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What happens in English generalist day centres for older people? Findings from case study research

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Summary

Reports of Covid-19 pandemic related day centre closures impacting negatively on their attenders and family carers have fuelled a resurgence of interest in day centres, a common, but often ‘invisible’, preventive service. The absence of detailed descriptions from the literature limits the day centre evidence base since outcomes data without context are less meaningful.

This report aims to further the understanding of these diverse, multi-faceted settings for potential collaborators and social care and health professionals.

Data included in this report are drawn from documentation provided by managers of four purposively selected English day centres for older people, interviews with 23 centre managers, staff and volunteers, and notes made during 56 full-day visits.

In this report, we present a rich, contemporary, non-interpretative, pre-Covid pandemic descriptive picture covering aims, funding models, location, internal environments, staffing, day structure, charges and a typical day.

Not all sub-typologies of day centre are represented here because of service reviews, declining numbers of centres and a lack of publicly available information.

Within the context of sustainability, social prescribing initiatives and other policy goals in England, this baseline data will support conversations concerning optimisation of these multi-faceted services in the post-pandemic recovery period and beyond: how buildings may be regarded as valuable community assets with potential, how other parts of the health and care system may better interact with day services to improve older people’s, carers’ and others’ health and wellbeing, and to benefit of staff working elsewhere in health and care, and the potential for other local collaborations. Further exploration of day centre cost-effectiveness is recommended.

Key words: day centre, day care, older people, community care, context, case study

1. Introduction and background

There has been a resurgence of interest in English older people's day centres. Day centre closures during the 2020 Covid-19 pandemic, due to restrictions being placed on numbers of people allowed to gather, impacted negatively on many attenders and family carers (Giebel et al., 2020, Tuijt et al., 2021). Previously, English national media had reported potential negative health, wellbeing and financial consequences of day centre closures primarily resulting from local government funding cuts (Roberton, 2018, Green, 2018). Following a dearth of day centre research in England for several years, positive experiences and outcomes for day centre users, carers, their staff and volunteers have recently been reported in the United Kingdom (UK) (Lunt et al., 2021b, Hagan and Manktelow, 2021, Orellana, 2018, Orellana et al., 2020a, 2021a, 2021b), and a study of collective day services is currently (2021-23) being undertaken.[1]

Day centres have been an integral part of social/community care since the middle of the twentieth century (Tester, 1989, Tucker et al., 2005, Thane, 2009, Hagan and Manktelow, 2021) but began to decline in numbers alongside the introduction of the policy of 'personalisation' (choice and control) (Needham, 2011), combined with public funding constraints and substantial cuts to day care provision (Ismail et al., 2014).

Day centres are diverse and complex building-based services that provide care/health-related services/activities specifically for older people who are disabled/in need, which people can attend for a whole day or part of a day. They may be owned by different provider types, operate in different building types, and may differ in size, target clientele and funding. They offer a variety of programmes (interventions) and the opportunity to socialise. They may be known as their local name (e.g. Tulip Centre) or as day care/clubs/care/services or senior/multipurpose centres (Orellana et al., 2020b). Additional complicating elements of diversity contribute to uncertainty around the day centre intervention, for instance number of days attended, variability of individual experiences, and inherently different services provided where a person-centred approach is taken (Fields et al., 2014). English day centres are not regulated by the health and social care regulator (Care Quality Commission) and the absence of a national representative body means accurate details of provision are unavailable. Their diversity, together with being a service described by its location, instead of its aims, makes day centres difficult to research or evaluate (Fields et al., 2014), perpetuating the under-developed evidence base for social care preventive services (Allen and Miller, 2013). This is problematic as evidence-based commissioning is encouraged (Local Government Association, 2015, NHS England et al., 2014).

