM	
				L					L					L					L					L					L	
				PM					PM					PM					PM					PM					PM	
				EOD					EOD					EOD					EOD					EOD					EOD	
				M					M					M					M					M					M	
				BPSD					BPSD					BPSD					BPSD					BPSD					BPSD	
				PC					PC					PC					PC					PC					PC	
				AM					AM					AM					AM					AM					AM	
				L					L					L					L					L					L	
				PM					PM					PM					PM					PM					PM	
				EOD					EOD					EOD					EOD					EOD					EOD	
				M					M					M					M					M					M	

Daily totals (in Hours:Minutes)

Monday		Tuesday		Wednesday		Thursday		Friday		TOTALS (Hours)	
BPSD	0:12	BPSD	0:12	BPSD		BPSD	0:20	BPSD	0:12	BPSD	0:56
PC		PC	1:30	PC	1:30	PC		PC		PC	3:00
AM		AM		AM		AM		AM		AM	
L	0:04	L	0:04	L		L	0:04	L	0:04	L	0:16
PM		PM		PM		PM		PM		PM	
EOD		EOD	0:10	EOD	0:10	EOD		EOD	0:10	EOD	0:30
M	0:40	M	0:40	M		M		M		M	1:20
	0:56		2:36		1:40		0:24		0:26		6:02

KEY:
BPSD Behavioural/psychological symptoms of dementia
PC Assistance with personal care
AM Support with morning tea, toast & biscuits
L Support with lunchtime eating & drinking
PM Support with afternoon tea & biscuits
EOD Support with escorting onto transport (End Of the Day)

Esther Wiskerke MSc

Handovers and reflective conversations guided by daily wellbeing conversations and using handheld mobile devices

The advantages of a day centre adjoining a care home include the availability of technology for daily management and having a culture of undertaking handovers between staff shifts in the care home. At the Devonshire Dementia Day Centre, mobile devices are used to gather information about guests' days and to generate reports. Such technology is viewed as an important area for investment.

A morning staff handover briefing covers plans for the day and who are the guests who will be attending.

During the day, staff informally gather information (i.e. during usual conversations) and enter this information onto the handover devices. They ask about wellbeing and scores for quality of meals. They note food and drink, numbers of toilet visits (including bowels opened), and accidents or incidents (e.g. falls or episodes of incontinence). They make a record of what each guest has done during the day. As guests leave, staff ask if they would be happy to come back again and record their answers.

At the end of the day, staff discuss how the day went, if anything needs to be followed up and any feedback or concerns from the families (e.g. glasses or hearing aid gone missing). Wellbeing/meals/willingness to return data is used to guide reflective conversations with staff (i.e. self-audit). For example: What went particularly well? What went wrong? Where could improvements be made? These conversations enable staff to reflect on their practice enabling them to improve the service they deliver and, in turn, improve guest experience.

Local collaborations bringing music into day centres

Two day centres have brought music into their centres in different ways.

- **The Ladywell Day Centre in Lewisham, for older people living with dementia and adults living with profound learning disabilities and complex physical needs.**
- **The Devonshire Dementia Day Centre in Kingston-upon-Thames.**

What the research says about the impact of music

Research has found that participation in musical activities is beneficial for cognitive functioning and behaviour. The benefits for people living with dementia are both physiological and psychological.

- Listening to music, playing music, dancing and music and movement can improve cognition and depressive symptoms in older people with mild cognitive impairment or dementia [101]. Music therapy (for 6-16 weeks) has reduced depression in people living with dementia [102]. *(Physiological and cognitive impact)*
- Music helps to balance blood pressure, heart rate, respiratory rate, and hormone levels [103, 104]. *(Physiological impact)*
- Music helps to reduce mood fluctuations, depression, and behaviours such as agitation and aggression [105-107]. *(Behavioural and psychological impact)*
- Music improves communication skills, quality of life, wellbeing, memory, self-awareness, and environmental awareness (the ability to distinguish between the surroundings and moments of the day) and pain management [103, 108, 109]. It can enhance language skills, verbal and non-verbal expressions, social activity and communication, raising cognitive levels and self-awareness [105, 110]. *(Cognitive impact).*
- Music also supports emotional wellbeing, engaging attention (reducing apathy) and improving self-esteem and communication, all of which improves behaviour that is caused by poor emotional wellbeing [111]. *(Psychological impact - emotional wellbeing)*
- Dance can benefit older people's health and wellbeing: physical, mental, and social wellbeing [112], physical function, mobility, and endurance [113]. Dance is very adaptable to different abilities [114]. It is popular across different backgrounds and cultures [115]. It does not require expensive equipment [115].

Musical performances

A staff member of the Ladywell Dementia Day Centre contacted a community jazz band inviting the musicians to use day centre space, in the dementia area, for weekly practice. This meant that day centre attenders benefited from free live music.

The BigHeart Band, a group of volunteers who sing in care homes, visits the Devonshire Dementia Care Home and Day Centre on a bimonthly basis, giving performances for residents and 'day guests'.

Music and movement

Professional networking led to the Ladywell Day Centre providing space for music and movement sessions run by an arts organisation. Entelechy Arts' 'Ambient Jam' sessions are for people with profound learning and physical disabilities. They agreed with the day centre to hold the sessions there which enabled the people attending it (who live with dementia or profound learning disabilities and complex physical needs) to have free access to these therapeutic activities. This collaboration benefited the day centre, its clients, and the arts organisation.

Music therapy

Nordoff Robbins is a music therapy charity that uses music to enrich the lives of people with life-limiting illnesses, disabilities or feelings of isolation. It heard about the Ladywell Day Centre and offered to provide music therapy for one day a week, for a year, free of charge.

The professional music therapist draws out people's abilities and successfully engages them in music. One older man with dementia became actively involved in drumming sessions and positively engaged with the moment; he was usually quiet and did not initiate conversation or other activities.

Working closely with the therapist in practice has enabled a transfer of skills. Staff now apply principles used in these sessions at other times which has led to increased positive engagement.

Bringing the community into day centres: local theatre group and secondary school performances as entertainment

Merton and Morden Guild attenders benefit from live theatre and musical performances. This enables them to enjoy the arts and gives them conversation material to take home ('**fresh news'** [44].

- A local street opera and theatre group, **Baseless Fabric,** performs for attenders, and does dress rehearsals (e.g. Madame Butterfly
- A local theatre, **The Colour House**, brings performances to attenders (e.g. pantomimes)
- A local secondary school, **Wimbledon High School**, visits to do dress rehearsals with an audience for their big shows.

Partnership working with the National Citizen Service leading to transformation of an unused locker room in a day centre into a sensory room, fundraising for this and storytelling workshops.

A new sensory room was decorated in partnership with the National Citizen Service.

Central Hill Day Services, a local authority run day centre for people with moderate to advanced dementia in Lambeth, partnered with **The National Citizen Service**, a voluntary personal and social development programme for 15–17-year-olds in England and Northern Ireland, funded largely by money from the UK Government. This resulted in the transformation of an unused locker room into a sensory room, fundraising for this and storytelling workshops. This formed part of the young people's social action (volunteering and campaigning) programme.

Why we got involved with NCS and what it involved

The aim was to offer young people an opportunity to showcase their skills and abilities whilst bringing something positive to the people who use our service: a partnership. The partnership was first formed 2014. Visits took place between mid-July and mid-August 2018.

The place becomes animated when young people are around which gives off a positive vibe, and only adds to a client having a good day. Each group of young people working with us gets a short informative insight into Dementia and the effects if can have on people living with it and their families and friends.

There were six visits to the day centre by NCS young people. The first two visits involved life storytelling workshops with clients to get to know our clients and they them. The young people then went away to design and put together their ideas for the agreed Sensory Room and for a final Fun Day which they presented and were agreed in visits 3 and 4. They informed us they had started to fund raise to cover the costs of the paint and decorations. For Visit 5, the young people brought paint, decorations, sensory items. They decorated the locker room – which had been painted white in preparation. Visit 6 was for the 'fun day' which they organised and where the sensory room was shown off. The group decided to surprise us with an original song and rapping. Everyone was thrilled to watch and take part.

Resources needed

- Fundraising was undertaken to cover costs. NCS young people organised a GoFundMe page, stating that leftover funds would be donated to the day centre. £54.33 was raised in total.
- Staffing: The manager x 3 hours. 1 Senior x 2 hours
- Space for young people to gather to have a break.
- Refreshments for young people

- Expertise in sensory spaces: The day centre manager had worked in and created sensory spaces previously. Her background is in supporting disabled people, particularly those with profound and multiple learning difficulties.

Outcomes

Feedback from NCS: 'Once again, thank you for your commitment towards helping the young people in your community to interact with those they wouldn't normally, and allowing them to develop the many skills they have gained on the programme'.

The room is a lovely space. Value-wise, it is an asset for Central Hill. The decoration was beautifully done, and it is a safe space for people needing somewhere quiet.

Our clients enjoy using the room for conversations (mood lights and aroma only, not sound). The room is used by staff if they need a quiet moment. It can be adapted to hold confidential meetings with carers and social workers. Staff enjoy using it for meetings with clients' family as it is less formal that an office. It also provides a pleasant, secluded place for clients to receive minor medical procedures, such as injections, by the visiting district nurse.

One to one support is offered to people who may need time alone: here we use the projector/fibre optic/music/sounds/smells/touch, such as hand massage and foot spas depending on their preferences and communication preferences.

The process

NCS are professional and organised. They make each project with them seamless. They are great communicators and hold your hand every step of the way. They give relevant information which supports us and the process of partnership working. We make ourselves available. Due to the Covid-19 pandemic all partnership worked stopped however we will willingly restart this partnership.

What are multisensory environments, who could benefit from them and what is the research evidence for them?

Multisensory Stimulation (MSS) involves using equipment (e.g. tactile objects, lights, music and smells) to stimulate the five primary senses but without placing intellectual demands on individuals. Research has found that Multisensory Stimulation significantly improves functional performance in people living with moderate-to-severe dementia. It promotes wellbeing, reduces some agitated behaviours and improves mood, functional behaviour and social interaction.[116]

Guidelines produced by the National Institute for Health and Care Excellence, which suggest that multi-sensory training should be provided to staff supporting people with moderate to severe dementia and communication difficulties. These are evidence-based recommendations developed by independent committees, including professionals and lay members, and consulted on by stakeholders. See **NG97: Dementia: assessment, management and support for people living with dementia and their carers NICE guideline.**

Information about understanding sensory loss in dementia care, including a 15 minute introductory video, can be found on the Social Care Institute for Excellence's website. The website also offers a free '**Dementia awareness e-learning course**'

A sensory room in a day centre could be a community resource for, for example, care homes, local schools, youth groups, disability support groups, pre-school children, and people with dementia living in the community.

Photos of the locker and reminiscence room

Left: The locker room before the transformation
Right: Completed paintwork with the young people who decorated

The new sensory room - ready to use, complete with soft lighting, fibre optic machine and bubble tube. Older adults prefer these upright supportive chairs. The room is too small to accommodate beds/hoists, but there are recliners.

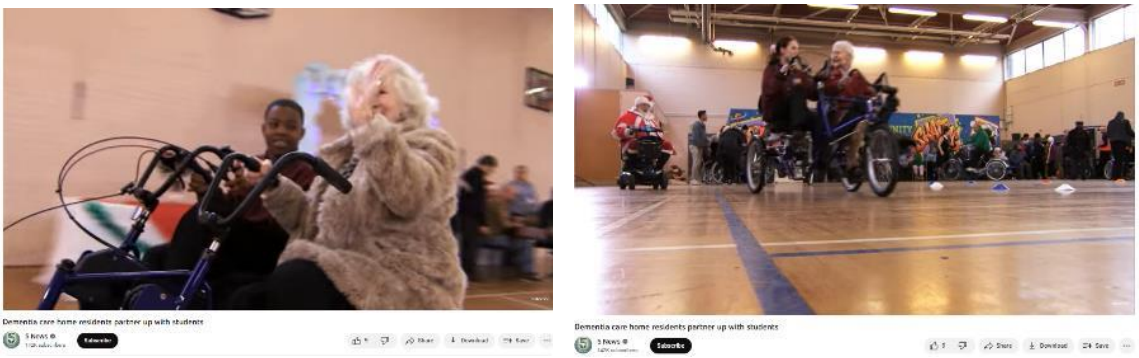
Andy Lorentson, Manager, Central Hill Day Services, London Borough of Lambeth
ALorentson@lambeth.gov.uk

Introducing cycling for day centre clients. Adapted bikes, storage and intergenerational support all made possible through local collaborations.