Rich contextual data are often missing from research or systematic reviews (Wye et al., 2015). This absence of detailed descriptions of day centres and their aims may lead to assumptions of homogeneity and hamper understandings of this complex service and any outcomes resulting from its use – for attenders, carers, staff or volunteers - to be meaningfully gained. Manthorpe and Moriarty (2014, 2013) argued that having better data about day centres is important for those funding services or purchasing them on individuals' behalf. Details also would provide baseline information about what organisations potentially working together locally might offer each other, given that local partnership working is encouraged (HM Government, 2014). These points are particularly pertinent as day centres

[1] Reimagining collective forms of day care provision for older people https://www.sscr.nihr.ac.uk/projects/p164/

have been criticised for being unimaginative and institutionalising (see Hagan and Manktelow, 2021, Needham, 2011, Orellana et al., 2020b). Day services' broader potential may also have been obscured by cumulative effects of various (e.g. financial) challenges or inclination towards individual support or alternative daytime activities, such as those delivered by micro-enterprises (Reddington and Fitzsimons, 2013) or green care (Finnanger-Garshol et al., 2021). The lack of knowledge and assumptions about day centres, particularly by those in a position of influence such as over referrals, extends even to palliative day care services which are also heterogeneous but unknown to many health care professionals (Hasson et al., 2021).

Four day centre case studies, now historical due to changed service structures, ethos and provision, are notable for their in-depth reporting of the setting itself and their contrast with contemporary contexts. Both Hazan's (1980) anthropological study of the concept of time in one English older people's day centre and Smith and Cantley's (1985) pluralistic evaluation of an English NHS psychogeriatric day hospital dedicate a chapter to describing the settings. Tester's (1989) study of day care services in England and Wales devoted part of one chapter to seven very brief case studies of different types of centre. Gubrium's study (1986) in the United States was set in a dementia centre.

This report describes and discusses the characteristics of four English day centres for older people. Recent reviews of English language literature have recommended research on day centres' characteristics to better contextualise their outcomes (Lunt et al., 2018, Ellen et al., 2017, Lunt et al., 2021a, Orellana et al., 2020b). Literature not included in these reviews devotes little space to contextual descriptions while reporting experiences, outcomes**,** centres' acceptability for short breaks/respite, attender characteristics, access routes, programming, person-centred-ness, potential to support hospital discharge planning and post-hospital care , evaluation and planning (Thompson and Fletcher, 2019, Naruse et al., 2020b, Rokstad et al., 2019, Lunt, 2018, O' Shea et al., 2020, Leong et al., 2020, Naruse et al., 2020a, Liao and DeLiema, 2021, Hagan and Manktelow, 2021, Ruggiano et al., 2018, Orellana et al., 2020a, 2021a). Most (short) descriptions of day centres and their activities concern day centres outside England, some of which also offer clinical services: Northern Ireland (Hagan and Manktelow, 2021), US (Salari et al., 2006, Hostetler, 2011), Israel (Iecovich and Biderman, 2012), Norway (Boen et al., 2010, Lund and Englesrud, 2008), Japan (Kuzuya et al., 2006), Canada (Wittich et al., 2014) and Taiwan (Liou and Jarrott, 2018, 2013).

Apart from the study informing this present report, the most detailed contemporary data about English day centres for older people with multiple long-term conditions are reported in Lunt's (2018) doctoral thesis. Contextual data (funding, charges, places available, transport, opening times, activities, target/current attenders, access, referrals, staffing) are heavily summarised and blended across day centres for older people, people with dementia or learning disabilities her purpose was to analyse impact by staffing model (Blended - staff and volunteers; Voluntary - volunteer run entirely; and Paid - staffed by paid workers).

In summary, the homogeneity characterising some social care services – such as home care which typically involves care workers visiting a person's home to undertake washing, (un)dressing, toileting assistance or incontinence pad changing, support with eating and drinking, perhaps simple meal preparation, and mobilisation support – is not found among day centres for older people. Researchers are expected to report settings in which interventions take place and their details yet day centre scholars reviewing their subject literature have commented on scant data. The lack of detailed information about day centres and what happens at them is a dilemma this report aims to address.