The Ladywell Day Centre's long-term partnership with Wheels for Wellbeing has led to the introduction of inclusive cycling and storage provision for these bikes. Adapted bicycles are used by day service clients who are living with dementia, in a large gymnasium within the day centre and in the neighbouring park, enabling access to nature.

Another partnership involves students of the Abbey Manor Pupil Referral Unit, who were already volunteering with Wheels for Wellbeing to repair these bikes. The dementia day centre's manager gave students information about dementia. A small number were then selected to support clients during bike-riding sessions, with supervision. This intergenerational work benefits both groups who were experiencing marginalisation within society: the older people with dementia, some of whom may not have regular contact with young people, and students who benefit from feeling trusted and from enjoyable contact with older people during a fun activity.

This work was highlighted in a **news report by Channel 5 news (see video)** (which incorrectly states it is a care home rather than a day centre). The news report shows bicycles in use, interviews two young people, an older person and the day centre manager.



Still images taken from the news report video.

Considerations for day centres developing similar programmes:

Older people without dementia or with less advanced dementia attending day centres may like to be involved with bicycle maintenance. This could give them a great opportunity to share their knowledge and reinforce their sense of purpose and self-esteem.

Outreach to support and include older women members of a local Mosque

Merton and Morden Guild (M&MG), a voluntary sector day activity centre in the London Borough of Merton, made links with its local Mosque and invited its older women to a Platinum Jubilee afternoon tea with a view to opening up some local opportunities for them and enabling existing members to meet new people.

Although M&MG is fairly multi-cultural, there is very low uptake by Mosque members despite informal links already being in place. Some M&MG attenders had been on a tour of the Mosque and had also been invited to attend Eid celebrations a few years previously. During the Covid-19 pandemic, Mosque members gave M&MG donations for attenders (e.g. chocolates) who were unable to get out and about.

The invitation to the afternoon tea was initiated after chatting with a younger Mosque member during a tour, and then phone calls. The younger Mosque women wanted the older women to be less fearful of mixing in the local community and to meet people. They were worried that the older women did not have access to exercise classes, were keen for them to have better access to local facilities and were encouraging them to go beyond the Mosque environment.

M&MG visited the Mosque to speak with the older women to enable the women to meet some of the day centre staff in a familiar setting. During this visit they were invited to this special afternoon tea.

This initiative introduced the older women to M&MG, its facilities, and members, with a view to both sides learning about and getting to know each other and having fun together. The Mosque contact provided some guidance to ensure dietary requirements were met.

What the research says about Mosques and their older members

Research by the Muslim Council of Britain and the University of Cambridge found that Mosques and their community centres tended to give low priority to engaging with and offering facilities to their older members. [117]

Two people interviewed for the study highlighted the role of Mosques in the health and care needs of older Muslims and Muslims at end of life.

- "*Our mosque is sometimes almost like a day centre. (…) Elderly people spend a lot of time in the mosque conversing with each other. There is a social environment here in different languages. Many come in the morning and leave in the evening*." (Mosque director, East London).

- "*We have daily tajweed classes for the elderly, but we are not doing enough. Our focus is on the youth, but we must start something for the elderly – coffee mornings . . . this is a hidden problem, our elderly are invisible*." (Mosque Iman, South of England).

Introducing technology in a day centre (iPads and static cycling)

After a self-assessment, Central Hill Day Service in Lambeth, improved its offer for service users who live with dementia by introducing technology such as iPads and static cycling with virtual scenery.

iPads

Service users are individually taught how to find music they remember and wish to listen to. Some choose to sing along or dance to the music. The iPads are linked to a speaker by Bluetooth. Using 'Google Earth', people can revisit places they have lived. This starts discussion and rekindles memories. The next step will be to use Facetime or Skype to enable carers to become involved.

Static cycling with virtual scenery and sound (https://motitech.co/)

Using a specially adapted static exercise bike and a monitor, people can 'virtually' cycle along the streets they remember, beautiful scenery or favourite holiday destinations whilst keeping fit.

Using special software in combination with an adapted bike allows people to pedal – with feet or hands – through destinations such as the Peak District or the South Downs in the UK, Niagara Falls in Canada, or even through the town in which they were raised. They can do this while listening to their favourite songs or immersed in ambient sound.

Motiview software (which originates in Norway and requires a license) is used with these **Motitech bikes**. Motitech ensures there is a video of the license holder's local area, made in cooperation with the user site.

Central Hill's service users have taken part in a global competition, and events such as **Road Worlds for Seniors**, which takes place in autumn each year.

Service users enjoy the bikes so much that they now sign up to compete against each other. Cumulative mileage for all service users is recorded. In the first two months of having the bikes, service users had cycled around 800 miles collectively.

Motitech static bikes were sourced from the Association of Directors of Adult Social Services (ASASS) and Sport England.

A local partnership led to use of a day centre kitchen for training adults with learning disabilities

Ignition embarked on a partnership with Lewisham Council and Lewisham Mencap that aimed to help learning disabled residents of the borough into paid work. They are a local social enterprise that employs and trains local people with learning disabilities and pays the London Living Wage.

Ignition Ice is one of Ignition's business initiatives.[10] Ignition creates training opportunities, secures qualifications required for employment, and creates enterprises such as Ignition Ice which will create jobs and make great products. Ignition Ice uses Ladywell Day Centre's kitchen as a base to train people with learning disabilities to work. Ice cream in a range of gourmet flavours was launched in summer 2022.[11] [12] [13]

Employment is one of the three things contributing to health and happy lives for people with learning disabilities (alongside wellbeing and independence). Only 7.7% of service users with a learning disability who receive long term support are in paid employment (ASCOF 2019/20). Nationally, 94% of people with learning disabilities are unemployed.

[10] Another is Ignition Brewery.

[11] See announcement on Lewisham LA's website **Using ice cream to help residents with learning disabilities into work**

[12] See **Proposal for a Co-productive Approach to the Modernisation of Adult Learning Disability Day Opportunities**, Lewisham Mayor and Cabinet meeting, 8 December 2021

[13] See News from Crystal Palace article **Ignition brewery securing employment opportunities for residents with disabilities (including a 2022 lift-off for an ice cream enterprise),** 22 December 2021

Providing a day centre for mixed service user groups: older people, people with dementia and adults with disabilities

Age UK Wandsworth's Gwynneth Morgan Day Centre provides specialist support for people aged 60 and older, people living with dementia and adults with physical disabilities; some service users also have learning disabilities. The day centre is open from 9am to 5pm, Monday to Friday. Referrals are made following a social work assessment.

Background

The service operated as an 18-month pilot, until March 2023[14] in purpose-built premises under a contract with the London Borough of Wandsworth to provide specialist day services for three service user groups: older people, people living with dementia and adults with physical disabilities.

Various organisations (e.g. Social Services, Leonard Cheshire) had provided services in the council-owned building over the years, but, most recently, it had been a day centre for adults with physical disabilities. A service review about the way forward for day services in the borough led to Wandsworth Council deciding to refurbish the building, add a second storey and repurpose it as a community hub, offering a day centre and community outreach. Service users were temporarily moved to another site while work took place.

Age UK Wandsworth was awarded the contract to run the pilot service. Age UK Wandsworth had previously been providing services for people aged 60 or older (but not a day centre), and Leonard Cheshire for adults of all ages with disabilities. Leonard Cheshire staff, who had been operating the day service for adults with physical disabilities prior to the building work, were transferred to Age UK Wandsworth (via TUPE). This pilot aimed to test Wandsworth Council's vision for a mixed service user group day service.

Service users and staffing

Intake of service users was on a staged basis after a month of setting up rooms and intensive staff training. Some people with disabilities, who had accessed the service onsite previously, were ready to start immediately. On average, around 18-25 people now use the service every day, with approximately one-third in each service user group (older people, people with dementia and adults with disabilities). Plans are to continue to grow numbers gradually. The waiting list includes a very high proportion of people living with dementia.

The ratio of staff to service users is 1:6-8. Some may need 1:1 support for part of the day, but not at other times, and staff are allocated individually where this is identified in the initial assessment.

[14] At the time of writing (August 2023), the contract following the pilot period was being finalised.

The service takes a person–centred approach, promoting independence and social inclusion in a safe, relaxed and warm environment. Staff are kind, caring and experienced, and treat everyone with dignity and respect. All staff, regardless of role undertake the same training programme in safeguarding, sensory awareness and dementia. Specialist training includes online and classroom-based training which cover the different types of dementia, different types of mental health problems and communication strategies for people living with dementia. Classroom training includes virtual reality activities, such as staff wearing sensory equipment that enables them to experience the challenges faced by people living with dementia.

Facilities

All rooms are spacious and well-ventilated with natural light and large windows.

Several rooms are downstairs: a dining room, a fully adapted kitchen, the IT suite and reminiscence/quiet space. An accessible garden is outside.

Upstairs, which is accessible via a keypad and a lift, are the reablement room, exercise and games room, salon for hair and podiatry, and The Daffodil Room. The Daffodil Room hosts a specialist service for people with moderate to advanced dementia. A sensory area includes a **Magic Table 360** which is an interactive projector that provides games, music and tranquil visual backgrounds.

Refreshments and lunch are taken all together downstairs, in the dining room.

The day: activities, meals, transport, access to the service

Service users can engage in a social, friendly environment or relax in peace and quiet.

Various activities are organised downstairs. Usually around five or six activities run at any one time and are open to any service user.

Specialist activities for service users with more advanced dementia take place in the Daffodil Room for about 30-45 minutes (to cater for those with a shorter attention span). Staff use this specialist dementia training and knowledge of a person's needs and individual interests to personalise activities and games. These service users then join others downstairs where other activities (for mixed groups) take place.

Staff work closely with service users and their families to discover what people like and enjoy, what their interests are etc., and plan activities accordingly. Some activities share a title but are tailored for different abilities. For example, one crossword puzzle group activity may involve a group of people working together to solve a crossword. Another would take place in The Daffodil Room using the magic table that shows a wordsearch which reveals a word as a hand moves over it. Likewise, individuals can listen to their choice of music with headphones using an iPad, or there are larger music groups that anyone can join in with. Some activities, such as exercise to music, involve all service users and all staff.

Newspapers, board games, puzzles and arts and crafts are always available. Staff regularly organise bingo, quizzes and films. Exercise sessions include regular seated exercise and exercise bike sessions and 'pop-up activities' such as seated yoga and Zumba. Themed pop-up activities (e.g. carnival) are also held for one week in each month.

A gym and reablement equipment are available. Staff can assist service users with personalised goals and an exercise plan. Equipment is owned by the council.

The large IT suite includes accessible features such as height-adjusting tables, keyboards with large keys and trackball mice. Service users may use the IT suite whenever they would like to go online.

Weekly themed coffee mornings for service users and other Wandsworth residents aged 60 or older aim to connect the centre with the community.

Refreshments are available throughout the day. A nutritious two-course lunch is cooked onsite and caters for specific dietary needs.

Transport is provided on modern minibuses. Service users can be assisted in/out of their homes. Times of pick up and drop off vary. There is space available for wheelchairs and walking chairs.

To access the service, a social worker must carry out an assessment to ensure a person meets the service eligibility criteria to attend. If eligible, a free taster day is offered. The person can decide if the facilities offered suit them and support can be arranged for any ongoing attendance.

Day-to-day experiences of providing care for mixed groups

This mixed service user day service was a new initiative that was set up with certain contractual specifications, such as making available a room specifically for people with more advanced dementia. However, a good degree of freedom in its day-to-day running has been possible. Providing the service has been a learning experience that has involved testing ideas to discover what would work best. For example, having activities downstairs and refreshments/lunch upstairs was not successful as the 'dining room experience' was felt to be missing. Consequently, meals and refreshments are now all taken downstairs, as one group. Having a designated smoking area in the garden and using the upstairs specialist room for specific activities (rather than for the whole day) means that service users with dementia who smoke and can still be supervised while retaining independence.