Aim and structure of this report

This report provides rich descriptions of the four English day centres for older people that participated in a pre-pandemic mixed methods study (Orellana, 2018), thus aiming to further understandings of this face-to-face, out-of-home care service.

After describing the methods used, we outline the day centres' main characteristics, aims, model and their locality. We then describe centres' internal environments and summarise formal and informal care provided. Next, operational hours, daily timings, available 'extras' and charges made to attenders are set out. Finally, 'typical days' are narrated. We end with a discussion and conclusions.

2. Methods

This report draws on findings of a doctoral study of 'generalist' day centres[2] that used mixed methods within a case study approach to paint an in-depth and contemporary picture of four English day centres for older people, in the environment of 2014-2017, by investigating what they offered, their use, relationships with local health and care services, and professional perceptions (Orellana, 2018). The wider study gathered the perspectives of 69 stakeholders (local authority referrers and purchasers, day centre providers/managers/staff/volunteers, attenders and family carers) and operational data.

Case studies capture complexity of a contemporary phenomenon in its real-life context by using multiple sources of evidence (Yin, 2014, Stake, 1995). Generalisability is enhanced by strategically selecting cases (see Hyett et al., 2014, Flyvbjerg, 2016); generalisability, however, is less crucial than the use made of the case studies (Ruddin, 2016).

Sample and recruitment

Using maximum variation non-probability sampling (Creswell, 2013), four day centres in different local authority (LA) areas, with different population characteristics, deprivation levels and local political administrations, were recruited against a matrix of typological characteristics:

- provider type (LA/non-profit/private)
- building designation (standalone/multi-purpose/adjoining care home/other)
- admission criteria (referral only/open access/mix)
- attender numbers (large/medium/small)
- target users (low support needs/religious affiliation/physically frail/other).

Time and funding constraints necessitated recruitment from South-East England.

Thirty day centres potentially matching different combinations of typological and area characteristics were identified by consulting service directories, LA websites, provider web pages and internet searches. Four were selected to potentially represent the broadest range of characteristics, nine as preferred reserves, and 17 as further reserves. Shortlisted centres were telephoned and emailed to ascertain interest and invite managers to discuss the study

[2] Generalist day centres do not offer specialist care solely to a specific group such as people with dementia or stroke survivors.

in person. Subsequent centre visits, necessary as websites typically provide incomplete data (Green et al., 2021) and service review plans unpublished, enabled further evaluation of day centres' typological match prior to recruitment.

All four invitations were accepted. The LA (day centre) subsequently declined since a local review meant its closure. An imminent service review meant the first reserve rejected the invitation. The third reserve participated.

LAs were approached directly about in-house day centres**.** Both participating voluntary sector day centres were recruited via the organisational manager, one of whom also managed the day centre, who consented on their behalf; another required a committee's approval. Approval from the housing association day centre manager's manager and a LA commissioner was needed.

Data collection and analysis

Data presented here, collected between October 2015 and December 2016, derive from documentation provided by managers (e.g. newsletters, activity programmes), single, qualitative interviews with day centre/provider managers (n=6), frontline staff (n=10) and volunteers (n=7) and fieldnotes. Data were collected by Katharine Orellana, a female social gerontologist with 15 years of experience in the charitable ageing sector and long-standing interest in day centres, who undertook 14 once-weekly, full-day visits to each centre (same day each week).

Table 1 shows data sources for operational sub-characteristics reported. These are further dimensions beyond the characteristics represented in day centre typologies.