Feedback from service users' family members was helpful during this development stage as it helped to consolidate some ideas. For example, the manager had, initially, envisioned a very integrated service in which people would mix. Someone asked if her family member (who had dementia) would have access to activities downstairs and was pleased that she would. This supported efforts to ensure that service users had opportunities to mix between groups.

Although everyone being together is a goal, some service users need some calm with low noise levels, and some people are very vocal and can sometimes monopolise activities. Therefore, the opportunity to have 1:1 activities or support must be available. Staff are also aware of individual needs with respect to balancing groups and managing people.

Having mixed groups has not led to any safeguarding concerns. The staffing ratio is good and all groups are supervised. Potential issues are documented and reported back to social workers after trial days and short settling in periods. Staff get to know regular service users and their behavioural characteristics well and are able to manage and defuse situations before these escalate.

The positives of delivering an integrated service, which are detailed in the next section, have outweighed the negatives.

Impact

Staff have enjoyed witnessing how integrating different groups of people has led to improved mutual awareness and personal growth. Family members have fed back similar outcomes to staff.

It has been noticeable how some of the service users with disabilities have 'buddied up' with service users with dementia, offering their help at meal, and other, times. Staff have observed how taking on a self-imposed 'mentor' role has helped some people develop. Families have also informed staff that they have noticed their family member growing in confidence.

Networking with local community groups and inviting local healthcare professionals and social workers to visit has been extremely helpful and is something Age UK Wandsworth will continue to do and to encourage. Feedback has been received that these visits have supported people to progress their thinking about developing projects to support the local community. For example, visitors have talked to people, individually and in focus groups, to find out what is lacking in their area.

Case studies demonstrating impact on individuals

Service user A is 81 and has been going to the day centre for a short time. He is blind and hard of hearing. He really started to enjoy himself during his visits. He joined in with exercise and topical discussion groups and is keen to listen to music on the tablet using headphones. His visual impairment means it can be difficult to participate in the current events discussion group, but he enjoys listening to others. The staff facilitator encourages him to attend and to offer his opinions which makes him feel valued and included, as well as reducing his feelings of social isolation. When it is time to go home, service user A tells staff that he had a lovely day. His daughter has complimented the service, saying that her father really enjoys his time there.

Service user B is 82. She started attending the centre in autumn 2022. She had a challenging start and found it hard to settle in. She would often say that she wasn't coming back when she left for the day. She now has a small group of friends she likes to sit with, and they can often be found laughing and engaging with the larger group during activities. Service user B has come out of her shell and become very sociable. Her love of music and playing the harmonica are clear. She dances and sings along during music activities. Service user B's daughter has fed back that her mother really enjoys going to the day centre now and eagerly waits for the transport to collect her on Wednesdays and Thursdays.

Service user C is an 85-year old man who has been attending the day centre for many years. He can often be ill-tempered and unsociable. Over time, staff have learnt how to manage his likes and dislikes. He would often refuse to take part in group activities. He has now started taking part in a dominoes group with other service users. The group does not talk much but there is a camaraderie between them, and they play all day long. He has become more social because of his connection with this group and it is clear he enjoys the domino games. He is more engaged with people round him and his mood has improved. Service user C smiles more often now and makes some small talk with the other players.

Service user D is an 83-year woman from the Caribbean who is living with dementia, is a stroke survivor and has multiple health problems. She has been attending the centre for a year. Service user D cannot communicate verbally and needs assistance with all aspects of personal care. Through music groups, staff established the songs she likes by noticing when she tapped her foot. After a few weeks of going to the centre as a wheelchair user and using MOTOmed Movement Therapy equipment[15], she was able to walk a few steps using a Zimmer frame. When a service user is unable to express their interests or goals, it takes great care and patience to try various activities and watch for different reactions. Staff were able to ascertain which music she liked and improved her mobility, even if only for a short distance. Service user D's son says his mum is more alert and happier when she returns home from a day at the centre.

Service user E is 87 and a long-standing service user who developed dementia. She was often quiet and did not engage with activities or other service users. She really enjoyed when there were sweet treats on offer. Staff knew she liked animals as she would tell stories about growing up on a farm and decided to try to engage with her by using the robot cat. Service user E would become more alert and talk quietly to the cat. She would light up and make eye contact with the people around her when she was brushing the cat's fur or feeding it biscuits.

[15] MOTOmed Movement Therapy, which uses device-based movement therapy, was developed for people with movement restrictions and complements physical, ergo and sports therapy measures. Users can train while seated in a wheelchair, from a chair or lying down. The day centre has several MOTOmed viva2s which are leg and arm/upper body trainers; passive or assisted settings can be varied to suit individuals, and programmes and timers can be set. For more information, see **www.motomed.com**.

The process: what helped and what was a hindrance?

- Growing the pilot service gradually, to enable staff to get to know service users and their needs individually and in a phased way, was a good idea that was well-received by the council.

- Being approached by healthcare professionals was helpful for local awareness of the service. Inviting social workers and healthcare professionals to visit allayed any concerns about how the service would manage individuals and counteracted any scepticism any may have felt about day centres, and, in particular, one that catered for mixed groups.

- Having regular meetings with the Council's commissioning team was supportive. These meeting both enabled feedback - of concerns/issues and positive stories - and built trust.

- Regular meetings to draw on the day-to-day experiences and knowledge of the support team (who drive the minibuses, run activities, provide personal care, and do paperwork) were an important contributor to getting things right, as was trial and error.

- The building was fitted with a mirror inside the lift. This positioning has been problematic since people with more advanced dementia can find their reflection in mirrors quite distressing and the specialist activity room for this group is upstairs. We have covered the mirror with paper.

Tips for others

- Challenges are to be expected when providing a new service to a mixed group. Be open-minded. Realise that you might try something but will still need to consider alternative options.

- Trial days are important for service users, family and the provider.

- Regular meetings to draw on the day-to-day experiences and knowledge of the support team (who drive the minibuses, run activities, provide personal care, and do paperwork) is key to getting things right. Feedback on how things generally/specific initiatives are working and any ideas should be discussed in these.

- Schedule and hold regular meetings with the Council's commissioning team. The day centre manager finds this very supportive and these meetings provide her with the opportunity to regularly share feedback.

- Invite social workers and community health professionals to open days and provide an opportunity for questions as these things break down barriers, address preconceptions and build trust.

- Being active on social media (Instagram and Facebook) helps the community know what the centre does and what can be offered. Families enjoy seeing what their loved ones do at the centre (and consent to their images being uploaded).

Resources needed

- **Staffing**: for every staff member, there are 6-8 service users.
- **Training**: Staff, who were TUPED[16] over to Age UK Wandsworth from Leonard Cheshire's disability service were already knowledgeable about disabilities, were given intensive training in dementia (by the service manager whose background was in dementia care. The organisational Chief Executive and the service manager have attended extensive training.
- **Funding**: An 18-month pilot, funded under a service contract with London Borough of Wandsworth, ended in March 2023). The follow-on contract is currently being finalised (at time of writing – August 2023).
- **Daily charge** £52 (set by Council and subject to financial assessment and invoiced by the council) + £7.50 for refreshments/lunch (collected onsite).

Website: **www.ageuk.org.uk/wandsworth/our-services/gwynneth-morgan-day-centre**

Instagram: **https://www.instagram.com/ageukwandsworth**

Facebook: **https://www.facebook.com/WandsworthAgeUK**

Linktree: **https://linktr.ee/ageukwandsworth**

[16] TUPE: Transfer of Undertakings (Protection of Employment). A 'TUPE transfer' happens when a service or organisation is transferred from one employer to another.

'Redesigning for survival': an in-depth case study of re-designing a day centre for people with dementia, Ray Baird, Braid Health and Wellbeing Ltd

This case study was presented at the Day Centre Research Forum on 23rd June 2022, and updated in May 2023.

Summary

This in-depth case study examines the experiences of redesigning and modernising a traditional day service into an innovative, creative centre for wellbeing for older people. It is a '*warts and all*' account of a service fighting for survival through unprecedented times including pandemics and local authority cuts, and the struggle for recognition from statutory organisations in relation to its place in the care continuum for clients.

It covers recognition that day services' value is under-recognised, how Ray Baird, the new Chief Executive Officer, started the process of gathering knowledge about the service and understanding the Board (and the challenges this involved), starting to implement change during the Covid-19 pandemic and the process for change – how a culture of continuous improvement was nurtured and how 'system drivers' were explored.

Changes included:

- introducing KOMP communication devices (simple, one-button instant communication devices)
- buying a Magic Table
- developing a dark and a light sensory room
- introducing person-centred care and starting to monitor this using the PERCCI (Person-centred Community Care Inventory) evaluation questionnaire
- appointing a resident artist
- developing a life skills/reablement centre and courses (now a self-contained business within the day centre)
- employing:
  - a professional fundraiser was employed who has attracted new projects and funds
  - a marketing assistant from the government's Kick Starter scheme
  - an occupational therapist
  - a Link Worker
- establishing a relationship with Education Scotland which has led to the day centre becoming a recognised placement for NHS allied professional students (OTs, paramedics, physiotherapists, podiatrists and nutritional therapists) and for nursing students
- developing a partnership with the Advanced Research Centre for Care at Edinburgh university which led to a programme of research and innovations at the centre.
- changing the service name and branding.

Apology for misrepresenting day services in my previous roles

I am going to start this presentation by breaking one of the major rules of presenting and that is, starting with an apology. An apology for past misrepresentation of day services in past positions. An apology for underestimating the effectiveness of day services, an apology for ignoring day services in past redesigns and improvement programmes and an apology for never really truly understanding the part these services play in the care sector.

I am embarrassed to admit that over a 33-year career within the health and social care system I had never worked with or included day care providers and specifically, those dealing with older people, in any programmes of work I have undertaken. As a so-called 'expert for redesign and improvement' I have worked at the highest level within the Department of Health, NHS Trusts and Clinical Commissioning Groups as well as being an international advisor for the World Health Organisation for improvement within mental health services and as I have already mentioned, not once have I included day services into any redesign or improvement plans.

I now find myself in the position where I am trying desperately to raise the profile of these services to people just like myself in the past, who have a degree of influence but do not utterly understand what it is we provide and the effect we can have on individuals and families.

Introduction to this case study presentation

This presentation deals with redesigning a large day care service within West Lothian, Scotland.

I will explain the distinct phases of the change process as they happened to me. It would be fair to mention at this point that the lack of any internal market and competition has lessened the need for continual change in Scotland. My organisation is a particularly good example of this as it probably never changed drastically for more than 25 years because no one has ever asked or shown an interest in what we do or for evidence of our outcomes we were achieving.

Phase 1: first 3 months in post

Knowledge gathering and getting the Board on board

I was appointed CEO to Braid House in November 2019. I was coming from a role of director of redesign and improvement at Barnet, Enfield, and Haringey CCG and it was the first time being employed directly in the 3rd sector. I had extensive experience of working alongside the 3rd sector in redesign and improvement programmes but never employed by them, so you could say it was a bit of a change!

This was also the first time that I had worked in Scotland and West Lothian is an interesting area, serving a population of almost 200,000 in an economy with its roots in mining and heavy industry. Like Scotland as a whole, West Lothian has seen an increase in the age of its population with the over seventy-five's seeing the largest percentage increase between 2012-

2022 with a 46% rise. Dementia and Alzheimer's disease is the leading cause of death for females (13%) and the second highest reason, behind ischemic heart disease for men (8%) in the West Lothian area so the need for support is certainly there.

Another reason for moving back to Scotland was due to my father becoming seriously unwell and living with dementia himself and struggling to manage day to day. This opportunity would give me the chance to support my father and family as he approached the end of his life. When I look back at this time it was partly his experiences of services that drew me to the job and working in a day care environment or as my dad would call it, his 'Gentlemen's Club', never a day centre!

The board at Braid House (as it was known then) was confronted with a major decision following the retirement of the service manager who had been in post for more than 20 years.

Did they replace that individual with someone similar, probably from within the existing workforce or did they open the position up to someone from a different background and perhaps who would open their thoughts to new ideas and opportunities?

To their credit, they took the less easy option of going out to advert and employing a specialist recruitment agency in attracting a new manager. The position of Chief Executive Officer was also a new role and came about after in-depth discussions and advice with the recruitment agency as they felt this would attract a different and higher calibre of individual. (That sounds pretentious on my part, and it's not meant to be, but I think we all have a good idea how recruitment agencies work??).

At the initial interview, I was informed that the role would also include acting as CEO for the collective of day services across the whole of the West Lothian Area involving five other services. To me this was a bonus as I could instantly see the opportunities and benefits of working with six services rather than just the one, if only that had been the case!!

Once appointed and in position it became clear very quickly, that there had been a split in the board and the appointment of a CEO was not unanimously agreed upon. Several of the board felt it was unnecessary and an unwarranted expense, some felt that they had been successfully delivering the services for ex number of years so why would there be a need for change. It was also clear that the role of CEO was misunderstood and viewed purely as an 'operational manager' just under a new name, so the first phase of change very much started with the board.

At the same time, and as I have already admitted, my personal understanding and knowledge of day care services was extremely limited, so I had to do something to raise this awareness.

I did the usual things of researching and reading, looking at policies and visiting but the single most important task I undertook was to work alongside all the staff. As a registered nurse, I at least had some credibility with the carers although it had been a long time since I had delivered personal care which staff took great delight in highlighting my poor skills!

I spent the next 3 months working alongside all the staff from carers and office administrators to cleaners and drivers, gaining an in-depth understanding of the roles they undertook, their values and their approach to the clients and their jobs. I listened to their complaints and ideas in how to improve their experiences. This period gave me the opportunity to develop a relationship with the workforce and more importantly for them to get to know me.

The board, well that was a much bigger challenge. We arranged an away day which I think is a standard thing to do, to start exploring what the future might hold and for them to hear my thoughts. To my surprise, this was the first time they had undertaken such as an exercise, but it gave everyone the opportunity to get on the same page, to gather ideas and to set a future direction for the charity or that was the hope.

As in the introduction, this is a 'Warts and All' account of changing an organisation and I suppose this is where it starts to get a bit ugly.

The away day further opened a split that was already there between board members into a chasm, those who wanted to change and those who felt there was absolutely no need, and everything was fine.

I presented my thoughts on day services, including my first impressions of the centre and the staff (on reflexion, I could have been a little gentler here!) quoting numbers and criteria and looking at the fact that numbers had drastically fallen in the last year. I asked the question, "Did this present the fact that we were no longer delivering a service which people wanted," and this was seen by some of the board members as a direct attack on the charity and it was certainly anything but.

I also used evidence from my fathers' experiences of attending day services and how that service had been extremely flexible in meeting his needs and understanding his strengths and importantly, reducing his anxieties about attending to the point they were happy to call it the 'Gentleman's Club' to reduce his stigma at being seen attending a day centre. My dad had been a master stonemason, and a great little touch is that once the service found this out, they actually arranged for him to visit a local stone mason so he could go 'back on the tools' for the day and that sort of care and understanding had a major effect on me and my thinking about the sort of service I wanted to see for our own organisation.

It became apparent that one of the opponents of the changes to a CEO was the then Chair. This individual had a remarkably close relationship with the past senior manager and was heavily involved in the day to day running of the centre so much so that some staff viewed this individual as the senior manager after the previous member retired!

Over the next few weeks, I worked and met with individual board members, raising awareness of the CEO role and what was involved and starting to embed my thinking and ideas. Some were receptive and others, completely disinterested. Things came to a head when the Chair and I had a disagreement when that individual became directly involved with a staffing issue and did not pass the information on to me. Looking back, I do not think that this individual had

ever been challenged within the organisation before and it came as a surprise when it happened and within a week they had decided to resign from the board.

The next month saw a flurry or resignations of board members. The board went from 10 to 4. Interestingly, the staff within the organisation showed no interest whatsoever as they felt the board had been completely removed from the workforce and most did not know who the board members were, let alone understand their value. It goes without saying that things were a little tense during this period but as soon as the first board meeting took place after the resignations those who were left appeared far more relaxed, driven, and committed to change, probably because they were the ones who wanted that change to happen.

It is an important point worth noting at this point, that the change process I was introducing wasn't just based around the charity and workforce it included myself. I was learning extremely quickly that I was no longer in the statutory sector and therefore there was a huge amount of change that needed to happen within me if this was going to be a success.

I will come back to the board later in the presentation, but I will move on to the other five boards that I was now CEO for and if I thought the Braid Board was a challenge it was nothing compared to these ones!

I spent a great deal of time in those first couple of months visiting and being in the other centres which ranged in size and skill levels for delivering services. What was clear right from the beginning is that there was 'NO' joint working. Each centre had its own board, senior managers, carers etc. They all worked differently, there was no consistency of approach, no joint training, no sharing of resources, no joint strategic thinking. Each had its own relationships with commissioners and council representatives which they guarded like the crown jewels.

The concept of a single CEO to represent all the centres was an idea to help bring these things together but just like the Braid Board, not all those sitting on the other various boards agreed, far from it. For some it had left a bad taste in their mouths, and they were going to do everything in their power to prevent this being a success.

By this time, I was starting to see regional and local issues more clearly. The council (which all the centres are reliant on for most of their funding) were starting a review of day care provision across the whole of West Lothian, (strangely without engaging any of the actual services!) their criteria for clients accessing the services had recently changed to 'Critical and Substantial' which resulted in a high number of clients not being eligible for the care they had been receiving and I could see that this was inevitably moving towards a reduction in the numbers of day care providers or at the very least a reduction in grants awarded to each service.

I presented my thoughts and concerns and aired the concept of partnership working across the different centres and organisations and the potential benefits this could have to each centre and more importantly to the clients and communities we were delivering services to. I also aired the potential idea of amalgamating several centres! (Yes, I agree, that might have been a step too far at such an early stage!)

More partnership working would have had the effect of saving money through such things as a single management team, sharing buses for client transportation etc. It would have enabled us to create a clearer service specification and develop a consistency in approach.

These ideas and thoughts fell on deaf ears and the individual boards were adamant that they would remain separate, there was no interest in working together and each board refused to believe that there was any threat to their centres due to the 'special relationships' they had with the council or commissioners.

As an individual I don't give up easily and I have a bit of a reputation for getting things done in very challenging circumstances but through experience I have also learned to pick the battles worth fighting and I could see that trying to bring the services together was either going to take years or a directive from the Local Authority telling them they needed to work together, or funding would be stopped. Unfortunately, neither of these things were going to happen. I could also see that trying to bring the services together at this stage could have a detrimental effect on the services being delivered so after consultation with my board and other key individuals including local authority officers we all agreed that the CEO role representing the collective of Day Centres was not going to work and I therefore resigned as CEO for all the centres and solely concentrated on Braid.

Yes, I was incredibly frustrated, as I felt they had missed a fantastic opportunity to form a collective. However, Redesign managers will know that you face these issues all the time when improving services but using skills and tools you can usually bring those outliers into the programme eventually. This particular group was so adamant that things would remain as they were that it was seen as a pointless exercise even trying and all those involved with this agreed.

As far as my board and myself saw it, there was a window that was begging to be opened but the lack of foresight and strategic thinking was not there instead, there was a complete selfish focus on individual services and only thinking about what they could achieve rather than exploring opportunities to deliver integrated services to a wider clientele.

Phase 2: 3-6 months?

Implementing change…whilst reacting to a global pandemic!

Speak about a baptism of fire, in 3 months I had gone from being the CEO of 6 day centres to 1, the majority of my board had resigned, I was seen as a disruptive and challenging influence from the majority of those already involved with other day services across West Lothian, as an 'outsider' from other organisations and occasionally the 'Who does he think he is' attitude from other CEOs. From my perspective, I was only just getting started at this point and had not really introduced actual change to date!

Staff were however getting to know me, and they were starting to hear some of my thoughts, and I was listening to theirs about how we could deliver services in diverse ways. Ideas around 'person centred care, choice, smaller groups working, using other services to support us,

looking at a new client group, younger clients, carer support, these were all being explored with enthusiasm which gave me encouragement.

Just as I thought we started to get some momentum the then senior operations manager left for another position and that sent us backwards for a few weeks, but it also gave me the opportunity to promote a senior carer that I recognised potential in, into that role and this was singly, one of the best decisions I have ever made in my entire career. Having a good senior team around you makes the job so much easier as everyone probably knows.

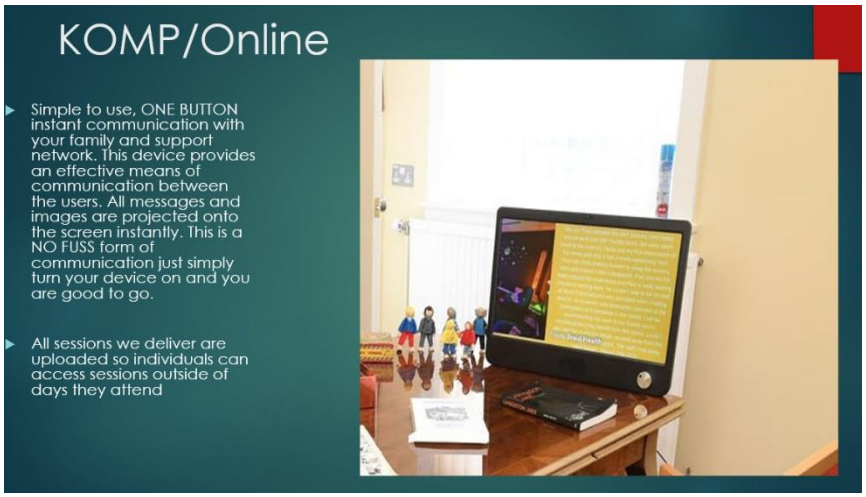
Then came along Covid, wow, what can I say.

Lots has been reported and written about how care homes were treated throughout the last 2 years and rightly so, but I have seen extraordinarily little reported about how day services were left completely up in the air without support or advice, and it is equally distressful.

I could easily do a whole presentation on this subject, but I imagine we are all pretty fed up with it all now but its something that certain individuals and governmental departments should be ashamed of.

As soon as it was clear we were going to go into lockdown we/I, made the decision to remain open in some form. Initially for the first 2 weeks we closed to all clients coming into the centre, and we moved to delivering support through home visits and innovative alternatives.

The week before, we had taken possession of x8 **Komp[17] devices,** this was the first step in starting to do things differently and the staff were going to be having extensive training in its use. Covid meant we had to do this over the phone, and it was very much trial and error for the next few weeks.



Internet support was another development that had been planned to be introduced over an extended period, but the circumstances dictated that it was delivered within weeks. Interestingly, when I had initially discussed this with the staff it was very poorly received.

[17] KOMP are Simple to use, ONE BUTTON instant communication devices which provides an effective means of communication between the user and carers. Calls are quickly and simply answered, and all messages and images are projected onto the screen instantly. This is a NO FUSS form of communication without the need of Wi-Fi.

There was an initial belief that Older People would not be able or willing to use the internet. In fact, this was more about the lack of knowledge and skills in the staff's ability to use the internet and Wi-Fi rather than anything to do with age!

As bizarre as this might sound, Covid and the pandemic gave us the burning platform to engage and redesign services far more effectively than had we been operating normally. We still supported the same number of people, in fact more than normal because we were supporting a higher number of carers and extended families. We were producing freshly cooked meals from our kitchens and over the period of the pandemic we provided over 50,000 meals to the local community.

Within a couple of weeks, the centre was ready to open to the most 'At Risk' clients who were either living alone or receiving no support. We were not advised to do this; we took that decision on our own because we felt it was the right thing to do. We operated under strict protocols and social distancing, and we never recorded a single case of Covid within the centre.