Table 1: *Data Sources*

Report sections	**Field notes**	**Documentation provided**	**Manager interviews**	**Staff and volunteer interviews**	**Study planning** (pre data collection)
Aims and funding models	X	X	X		X
Locational contexts	X				X
Day centre environment	X		X		
Formal and informal care and support	X		X	X	
What is in a 'day'	X	X	X		
Charges to attenders		X	X		
Narrative of an observed typical day and variety of activities available	X	X			

Managers were asked about their centres and to supply background documentation. Staff and volunteer interviews covered their roles, amongst other topics. Fieldnotes made during visits supplemented interview and documentary data. As a qualitative but non-ethnographic study, these informed an objective, non-evaluative account of the setting and contextualised interview data, thus were different in nature than for an observational ethnographic study reporting a researcher's interpretative perspective.

A donation of £100 was given to each centre following fieldwork, a strategy intended to enable all attenders, carers and centre personnel to feel appreciated whether or not they were interviewed.

Fieldnotes were typed up. Interviews were audio recorded, transcribed, anonymised and entered into Nvivo (QSR, 2015) software. Katharine Orellana distilled data, from fieldnotes, documentation and interviews, into four individually presented day centre case studies (Orellana, 2018 92:114). For this report, she identified further operational characteristics, discussing and verifying these with Jill Manthorpe and Anthea Tinker. Presentation protects anonymity. As this present report aims to be non-evaluative by presenting factual details, not perspectives or interpretations, fieldnotes and interviews are not cited. This report follows the Consolidated criteria for reporting qualitative research (COREQ) (Tong et al. 2007) and Standards for reporting qualitative research (SRQR) (O'Brien et al. 2014).

Involvement

Involvement was via an Advisory Group of people with day centre experience assembled for the study, which met three times, and an Advisory Group that acts as a critical friend to the NIHR Policy Research Unit in Health and Social Care Workforce. Groups were consulted about study materials and interpretation of the findings. Case study site representatives attending a workshop were also consulted about their interpretation.

Ethics

Ethical approval was received from Health Research Authority's Research Ethics Committee (ref: 15/IEC08/033) and LA Research Governance approvals given. After receiving information about the study and having the opportunity to ask questions, interviewees gave written, informed consent to audio recording of interviews and pseudonymised use of data.

3. Day centre aims and funding models

Table 2 provides an overview of case study day centres' organisational and funding characteristics.

All centres aimed to improve their attenders' quality of life by focusing on their mental and physical wellbeing, mainly by making available social opportunities and a range of activities. Additionally, two aimed to offer nutritious meals and physical rehabilitation (DCLA, DCV2), two to provide information and advice (DCHA, DCLA) and one to support family carers and be a resource for the local community (DCLA). Two set their overall aims within a framework of enabling attenders to remain at home (DCLA, DCV1). Centres' differences extended to

their providers, premises, operational days and hours, access arrangements, attendance numbers, funding and charges, activities, staffing, meal provision, links with the voluntary and community sector, social care and the NHS. One voluntary sector centre specified also aiming to work in cooperation with other agencies for the benefit of its attenders.

Table 2: *Overview Organisational and Funding Characteristics of the Participating Day Centres*