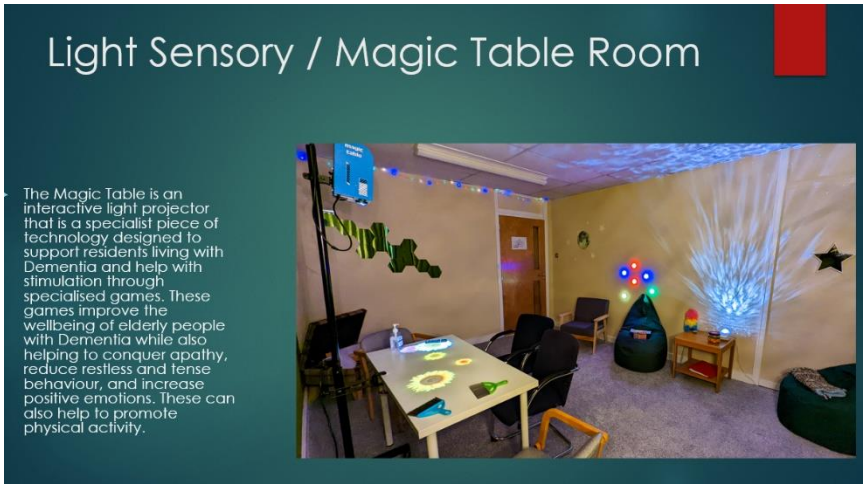
The reason for describing what we were doing is that I want you to realise we were just as busy throughout this period as we would have been during normal times the only difference was the actual numbers of clients coming into the centre which freed staff time to help me to review and redesign the services. The only other point I would like to make in relation to Covid and the lack of support is that 'No One 'in any official capacity was ever prepared to give direct advice about anything and especially for Day Services. The quotes that I continually heard was that "no guidance was available for your services so it's down to you to make that decision." Without wanting to blow my own trumpet…thank goodness my organisation had a CEO to take these tough decisions! The other thing I heard was "what is it you actually do in a service like that" when I mentioned Day Services. That said a great deal to me.

Phase 3: 6 months onwards.

Process for change – motivating and mobilising a culture of continuous improvement

Each week, perhaps even twice a week or more, we *would meet as a staff team to look at new ideas and concepts from other areas* locally but also nationally and internationally. I suppose if you were following the change process this would be viewed as developing the 'Shared Purpose' phase. Individuals started to recognise that there was a different way to provide care and support in the setting we were working in. They became more interested in finding things out and creating a need for meaningful work. Not everyone was on board which is always to be expected and the individuals that I had concerns with while working with them were the ones that did not engage. Some of these individuals had been in the job for 20+ years and could not understand the need for anything to change, others were there as it was just a job until something better came along!

These meetings allowed ideas, thoughts, and good practise to be 'Spread and Adopted' across everyone and one of the first decisions we made as a group was to buy a *'Magic Table'* after extensive research and discussions with the makers. *(Interactive Projector specifically developed in Switzerland to engage with clients experiencing dementia and other age-related conditions).* Not a huge change but a real start in using new technology, and a physical reminder of the change journey we were on together – something we could all feel proud of achieving as we were the first day centre to take ownership of a Magic Table.



We started to think about measurements, not only around the changes but more importantly around the outcomes of the interventions we were carrying out with clients. No one, even the funders had ever asked for evidence around client outcomes. The only evidence requested, was client numbers attending the service on a daily and weekly basis – very transactional. No one had ever engaged with clients and carers to find out if they enjoyed coming to the centre and what they got from it and importantly what they would like to see in terms of innovative ideas. As part of moving to a relationship-based approach, we now carry out regular satisfaction questionnaires and we have a client focus group which helps us set the future thinking of the charity.

We also started to consider and *explore the 'system Drivers,'* what is our strategy, where do we sit in the care system, how do others view us, do we need to change? These were the questions that were being posed to all the staff and quickly most were coming to the conclusion that change was needed.

Throughout these meetings I would continually explain that the staff owned these potential changes and improvements. These were not 'MY' changes; this was really the motivating and mobilising phase of the programme and meant that leadership skills were of paramount importance. The new operational manager came into her own at this point and led the team superbly well and because she had the credibility with the staff, as she had been collaborating with them for 10 years + as a carer and then senior carer, they were prepared to fully participate in the changes. This was quickly followed by the concept of 'leadership for all.' After a period, staff started to use their own initiative, they grew into the change process, shared in the vision we were creating, and developed a desire to be the best in what they do.

It is also worth noting that the board would join us for these sessions, and it built a bond between the remaining board members and the staff and created a very strong singular vision for the organisation.

During the pandemic we could not recruit any new board members, so we operated on the quorum of four. Looking back on this time, this was a blessing in disguise because the remaining board members were committed to changing the charity and the smaller board allowed us more time to explore and identify new options for services and more time to develop a new business plan. Since then we have successful recruited new board members and are now back up to seven members which a wide range of skills and experiences.

Change can also result in some staff leaving the organisation and this is always a difficult time especially when you lose experienced staff but if they do not have the same shared or core values as the rest of the team then sometimes this can be positive, and it so happened to be the case for us. Certain individuals were watching things change on a day-to-day basis and when expressing their dislike or disagreement with these changes they found themselves being challenged, not by myself or the senior manager but by other staff members and it is at that point those individuals usually make the decision to embrace the changes and be part of the process or leave.

The remaining staff found it easier to introduce change as they were no longer being challenged at every step. That isn't to say we do not challenge each other; this constantly happens, and we are always reviewing the care and interventions we deliver. However, we now challenge on the benefits of the changes we are proposing, rather than whether or not change is required! To support this, we have introduced the PDSA cycle (Plan, Do, Study, Act); someone introduces a new idea, study the effects both on clients and staff and then we would change or improve or in some cases drop the idea altogether. This way of working is now embedded within the staff, they understand the need for this, and they feel it helps them improve the care they deliver.

It goes without saying there are numerous tools and models to support change in organisations and I am sure you have all tried various methods and techniques and I have certainly introduced a number over the last 2 years, but I have also found that the simpler ones are usually the most effective. Complex redesigns are exactly that, complex, but only for a small number of people. The real skill in redesigning services is the ability to engage, enthuse and communicate those changes in a straightforward manner that everyone can understand. It is the classic swan analogy, a change manager should be calm on the surface but paddling like hell underneath the waterline!

The other changes we have introduced into the workforce is '*Person Centred Care*'. Now it might surprise you that this was not already there, but the service previously delivered the interventions by doing things '**for**' the individual rather than '**with**' the individual. Most thought they were doing the right thing but after a while and reviewing other services and listening to clients and families they quickly recognised that they were doing what they wanted or because it was easier, rather than recognising the client as an individual and understanding their needs and strengths.

Moving away from doing everything for a client is not an easy task and it certainly does not happen overnight. It is a slow process, and this is where the concept of 'Leadership for All' is so

important as individuals challenge and remind each other on what is expected and what they should be doing.

New assessments and care plans were introduced which helped capture individual needs and outcomes as well as introducing evaluation tools such as PERCCI (Person-centred Community Care Inventory[18]), which would evidence and evaluate the principles of person-centred care. These tools also form the basis of performance management of the staff.

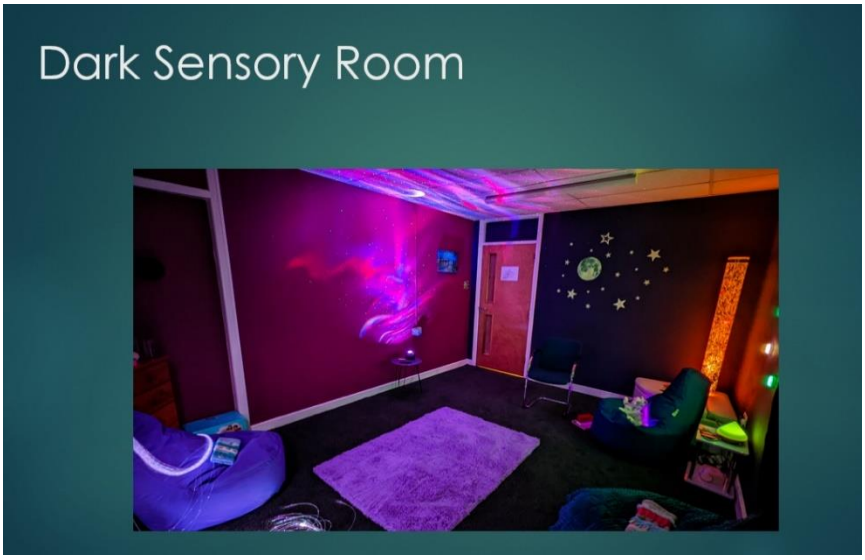
It is a funny thing but after a while and if introduced correctly, the change process starts to take on a life of its own. There is a desire to try out new ideas, to introduce new approaches and it becomes much easier to explore new concepts and this is exactly what happened in the organisation. One change led to another. The concept of person-centred care led to smaller working groups. There was then a recognition that individuals had specific skills so there was then the need to bring in new activities, such as Wood Working, Model Trains, Art and Design, Theatre groups, Singing, Dance and the list goes on. These activities led to the **appointment of a resident artist** who we commission from another organisation. We also employ other individuals who deliver specialist sessions, and this helps develop our partnership working and promotes our changes and new approach within other organisations.

We took the huge step to *change our name and branding*. We dropped the day care title and brought in a Wellbeing and Specialist care title so we could attract a new clientele. The 'day service' title was off putting to some newer clients, and this had been communicated to us on numerous occasions as it had connotations with a negative stereotype of old-fashioned care. I often go back to my dad's idea of his Gentleman's Club and not the day care centre!

We started to engage with clients and families about specific skill courses helping to maintain life skills and independence for longer. From these conversations we *developed a Life Skills/reablement centre and created specialist reablement courses*. The centre includes a fully equipped skills rooms including bed, hoist, bath, toilet etc. A fully functional small kitchen for 1:1 support.

[18] PERCCI (pronounced 'percy') is a short (12 questions), straightforward standardised questionnaire that measures quality of care experiences. It was co-designed with people with lived experience of care services and is based on evidence. It can also help to demonstrate whether the service/provider is well-led. An infographic summarises PERCCI. Read more about how it was developed in a presentation given to the Day Centre Research Forum, June 2020 https://www.kcl.ac.uk/hscwru/assets/events/dcrf/2020/wilberforce-25jun20-dcrf.pdf.

A *dark and light sensory room* to help in relaxation and in managing challenging clients. A fully equipped reminiscing room and numerous other activities and technologies. We deliver targeted and intensive courses for clients and families who have either been recently discharged from hospital or require increased support to maintain skills and confidence helping them to remain at home. These courses are available as a separate service and do not require individuals to be a client of the day centre to access.



These developments and concepts took money and that is where the decision to *employ a professional fundraiser* came into being. This was a high-risk strategy but one that myself and the board felt was necessary to ensure we could deliver the changes we wanted to see and to move to become less reliant on local authority funding. Just like my post, we made the decision to employ a specialist recruitment agency, and this paid huge dividends because the number and calibre of candidates was incredible and once again Covid had played its part. Many fundraisers had found themselves being paid off and very few organisations were recruiting. The timing for us could not have been better because we got to pick from individuals that I don't think would have looked twice at us if we had been up against other better-known charities.

Our fundraiser hit the ground running and has been an enormous success over the last 12 months. She has manoeuvred us into new projects which attracts new funds. These pilots and projects help us to continue to update and change the way we work by exploring new ways of working. The building received a makeover and is now fit for purpose when before it had the feel of a run-down community centre. The biggest benefit from having a fundraiser is not just the money she manages to attract but also the awareness she is raising in other organisations about Day Care. We are being told that many funders have never historically funded services like ours so whilst this can prove to be challenging as it requires far more explanation, we are also experiencing a high level of success with applications. Saying that the next few years are always going to be tougher as funders have already heard your story!

These new services need to be advertised so a *marketing assistant was employed from the government Kick Starter scheme.* So successful was this individual in building our private income for us that we have now employed them fulltime, and this acted as a good news story for the Kickstarter programme.