Day Centre	Overview
Housing Association Day Centre (DCHA)	Five-day operation on ground floor of extra care housing (supported living apartments); accepted LA referrals only; for older people with eligible needs (social isolation and needing support with personal care and transport) referred by the LA. Funded by a 10-year block contract. A LA day centre review document stated annual running costs were £304,300 excluding transport (February 2015). Manager (on secondment) reported not always having sight of the centrally-held budget. Paid frontline staff. Capacity of 20 (14 registered attenders at time of research); 9-12 people were observed to attend daily during research period.
Local Authority Day Centre (DCLA)	Five-day operation in a purpose-built centre; accepted LA referrals and drop-ins (without assistance needs) for activities and/or lunch; for older people with eligible needs. Funded by an internal budget; 2015-16 expenditure £679,588 excluding transport. Paid frontline staff and one part-time volunteer. Capacity (with unchanged staffing levels) of approximately 25; 22-28 people were observed to attend. It was also open to drop-in users who were self-sufficient and without eligible needs; up to 10 were observed to join the group for lunch daily.
Voluntary Sector Day Centre 1 (DCV1)	One-day operation in a church hall, provided by the local arm of a national charity; open access for people of any religion/race/ethnic origin aged ≥60 years and housebound, socially isolated who may receive care from statutory or voluntary agencies, but not for people needing lifting/personal care/nursing/specialist care for mental illness. Funded by i) 2014-2017 Service Level Agreement (SLA) (national provider body) of £5,054 (annual maximum) (for 20 weekly attenders, released for actual numbers), ii) fundraising, iii) donation of office rental cost (approx. £5,000) by church which allowed hall use free of charge, iv) annual LA core grant/SLA covering all services provided, not just day centre. Frontline volunteers. Capacity of approximately 25; 12-14 people were observed to attend. Annual three week closure over Christmas and New Year.
Voluntary Sector Day Centre 2 (DCV2)	Two-day operation in a multipurpose community hub, provided by a local charity affiliated to national charity; accepted both open and LA referrals; for socially isolated older people with transport needs. Not for people with personal support needs (only assistance was provided e.g. to get into shower or go to toilet). Funded under annual SLA with LA (extended annually for the previous 3 years after its 3-year contract ended) for up to 15 per day. Income and expenditure were integrated for provider's 3 centres, with each place costing the provider approximately £19. Raffle was additional fundraiser. Paid staff and volunteers. Capacity of approximately 25 (11 registered attenders at time of research); 6-11 people were observed to attend. Closed Christmas Day to 5th January.

4. Locational contexts

For older people accessing any services, proximity is often an important factor contributing to perceived accessibility (Van Dijk et al., 2015). Likewise, being located in, and part of, the local community can contribute to the sense that a service is a community resource. Therefore, data were collected on the local environment, noting indications of being part of local communities or otherwise, visible in localities or set aside and segregated (Goffman, 1961).

DCHA was near a busy road of shops in an urban district close to former heavy industry sites and near large public housing estates, in an area being developed and increasingly gentrified. DCLA was in a residential urban area, midway between two district High Streets. Both were in poorer communities, categorised by the English Index of Multiple Deprivation[3] (IMD) (Ministry of Housing, 2015) as within the 30% of most deprived areas. DCV1 was in the middle of a small town in an area of socio-economic extremes with more social housing than the national average, but in the 30% of least deprived areas. DCV2 was close to the middle of a rural town surrounded by villages, in an area of socio-economic extremes and the middle band of deprivation.

5. The day centre environment

One distinction between day hospitals and day centres lies in their ambiance and the messages the name gives about the building's purpose, the role of staff and volunteers, and the people who go there. Day hospitals are sites of treatment and clinical activity with single use and purpose (Smith and Cantley, 1985); day centres may convey a sense of socialisation and multiple usage. Some are purpose-built; others adapted to new functions.

Housing association day centre (DCHA)

DCHA's purpose-built building had flexible usage, with an activity room and three main areas that could be separated by folding doors (generally left open): the television area with upholstered armchairs, coffee tables and a goldfish tank; a recreational area, with wooden tables and plastic-cushioned wooden chairs, equipment and games cupboards, a small pool/snooker table and a table tennis table; and a dining room shared with the extra care facilities' residents. The main room overlooked an accessible garden. Toilets were off the corridor to the centre; one had a ceiling hoist track. The centre had been recently decorated in bright, homely colours. At the building's entrance were two sofas, another fish tank and a leaflet stand. Facilities communal to the extra care building also used by the centre were a hairdressing salon, the bathroom with a hoist and a Consultation Room. Extra care tenants joined attenders for lunch in the dining room, and, for a small fee, could join the group for afternoon refreshments and bingo. The building thus shared aspects of a communal age-specific building; with attempts to spatially separate different domestic activities; recreation, eating, and relaxation.

[3] Deprivation scores areas derived from income, employment, education/skills/training, health/disability, crime, barriers to housing and services and living environment deprivation.

Local authority day centre (DCLA)

Similarly, standalone, purpose-built DCLA's central area was a large L-shaped room (the 'dining room'), set with groups of tables with plastic-padded wooden chairs, surrounded by recreational activities: a jigsaw table, games, pool/snooker and table tennis tables, shelves housing games, books and playing cards, and a two-seater sofa. Leading off this room were an arts and crafts room (with piano), a computer room, a conservatory, a small meeting room with a kitchenette, a television room, a quiet room with books and videos on shelves, a treatment room (with a hair-washing sink, a bed, lockers and a massage table), a large kitchen with heated serving containers and a serving hatch to the dining room, and toilets. The room overlooked an accessible garden. Down a small corridor were a small office, a room with a bed for attenders feeling tired or unwell, and a bathroom with a toilet, an accessible bath and a changing table; both the latter had mobile hoists. Through this was a laundry. Fabric-upholstered chairs suffering continence 'accidents' were steam-cleaned by staff. At the entrance was the receptionist's and staff office.

Voluntary sector day centre 1 (DCV1)

In contrast, the long, rectangular hall where DCV1 operated adjoined the church's main worship area via a folding partition wall, making use of a community asset. With a high ceiling and windows, the room was bright, airy and warm. There was a raised stage and a kitchen with a serving hatch. Toilets, shared with other building users, were across the lobby through the main hall entrance door. The hall was set up in the morning by a volunteer and one 'active member' (a status assigned by the centre's manager to people wishing to be actively involved in providing the service). Three trestle tables were laid out at different angles for lunch and dressed with flowery vinyl tablecloths, small blue vases with artificial daisies, cutlery and flowery plastic tumblers containing a folded napkin providing an atmosphere of hospitality. On the other side, near the stage, was a semi-circle of fabric-upholstered wooden chairs with small, folding tables in front of pairs of chairs. On the stage was the day's paraphernalia (e.g. magazines). This fully accessible building also had several meeting rooms, a café (opened twice weekly), a vestry, the church office and the provider's office. Although in a shared building and in a hall with three doors, attenders did not get lost. However, at the end of the day, vigilance was key for the volunteers and managers as one attender with dementia repeatedly tried to leave before the driver was ready. Occasionally, chairs suffered continence 'accidents' and were placed aside to be cleaned by building maintenance staff.

Voluntary sector day centre 2 (DCV2)

The 'community hub' building DCV2 operated in was the site of a variety of community facilities and organisations, being one of those buildings increasingly described as an 'anchor institution' (Jackson and McInroy, 2015). Shared users included a library, a church, a housing association's offices, an Advice Bureau, a young people's organisation offering recreational activities and advice, a sensory room and a day centre for adults with learning disabilities that operated in the room used by DCV2 on its non-operational days. The hub also hosted sessional activities (e.g. blood donation sessions, health and wellbeing drop-ins run by charities, NHS Health Trainer support sessions and an outreach sexual health clinic), a young carers' group, an active retired group and classes (e.g. pilates, dancing, singing and children's activities). At times, LA advisors assisted with, for example, financial and benefits advice, disability equipment information, and death registration.

DCV2's entrance led off the library, beside the building's reception/library desk staffed by two LA employees. It was a large, bright room overlooking the garden. Furniture was arranged by day centre staff each morning. At the far end, brightly coloured, fabric-upholstered armchairs and two two-seater sofas were arranged in a small circle (with entrance/exit gaps) with small, folding wooden tables beside them. A wall-mounted television screen was next to glass fire doors leading to the garden and car park. Nearer the entrance were sofas, the tombola and sweet shop tables, and two six-seater lunch tables. Off the room was a cloakroom, two accessible toilets (one with an adult changing table, a shower and screen), a kitchen with a hatch through to the main area, a small meeting room, a therapy room, equipment cupboards and double doors to a sensory room.