The *life skills/reablement centre is a self-contained business within the day centre*, and it was recognised for this to have credibility it needed a skilled trained professional and we have recently *employed our own Occupational Therapist*. We not only use this space for our clients but we also hire this space to private clients and organisations. The development of a *Life Skills/reablement* centre came about following research of what was needed and what was already available in the local community. We found that the nearest sensory rooms were in Edinburgh, access to life skills and assessment suites were available in the local hospital but that there was a long waiting list to access these resources. We have developed a service we know will be used by the local community and we are meeting an unmet need.

The recruitment of a fulltime OT into a rather unusual setting, brought us to the attention of Education Scotland who are now in the process of *placing OT students with us from both Glasgow and Edinburgh universities*. OT students are regularly based in care homes but very few have placements in day services. We are also having *other Allied professionals placed with us* including Ambulance staff, Physiotherapists, Dentists, Dieticians and hopefully many more over the next few months. The benefit to the organisation and staff of having students is that they keep you in touch with new thinking and as well as raising the profile of the service across wider professional groups.

One special role that we gained funding for that I would like to describe in a bit more details was that of *Link Worker.* Now, link workers are awfully close to my heart as I created the role many years ago for a primary care programme and although not exactly the same, this role promotes the same principles. Our is employed to connect with other community-based organisations and services. Her role is to raise awareness of what we are, what we do, how we can help and support other organisations and what we can do for clients. They will explore new avenues for service developments and is basically our eyes and ears in the community. They also work with GP's doing the same thing. They will also do home assessments and work with the carers to provide and create unique and individualised packages of care for clients considering the home environment of the client so that what we do in the centre mirrors or enhances what is happening outside of the centre. The benefit of this role is that through raising awareness of our service the number of private referrals has increased. If you add this with our rebranding and advertising campaign, we are starting to see a new client group accessing our services. We have also moved away from offering the standard 'full day' package. Individuals can now access individual classes such as cooking and self-care, to half days and holiday respite care.

The *next stage is to explore our opening hours and the possibility of opening at weekends.* Historically day care operates on the classic 9-5, 5 days a week model but society has changed, and we need to change to keep up with modern life. This may mean we have to change the opening times say from 7.30am to 9pm and to open at weekends but this is work in progress.

It all sounds like a success story but the truth is it is not, well partially not. The *largest problem we have is gaining credibility from statutory organisations such as the mental health teams, hospitals, GPs.* They appear incredibly hesitant to recognise us as a potential resource they

could use to help achieve their outcomes and to reduce the backlog of cases built up over the last 2 years in terms of assessing and delivering targeted support.

They either view us as a threat, even though we have held open days and visited those services to inform them about what we can support them with or what do they need from us. Sadly, there just seems to be a block in recognising a Day Care provider in any other way than from the historical service it always has been.

Personally, I also feel there is a degree of service jealousy and snobbery involved and a feeling of how 'could a professional service ever go into partnership with a charity and what the hell does a day service do!'

That is one of the biggest differences I have experienced whilst working in Scotland. There seems to be a real lack of innovation when it comes to integrated partnership working. Lots of rhetoric around the subject and I am sure people believe they are working in partnership but its not equal and it certainly is not integrated, and I feel we are all missing a trick here.

The other challenge we are *facing is an imminent cut in funding*. Now, this was never going to come as a surprise and we predicted something was going to happen, everyone had a pretty good idea that the pandemic was going to place pressure on public finances and as you have heard we have been working over the last two years towards a new business plan, so we are not solely reliant on council grants. However, what we were not prepared for was unprecedented size of these cuts and much more importantly the time scales associated with them.

What is hard to stomach is the way the cuts have been calculated - the local authority have used the figures from the last year to evidence the reducing numbers in clients attending the service. Funny thing is we are still in the recovery period from the pandemic and what they do not account for in their calculations is the fact that many of our clients remain fearful of attending, many have sadly died and perhaps most astonishingly, the fact that the council control the referrals to us!

The introduction of stricter criteria has also had the effect of reducing client numbers. A suspicious or cynical person might suggest this was deliberate to keep referral numbers low so they could argue a cut…good job I'm a glass half sull Scotsman!! Fundamentally, the approach adopted misses the point that numbers may be lower, but the needs of those individuals are much more complex and high level to the point that many require either constant 1;1 or 2;1 care. Staff may have lower numbers to care for, but they are still under pressure.

This point is constantly argued but council officers and commissioners are sadly not interested, and they are potentially suggesting a **50% cut** from this September (2022), which gives us next to no time to secure other funds or to develop our private services further. Despite our hard work transforming our services over the last two years and providing care for some of the most vulnerable in the community, the immediate future looks bleak. Part of that future is a result of the local day services not having the foresight to come together to form a collective

and a single voice which would be far more effective against a large Local Authority. Instead, we are individual services being picked off one by one.

We are doing everything in our power to stay alive as a service that provides specialist care interventions for those going through the aging process. We have engineered a redesign and improvement programme which evidences our ability to change to meet the changing needs of our clients and the communities we serve. We are evidencing our effectiveness by capturing short, medium, and long-term outcomes of clients and families and we are beginning the process of research through partnerships with other organisations and academic institutions. We have reduced and streamlined our workforce, invested in training and ongoing development so that we now have some of the best trained and experienced staff in the region if not the country.

Is it enough, honestly, I am not sure, and I feel that is because as a service we are just not recognised or fully understood?

Is that because we have not been proactive enough as a collective?

Is it because there is a dearth of evidence and research around the whole subject of Day Care?

Is it because we are seen as an easy target because few people care what happens to the older generation and as a population, we do not want to think about the aging process?

Is it because as services we have not promoted what they do effectively?

The answer is probably a yes to all those things and as at the beginning of this presentation I started with an apology I end with an apology, as I was one of those individuals who did not recognise or value the contribution that day care makes to the care system and now that I do it might be a little too late!

FOOTNOTE

On the 10th June 2022, the Care Inspectorate in Scotland published their new 3 year strategy for Health and Social care. Sadly, Day care services for Older People are not mentioned, once! Should it come as a surprise, maybe not, but it certainly supports my feeling that we are being misrepresented at the highest level.

Braid Health and Wellbeing update May 2023

It has been 10 months since I presented our story of a service redesign programme and all the issues that went along with this. In those months, we have seen many developments leading on from the description that I gave.

One of the most pleasing developments has been the creation of a very successful relationship with Education Scotland. This has seen the recognition of the Day Centre as a regular placement for NHS allied professional students.

We initially set out to be a placement for Occupational therapists which we trailed for 6 months. This was the first time that Education Scotland had used a Day Centre as a potential learning placement and there was some anxiety that students would not have the necessary environment and learning experience to meet their objectives. These initial anxieties were unfounded and feedback from students and placement mentors was so positive that 6 months has turned into a regular placement not just for one university but three. Glasgow, Edinburgh and Aberdeen. Sadly, student placements from Aberdeen didn't work out due to the distance between the university and the building but for the other 2 it has been a great success.

Interestingly other allied professional courses made contact after hearing the success of the OT placements and *we have had Paramedics, Physiotherapists, Podiatrists and Nutritional therapists as students within the building*. These have benefited all those involved and not least the clients themselves. We have been able to develop and offer services with support from students and supervisors. The number of students we now receive means that we can offer a rolling programme of therapies and interventions that we could have only dreamt about even a year ago.

We as a service do not get paid for these students but what they bring in terms of new knowledge, skills transference, a new workforce experiencing day services for the first time, gives us something that is difficult to put a monetary value on.

We have extended out to *offering nursing student placements* and this was again as a result of the positive OT placements. I think we can say that once the first step had been taken and we proved to supervisors that we were indeed a suitable and professional placement the word quickly spread across all educational departments looking for placements outside of the normal experiences.

Students have been surprised at both the level of complexity and the range of experiences they are gaining from this type of placement, and it is a service which is disappearing at an alarming rate which they may never experience again.

The 3rd and 4th Year students have gone on to gain local employment in professional services but an *unexpected benefit of these placements is that they have shared new understanding of the services we provide to a workforce that was unaware of the services and we have gained a number of extra referrals from these so we are creating new referral pathways*.

The next bit of good news was that following lengthy discussions and meetings with the Advanced Research Centre for Care at Edinburgh University, we developed a strong partnership with a number of key individuals and academics. This has led to a research programme and development of new, innovative approaches and equipment to support care and individual care packages.

We are now at the ethics approval stage and if all goes well there will be a number of innovations adopted by the service such as Hydration Cushions, Cutlery which monitors food and drink intake, Movement monitors which identifies possible relapse in specific conditions. We will also be trying new safety monitors which will enable all door to be left unlocked across

the whole of the building as it will use face recognition technology to ensure at risk clients can only leave the premises under supervision.

There are a number of other developments which will be explored as these partnerships strengthen and all the academics have reported the benefits of working alongside care staff, clients and their families to understand specific needs that they can help address through technological solutions. Client families have been heavily involved in a number of these new developments Once this research programme is fully introduced and reports are submitted the service will gain recognition as the first service to introduce some of these ground-breaking innovations and that is very exciting.

One aspect of the plan that I had described which was not successful was the possibility of employing our own Occupational Therapist within the service. For various reasons this did not come to fruition. Firstly, *trying to attract an OT into this type of service proved almost impossible.* We advertised on 3 different occasions without any interest. I had a number of conversations with NHS leaders and senior OTs and they described a potential negative perception from professionals about day care work. The inability for the service to mirror NHS pay scales and the lack of professional and personal development opportunities. I understand some of these points, but I do not accept others and as the student placements have identified day service can prove to be an incredibly worthwhile and fulfilling place to work which would meet professional and personal development needs.

There will always be an issue surrounding the ability to match NHS pay scales but that is something that all 3rd sector organisations struggle with as an ongoing organisational risk

I described in the initial presentation that we *secured funding for a community link worker*. Their role was to develop and raise awareness of the service within the local and wider community and professional services. This was successful to a point, private referrals certainly increased from the community but partnership working between social care teams and mental health services remained stubbornly difficult. The lack of engagement is hard to understand as this service could support and ease some of the pressures that these specialist services faced, not least respite care and early discharge from hospital. Reablement courses were something that we had promoted but sadly no outside referrals were received from other agencies or through NHS teams. That's not to say that we do not offer reablement courses because this is now a standard offer for all clients coming into the service. Staff will work on helping maintain, improve or teach new skills to support individual living.

Staffing and person-centred care: The single biggest difference across the organisation since we started this programme of improvement and redesign have been the staff. They have moved towards from a 'Do To' model to a 'Do With' approach to support and interventions. Recognition and acceptance of individual and strength-based care has not been easy for all staff to adopt, but with time the changes have started to become embedded across all staff. The staff we employ are not trained professionals, they are on the whole, level 2-3 NVQ staff. We ensure as an employer that we provide ongoing training and self-development opportunities and couple this with the reputation for a service that pushes boundaries and challenges the normal standard approaches to care introduces innovative new technologies,

we have not struggled to attract or retain staff, and this is something that we are very proud of.

Contract changes: Sadly, it has not been all good news over the last 10 months. In my initial presentation, I described the council's decision to tender of the current services. The way this whole tender programme was put together and costed was disgraceful and a prime example how the impact of Covid has been used to strengthen arguments to reduce services. The local authority calculated the numbers attending the service during Covid years. Unsurprisingly it evidenced a dramatic fall in individuals attending the service in person. They did not take into account that we were supporting the individuals at home, they were only interested in actuals in relation to attendees. No matter how much we highlighted this flawed approach they would not be moved from their calculations which meant that we saw an overall reduction in contract value by almost 70%.

We were successful in our bid for the contract, but the sad fact is, that after only 2 months of the new contract, the council are starting to recognise they have underestimated the need and are now reviewing the service contract!

In the meantime, we are in the position of delivering the same levels of interventions for a vastly reduced financial income. A large number of clients have been removed from council funded placements with no substitute service being offered. We are exploring new funding opportunities and our fundraiser is in the process of identifying grants and legacies which will enable us to support all out clients for the foreseeable future

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(*Details*: Once weekly interactive, experiential 'Happiness and Humor' sessions for 10 weeks. Each included an informational presentation about contributing factors to happiness and life satisfaction (pessimism and optimism; light exercise and music; exercise, nutrition, leisure and attitude and why these were important). Format varied from talks, interactive activities and group discussions, jokes (which were encouraged) and comedy videos. Props were used (e.g. sweets) to generate discussion. Participants were encouraged to share funny anecdotes about their lives. They were given 'laughter prescriptions'. Many shared deep feelings during these group psychotherapy sessions.