Being part of a busy building brought challenges to cohesiveness and security. People frequently came in and out to use the kitchen and fetch items from the meeting room. A learning disability centre attender often visited to take magazines and needed guiding back to another room. In the mornings, background noise came from children using the sensory room and the baby/toddler groups in the library. An additional staff member had been employed when the centre moved to this location because of its numerous access points. Despite the accessible toilet and therapy room having two points of entry/departure, no attenders had got lost, although staff needed to keep an eye on the attender with more advanced dementia. The provider's manager indicated the problematic nature of shared facilities, for example, some of the two-seater sofas were too low, and fabric chairs were not suited to a group experiencing occasional continence 'accidents'.

6. Formal and informal care and support

Using Lunt's (2018) categorisation, there was a mix of frontline personnel in centres. DCLA had one part-time volunteer in addition to its paid staff. DCHA was fully operated by paid staff. DCV2 was managed by a paid staff member who ran the service with two paid staff and one volunteer. DCV1's manager was also the manager of the provider organisation; volunteers provided the service, supported by the manager and assistant manager.

Centres with paid staff provided more personal care (help with continence/toilet, eating); this was formally undertaken in two centres accepting only LA referrals, but all staff roles were varied, described by one as a 50/50 care and social role. Work involved personal care; planning, running and supporting activities, playing games with attenders, organising occasional events; providing emotional support; monitoring attenders' wellbeing and health, often by chatting on arrival or during the day, and acting where necessary; making/serving refreshments; practical support; attending to logistical requirements, acting as a key worker for named attenders and maintaining paperwork.

With reference to domestic work, staff and volunteers at all centres set and cleared tables and served meals; at DCV2, they also washed up and loaded the dishwasher. Dedicated kitchen staff at DCLA and kitchen volunteers at DCV1 prepared meals (see Table 3 for further lunch details).

Table 3: *Lunch details*

Day centre	Preparation	Serving and Clearing
DCHA	Contracted independent caterer. Part cooked on-site (e.g. chips, vegetables) by contractor's two employees; part transported from provider's kitchen in insulated crates. (First 4 weeks: supplied by a meals-on-wheels provider; heated on site by supplier employee).	Served by meal provider staff. Taken to attenders/cleared away by frontline staff.
DCLA	Prepared on site by 3 day centre kitchen staff	Served by kitchen staff. Taken to attenders/cleared away by frontline staff.
DCV1	Rota of volunteer cooks (manager occasionally substituted)	Served by kitchen volunteers. Taken to attenders/cleared away by frontline volunteers.
DCV2	Prepared by local hospital; collected by minibus driver in insulated crates.	Served by manager/staff. Taken to attenders/cleared away by staff/volunteer.

All staff had received a range of training (see Table 4). Training reported included practical training relevant to work, other practical or specialist training, activity-related training and National Vocational Qualifications (NVQs) (possibly incomplete as not all participants referred to their training records). Staff leading chair-based exercise, a healthy eating group, a stroke group and an activity coordinator all held relevant qualifications. Training had been a mix of in-house, externally delivered and online, often in staff's own time using their personal equipment.

Two staff cited relevant training gained from their university degrees (DCLA, DCV2). One was trained in physiotherapy, having a degree in Sports Science which encompassed osteology (bones), myology (muscles) and kinesiology (movement). The second, also related to her degree, had taken drama and music training.

Volunteers' roles involved 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 buttons, buying aftershave locally). Volunteers specifically mentioned having received training in moving and handling people, first aid, food hygiene, falls prevention, dementia awareness, and in the Mental Capacity Act 2005.

Table 4: *Training Undertaken by Staff (as reported in staff interviews)*
Note: Data may be incomplete as not all participants referred to their training records.