The Life Satisfaction Scale (LSS) (self-rated validated scale measuring 5 dimensions of perceived life satisfaction: pleasure, determination, goal achievement, mood, and self-concept) was administered pre- and post-test with 15 people who participated in all 10 sessions.)

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(*Details*: 12 week programme of weekly 2-3 hour workshops (based on a successful pilot programme) run by a professional humourist and a social worker over 5 months. Workshops encouraged the use of humour strategies. Control groups attended DCs as

usual and were offered workshops after study concluded. Participants assessed at baseline and 6 months using validated scales:

- RAND Health Status Questionnaire-shortened version (health-related quality of life: physical functioning, role limitations due to physical and emotional health, energy/fatigue, emotional well-being, social functioning, pain and general health)

- General Well Being Scale (GWB) (psychological wellbeing/mental health: positive wellbeing, self-control, vitality, anxiety, depression and general health)

- Brief Symptom Inventory (BSI) (psychological distress).

Demographic data.

Statistical analysis was undertaken.

An average of 11 workshops were attended by intervention group participants.)

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(*Details*: Life review therapy provides individuals with opportunities to interpret their life through a process of review and evaluation. It can highlight life stories that may induce emotional reactions related to individuals' significant life events. For this study, eight 2-hour life review activities were conducted in group sessions once a week. These covered greetings, childhood memories, education, memories of growing up, happy and sad memories at the workplace, life recollections, personal wishes, and treasured goodbyes. Life review therapy can reduce depression and hopelessness and increase wellbeing.)

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(*Details*: 3 month intervention of 6 hour WEEKLY sessions of psychosocial group intervention work (3 groups: discussion with therapeutic writing, group exercise or art experiences) led by registered nurses, occupational therapists and physiotherapists. Sessions aimed to enhance interaction and friendships between participants as well as to stimulate them socially, and were based on the principles of closed-group dynamics and peer support.)

63. Fitzpatrick TR. Brain Fitness Activities and Health among Older Female Senior Center Participants in Montreal, Quebec. Activities, Adaptation and Aging. 2010;34(1):30-47. https://doi.org/10.1080/01924780903552287.

(*Details*: Participation in & impact of specific cognitive fitness activities participated in at DC (e.g. strength exercises, aerobic exercises, listening to speakers, volunteering, travelling, computer-based programmes, laughing, paid work, group work, language classes and taking career decisions etc.) measured by self-completed questionnaire covering use of DC, cognitive activities, mental & health status, and demographics. Measurement of mental health included modified version of the Psychological General Well-Being (PGWB) Schedule.)

64. Gallagher C. The Socrates Café: Community Philosophy as an empowering tool in a day care centre for older people. Irish Journal of Applied Social Studies [Internet]. 2016 20 Sep 2017; 16(2). http://arrow.dit.ie/ijass/vol16/iss2/5).

(*Details:* Replicated Socrates Café model initiated in US in 1992. Weekly 2-hour facilitated philosophical discussion groups of 10-16 people (Socrates Café). Participants included the centre manager, attenders and visitors (including students). Designed to encourage and enable conversations about important life matters. Facilitator opens with a question and leads discussion and dialogue. Examples: What is goodness? Is happiness a choice? Is money the root of all evil?)

65. Turner SG, Jarrott SE, Katz B. Intergenerational Programming Increases Solid Food Consumption for Adult Day Center Attendees. Journal of Applied Gerontology. 2023;42(2):160-9. https://doi.org/10.1177/07334648221134179.

(*Details*: The programme involved 20-30 minute joint activities (such as gardening, art, science) with 3-5 older people with 3-5 children aged 2-5 years from a local nursery, led by a facilitator. Staff were already trained to record percentage of food eaten and recorded percentages immediately after lunch.)

66. Boen H, Dalgard OS, Johansen R, Nord E. A randomized controlled trial of a senior centre group programme for increasing social support and preventing depression in elderly people living at home in Norway. BMC Geriatrics. 2012;12:20. https://doi.org/10.1186/1471-2318-12-20.

(*Details*: Weekly 3 hour group programme (7-10 people) for 35-38 weeks over 1 year consisting of transport to DC, exercise (developed by physiotherapists) and self-help group (discussion topics of participants' choice) aiming to address social isolation and increase life satisfaction thereby reducing depression. Control group offered intervention after 1 year but not followed up afterwards.

- Depression: BDI (Beck Depression Inventory).

- Social support: Oslo-3 Social Support scale (no. of people so close who can be counted on if great personal problems; level of interest and concern people show in what they do; level of ease to get practical help from neighbours if needed).

Life satisfaction based on QoL. Self-reported health. If made new friends or met other participants elsewhere.)

67. Dabelko-Schoeny H, Anderson KA, Spinks K. Civic Engagement for Older Adults With Functional Limitations: Piloting an Intervention for Adult Day Health Participants. The Gerontologist. 2010;50(5):694-701. https://doi.org/10.1093/geront/gnq019.

(*Details*: 5 week civic engagement (meaningful activity/volunteering) intervention in 3 phases:

- education about community group to be served (e.g. homeless, families of soldiers serving overseas) including sharing of own personal stories

- assembling of care packages of donated/bought items

- presentation of care packages to representative of community group and recognition of participation (certificates and celebratory event).)

68. Vogel A, Ransom P, Wai S, Luisi D. Integrating health and social services for older adults: a case study of interagency collaboration. Journal of health and human services administration. 2007;30(2):199-228.

(*Details*: Interagency collaboration (public health & a housing authority) delivered a health outreach programme in DCs that aimed to support OP living in public housing (i.e. lower income) to age in place by offering health services beyond what housing authority could provide. DC directors selected activities appropriate for their own clientele from the menu of services available. These included exercise classes, healthy cooking

demonstrations and tastings, vaccinations (flu & pneumonia), mental wellbeing activities and support groups, health education on a range of chronic and infectious diseases as well as services that were delivered in people's homes (e.g. counselling).)

69. Wittich W, Murphy C, Mulrooney D. An adapted adult day centre for older adults with sensory impairment. British Journal of Visual Impairment. 2014;32(3):249-62. https://doi.org/10.1177/0264619614540162.

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(*Details*: Minimum 16 session evidence-based, physically challenging exercise programme that was appended to a low intensity exercise programme. The entire session lasted around an hour. Exercise was initially led by a professional and, after training, by DC staff (registered nurses and qualified activity planners/leaders).)

71. Battaglia G, Bellafiore M, Caramazza G, Paoli A, Bianco A, Palma A. Changes in spinal range of motion after a flexibility training program in elderly women. Clin Interv Aging. 2014;9:653-60. https://doi.org/10.2147/cia.s59548.

(*Details*: Over 8 weeks, two sessions per week of core stability and flexibility exercises: 10 minute warm-up, 50 minutes exercises, 10 minutes cool down. No physical activity intervention for control group. Spinal ranges of motion (ROM) measured before and after using SpinalMouse r device.)

72. Ota S, Goto H, Fujita R, Haruta M, Noda Y, Tamakoshi K. Application of Pole Walking to Day Service Centers for Use by Community-dwelling Frail Elderly People. International Journal of Gerontology. 2014;8(1):6-11. https://doi.org/10.1016/j.ijge.2013.03.010.

(*Details*: The Timed Up and Go (TUG) test is a good indicator of balance and, therefore, falls risk, and may be helpful in determining levels of staff support needed in day centres. TUG is a standardised test that assesses mobility, balance, walking ability and falls risk. If repeated at intervals, this test can monitor change; it may be useful, for example, before and after specific programmes of exercise, for example. It may also indicate levels of staff support that a person may need at their day centre (e.g. going to the toilet or moving between activities). The test is simple, quick and requires no special equipment or training; a person is asked to rise from a standard chair, walk to a marker 3 metres (10 feet) away, turn, walk back, and sit down again. They do this while wearing their usual footwear and using their usual mobility equipment, if any (e.g. walking stick, walking frame). Different approaches are taken to scoring (i.e. being at risk of falling starts at 12 seconds for some, 13.5 seconds for some, or 20 seconds for others). The UK Chartered Institute for Physiotherapy defines a person being at risk of falls if the test takes 15 seconds or more. The Chartered Institute for Physiotherapy has produced a video that demonstrates the test https://www.youtube.com/watch?v=lAkVr5l7vOs.

Intervention groups used poles while walking/carrying out ADLs at DC for 3 months while control groups continued moving around as usual. Data was gathered pre- and post-test:

- MOS 8-item Short Form Health Survey (SF-8)- validated Health Related QoL measure (general health, physical function, role physical, bodily pain, vitality, role emotional, mental health, and social function).

Physical fitness measured using knee extensor strength, back muscle strength, one-legged standing time with eyes open test, and the validated TUG test which assesses mobility.

Posture was measured by videoing participants after placing markers at key points.

Read more about it the TUG test here: Podsiadlo, D. and Richardson, S. (1991), The Timed "Up & Go": A Test of Basic Functional Mobility for Frail Elderly Persons. Journal of the American Geriatrics Society, 39: 142-148. https://doi.org/10.1111/j.1532-5415.1991.tb01616.x)

73. Yamada T, Demura S. Continuous participation in a day-care prevention service improves the mobility of the community-dwelling elderly. International Journal of Health. 2014;2(2):45-8. https://doi.org/10.14419/ijh.v2i2.3214.

(*Details*: Falls prevention service focused on education: twice monthly lectures on improving nutrition, preventing cognitive decline, oral health, improving motor function) (i.e. 24 p.a.).

Mobility measurements, taken at 1, 2 and 3 years, were peak and mean transfer velocity of centre of gravity (PV, MV) (during Sit To Stand test) and 10 metre maximum walking speed (MWS). Using statistical analysis, measurements for groups were compared.)

74. Truncali A, Dumanovsky T, Stollman H, Angell SY. Keep on Track: A Volunteer-Run Community-Based Intervention to Lower Blood Pressure in Older Adults. Journal of the American Geriatrics Society. 2010;58(6):1177-83. https://doi.org/10.1111/j.1532-5415.2010.02874.x.

(*Details*: Over 6 months, blood pressure (BP) measuring sessions were run fortnightly in a volunteer-run programme that aimed to reduce BP by conducting ongoing monitoring in people with or without diagnosed hypertension. New enrollees' measurements were recorded on a tracking card that participants were encouraged to show to their GP. Volunteers also asked if people had taken prescribed BP medications in previous 24 hours. Participants were informed of BP using a low-literacy, colour-coded chart and advised about any actions they should take. An average of 6 volunteers per DC ran the programme.

- The programme had run for >20 years. Enhancements evaluated included updated hypertension management protocols, enhancing health literacy (via low literacy materials and regular reminders about medication adherence) and links with clinicians (letters informing GPs of study participation were developed). Automated monitors were used to measure BP.

Local Health Promotion Unit administered the programme and DCs received quality assurance visits to ensure adherence to guidance and correct measurement technique. Start-up material included volunteer training, 2 automatic BP monitors, tape measures and printed materials. Volunteers were given a manual after receiving 6 x 2 hour sessions of training from health educators in hypertension and practicalities (e.g. measuring BP, record keeping and communicating with participants.

- DC directors recruited volunteers and sent attendance data to Health Promotion Unit, stored materials and dealt with emergencies (approx. 5 hours p.a.). Some DC funding was dependent on participation in programme.

- First and last Systolic BP (SBP) measurements were compared using statistical analysis.)

75. Resnick HE, Ilagan PR, Kaylor MB, Mehling D, Alwan M. TEAhM-Technologies for Enhancing Access to Health Management: a pilot study of community-based telehealth. Telemedicine journal and e-health : the official journal of the American Telemedicine Association. 2012;18(3):166-74. https://doi.org/10.1089/tmj.2011.0122.

(*Details*: Hypertensive older people who were regular attenders were asked to monitor their blood pressure at least weekly for 10 months after being trained in equipment use. Nurses remotely monitored data (intervention group only), making rapid GP or hospital referrals in cases of clinically relevant changes in blood pressure. Data were retrieved automatically by the telehealth central IT system and monitored daily. Nurses were alerted by email to readings outside GP-defined parameters and then accessed

individual data to carry out appropriate follow-up. Blood pressure data for the non-intervention group were not monitored in this way.)

76. Dickson VV, Melkus GDE, Katz S, Levine-Wong A, Dillworth J, Cleland CM, Riegel B. Building skill in heart failure self-care among community dwelling older adults: Results of a pilot study. Patient Education and Counseling. 2014;96(2):188-96. https://doi.org/10.1016/j.pec.2014.04.018.

(*Details*: Group sessions (4-8 participants) of 60 minutes per week of self-care education run by trained lay health educators over 4 weeks. Sessions focused on 4 major self-care processes: adherence to medication, low-salt diet, monitoring symptoms, management of symptoms. Following assessment of self-care knowledge and practical skill levels, deficits were addressed (e.g. reading food labels, preparation of low salt meals) taking into account cultural and social requirements. Health educators also offered self-care lifestyle coaching and problem solving (e.g. access to care).

- Control group received usual care and was offered intervention after 3 months.

- Content based on patient education guidelines)

- Kansas City Cardiomyopathy Questionnaire (KCCQ) (23-item health-related quality of life measure that quantifies disease-specific physical limitation, symptom frequency, severity, and change over time, overall quality of life, social interference, and self-efficacy – those dimensions shown to be key aspects of HRQL in persons with HF)

- New York Heart Association NYHA classification

- Charlson Comorbidity Index (CCI)

- Duke Activity Status Index (DASI) (physical function))

77. Frosch DL, Rincon D, Ochoa S, Mangione CM. Activating Seniors to Improve Chronic Disease Care: Results from a Pilot Intervention Study. Journal of the American Geriatrics Society. 2010;58(8):1496-503. https://doi.org/10.1111/j.1532-5415.2010.02980.x.

(*Details*: Group screenings of 5 videos (20-45 mins each) over 12 weeks aiming to inform about and motivate self-management of chronic conditions prevalent among older people (heart conditions, diabetes, back pain) and advance directives, followed by discussion moderated by a facilitator trained in motivational interviewing (member of research team). Videos were shown multiple times to maximise viewing opportunities. Demographic and health data were collected.

Validated measures were used at baseline, 12 weeks and 6 months:

- Medical Outcomes Study 12-item Short-Form Survey (SF-12) (HRQoL – mental & physical)

- Patient Activation Measure (PAM) (activation: self-rated ability to take preventive actions, manage symptoms, find/use appropriate medical care, and make decisions about care with healthcare providers).

- WHI brief physical activity questionnaire (enables estimation of number of minutes engaged in walking/moderate/vigorous physical activity in previous week).

Likert scales measured subjective perceptions of change (12 weeks and 6 months): willingness to consult GP, confidence in ability to ask GP questions, general health, who has responsibility for managing health and what is done to manage health).

Open question about any changes made in how manage condition resulting from programme participation.)

78. Morrisroe SN, Rodriguez LV, Wang PC, Smith AL, Trejo L, Sarkisian CA. Correlates of 1-Year Incidence of Urinary Incontinence in Older Latino Adults Enrolled in a Community-Based Physical Activity Trial. Journal of the American Geriatrics Society. 2014;62(4):740-6. https://doi.org/10.1111/jgs.12729.

(*Details*: Behavioural intervention (Community-Based Physical Activity Trial) to increase in sedentary older Latinos. Steps per day measured using pedometers worn at all times, except bathing or sleeping, for a while week before scheduled data collection. Display was covered in a fabric case to minimise it functioning as a motivational tool rather than a measure of walking level.

Validated scales used:

- Physical performance - Short Physical Performance Battery18 (balance, gait, strength, and endurance)

- ADLs - Activity of Daily Living (ADL) summary scale (assesses difficulty performing 16 basic tasks).

- Health-related quality of Life - Medical Outcomes Study 12-item Short-Form Survey (SF-12

- Geriatric Depression Scale (GDS-5).)

79. Santacreu M, Fernandez-Ballesteros R. Evaluation of a behavioral treatment for female urinary incontinence. Clin Interv Aging. 2011;6:133-9. https://doi.org/10.2147/cia.s17945.

(*Details*: Daily pelvic floor muscle training (Kegel exercises) (3 times daily) at home for 2 months (9 weeks), following a class at DC teaching the exercises. In fortnightly supervision sessions, an expert supervisor (no details provided) gave instructions for further exercises. GPs had explained Kegel exercises to all participants, but they had not previously performed them. Participants were followed up 2 months complete of intervention.)

80. McGivney MS, Hall DL, Stoehr GP, Donegan TE. An introductory pharmacy practice experience providing pharmaceutical care to elderly patients. Am J Pharm Educ. 2011;75(8):159. https://doi.org/10.5688/ajpe758159.

(*Details*: As part of 1st year university module in pharmacy, comprehensive medication reviews were carried out with attenders of DCs and supervised by faculty members or fourth year students. Students followed up matters raised (e.g.: arranging an appointment with doctor to assess symptoms suspected to be a urinary tract infection, obtaining glucose test strips through Medicare for someone who has been paying for these.) Feedback informing the evaluation of the 2008 and 2009 'experience' programmes was obtained from students, supervisors (faculty staff or 4th year pharmacy students, n=13) and DC staff.)

81. West DS, Bursac Z, Cornell CE, Felix HC, Fausett JK, Krukowski RA, et al. Lay Health Educators Translate a Weight-Loss Intervention in Senior Centers: A Randomized Controlled Trial. American Journal of Preventive Medicine. 2011;41(4):385-91. https://doi.org/10.1016/j.amepre.2011.06.041.

(*Details*: 12 one-hour group sessions of adapted version of the Diabetes Prevention Program Lifestyle behavioural weight-control programme delivered by trained lay health educators; included self-monitoring, stimulus control, problem-solving, goal-setting, relapse prevention. Lay educators used a script; handouts were given to participants. Sessions and individual data collection took place in separate private spaces. Materials were provided to day centres without charge.

- Each DC identified 2-3 lay health educators. 40% were community volunteers and 60% DC staff; none had health or lifestyle intervention backgrounds. They received 32 hours face-to-face training and weekly support from the research team.

- Participant goals included 7% weight loss, 25% reduction in calories from fat, graded physical activity (up to 150 minutes/week). Pedometers were provided. Self-completion diaries recording diet and physical activity were reviewed weekly.

- Data collected: body weight (digital scale) (weekly), percentage loss from baseline to 4-month follow-up and proportion achieving ≥5% and ≥7% weight loss (≥7% is known to delay development of type 2 diabetes). At 4 months, participants completed a questionnaire about the programme's usefulness and whether they would recommend it. To address concerns regarding lack of treatment for control group participants, these received cognitive training (brain and memory function).)

82. Kogan AC, Gonzalez J, Hart B, Halloran S, Thomason B, Levine M, Enguidanos S. Be Well: Results of a Nutrition, Exercise, and Weight Management Intervention Among At-Risk Older Adults. The Journal of Applied Gerontology. 2013;32(7):889-901. https://doi.org/10.1177/0733464812440043.

(*Details*: 16 weeks of twice weekly 2 hour classes at DCs, led by dieticians and exercise specialists, at 2 DCs. First hour was low-impact physical activity that progressed from seated to standing exercises. Second hour was education about nutrition for managing chronic conditions (diabetes & high blood pressure) e.g. meal planning, food label reading, portion size. At the start, participants met with the dietician to discuss their specific needs and set goals. Participants were given a personalised programme manual. >50% attended ≥26 classes. Mean attendance 21.7 classes. Participants were encouraged to exercise between classes, alone or in company (peer support).

Measured at baseline and 4 month follow-up (face to face):

- Depression measured by validated scale: Patient Health Questionnaire

- Physical activity self-reported.

- Fitness levels measured by performance on 7 tests designed to measure flexibility, strength and stamina in OP (30-second chair stand, arm curls, steps taken on a 6-min walk, 2-min step-in-place, sit-and-reach, back scratch, and 8-ft up-and-go).

- Body measurements taken and Body Mass Index (BMI) calculated.)

83. Chang Y-T, Yu H-W, Lin P-S. Testing a new model of reablement-focused integrated care in adult day service users in Taiwan: a preliminary study. Innovation in Aging. 2022;6(Supplement_1):805-. https://doi.org/10.1093/geroni/igac059.2903.

(*Details*: Attenders & carers took part in ten one-hour sessions over two months. Attenders' physical & mental function and carer satisfaction were measured at the start and afterwards, and compared with a control group of similar people. There were no differences in physical and mental function between the attender intervention and control groups. Carer satisfaction was significantly higher afterwards compared with the control group. The intervention was described as being person-centred and therapeutic, but no further details were given.)

84. Anderson KA, Geboy L, Jarrott SE, Missaelides L, Ogletree AM, Peters-Beumer L, Zarit SH. Developing a Set of Uniform Outcome Measures for Adult Day Services. Journal of Applied Gerontology. 2020;39(6):670-6. https://doi.org/10.1177/0733464818782130.

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88. van Leeuwen KM, Bosmans JE, Jansen APD, Hoogendijk EO, van Tulder MW, van der Horst HE, Ostelo RW. Comparing Measurement Properties of the EQ-5D-3L, ICECAP-O, and ASCOT in Frail Older Adults. Value in Health. 2015;18(1):35-43. https://doi.org/10.1016/j.jval.2014.09.006.

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90. Podsiadlo D, Richardson S. The Timed "Up & Go": A Test of Basic Functional Mobility for Frail Elderly Persons. Journal of the American Geriatrics Society. 1991;39(2):142-8. https://doi.org/10.1111/j.1532-5415.1991.tb01616.x.

91. Powell M, Osborne SP. Can marketing contribute to sustainable social enterprise? Social Enterprise Journal. 2015;11(1):24-46. https://doi.org./10.1108/SEJ-01-2014-0009.

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9. Endnotes

[a] **Social enterprises** are hybrid organisations with dual social and business objectives. They apply business strategies to meet social outcomes – and with the income earnt from these strategies being used to further social impact rather than to maximise profit for shareholders.

[b] **Social prescribing** is being promoted widely by NHS England. Social prescribing link workers connect people with local groups and support services (i.e. non-medical support) to meet their wellbeing needs (e.g. social isolation, depression). Information about services available locally is key. Often people working in this profession previously worked in health or social care.

[c] The **Overview & Scrutiny** function is part of a Councillor's role as an elected representative. Overview & Scrutiny Committees help ensure that local public services are delivered effectively, efficiently and in the best interests of local people. They hold the Executive to account by reviewing and challenging decisions taken by the council, investigating services or policy areas and making evidence-based recommendations to improve services. Meetings are open to the public.

[d] **Healthwatch** is an independent statutory body that was established under the Health and Social Care Act 2012 to understand the needs, experiences and concerns of people who use health and social care services and to speak out on their behalf. Local Healthwatch are funded by and accountable to LAs. They gather people's views of local health and social care services, share these with people involved in the commissioning and scrutiny of services, report on and recommend how services could be improved, promote and support local people's involvement in service monitoring, commissioning and provision, provide information and advice, share information with and make recommendations to Healthwatch England. Healthwatch England guides and supports local Healthwatch organisations, escalates concerns and advises the Secretary of State for Health and Social Care, NHS England and English LAs of inadequate services.
https://www.healthwatch.co.uk/

[e] **King's Improvement Science** (KIS) is a research programme which aims to improve the quality of health and social care for people across south London and beyond.
https://kingsimprovementscience.org/resources/

[f] **Mental Capacity Act 2005 principles** concerning decisions around capacity: (1) A person must be assumed to have capacity unless it is established that he lacks capacity. (2) A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success. (3) A person is not to be treated as unable to make a decision merely because he makes an unwise decision. (4) An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests. (5) Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.