Type of Training Details	DCHA	DCLA	DCV1	DCV2
Practical training courses relevant to work				
Moving/handling of people (including during personal care)	X	X	X	X
First aid	X	X	X	X
Food hygiene	X	X	X	
Fire safety	X	X	X	
Health and safety (some courses covered use of hoists).	X	X	X	X
Other practical training				
Medication administration/storage (n=6)	X	X		X
Safeguarding awareness (n=3)	X	X		
Manual handling in emergencies (n=1)		X		
Mental health first aid (n=1)		X		
Dementia and mental health awareness (n=4)	X	X		X
Learning disability awareness (n=1)	X			
Infection prevention and control	X	X		
Nutrition and hydration	X			
Diabetic awareness		X		
Epilepsy awareness	X			
Pressure sore/ulcer awareness.	X			
Specialist training				
Diversity awareness and inclusion (n=2)	X	X		
Trusted Assessor certification enabling assessment for community equipment to assist with activities of daily living (n=1).		X		
Working relationships and information handling (n=1).	X			
Dementia (one staff was the internal dementia specialist, delivering short training sessions to other staff where time allowed).		X		
Bereavement support				X
Activities				
Chair-based exercises (n=2),	X	X		
Healthy eating (n=1)		X		
Craft and design (n=1)	X			
Teaching (n=1)	X			
Stroke, impact of brain injury (n=1).		X		
National Vocational Qualification (NVQ) qualifications				
Level 3 NVQ in Health and Social Care (n=3)	X	X		
Level 2 NVQ part-completed (n=1).				X
NVQ level 2 in Health and Social Care equivalent (from another country)	X			
NVQ assessor (n=1).		X		

7. What is in a 'day'?

Opening hours ranged from 4.5 to 6 hours. All centres differed, but all built in informal time at the start for arrival, refreshments and chatting, lunch, mid-afternoon refreshments and optional organised group activities. Programmes were influenced by facilities available. Tables 5-8 outline the research day at each centre and models of provision. DCHA and DCLA ran regular, timetabled activities whereas programmes at DCV1 and DCV2 varied, and DCV1 had an informal, semi-structured session. Activities included some with a therapeutic or rehabilitative nature, although this was not always explicit. Not all attenders participated in all activities. Additional services were available at some centres on request or through links with social care and health services or local community and voluntary organisations.

Table 5: *DCHA: Choice, activity, and socialisation. The Research Day and Model As Noted During the Visit Period*

DCHA	**10:00-16:00 Operational time: 6 hours**
10:00-10:15	Arrival and seating in television lounge area
10:15-11:00	Tea/coffee/toast in dining area
11:00-12:00	Staff-led themed art/craft (activity room) or baking in the small kitchen in groups of 3.
12:00-13:00	Lunch in dining area (2 courses: chips/mashed potato with fish/chicken/sausages; dessert options. Rota menu provided in advance, but same options every research day)
13:15-14:15	Staff-led singalong in activity room
14:15-15:00	Self-directed/informal activities in recreational area (dominoes, colouring or craft)
15:00-15:30/45	Tea/coffee/biscuits/baked items in dining area
15:30-15:45	Bingo in dining area (fortnightly) called by an attender
15:45-16:00	Attenders move to television lounge and prepare to leave; transport arrived and attenders left at 16:00.
Available on request	Nail filing and painting were available by staff (no charge).
Available through local links	Two clothes vendors visited regularly: one ran a 'clothes party' in the building's communal reception area; the second brought a selection of clothes from her market stall, ordering colours and sizes on attenders' request. Weekly podiatry; people usually attending on a different day could request an appointment (inclusive of transport). District nurses visited to change dressings by individual arrangement. Audiology visits arranged individually. Community Mental Health Team visited to carry out assessments.

Table 6: *DCLA: Choice, activity, and company. The Research Day and Model As Noted During the Visit Period*

DCLA	**09:30-14:30/10:30-15:30 Operational Time: 5 hours**
09:30 & 10.30-11.00	Arrival, refreshments, toast on request (in main dining room)
11:30-12:00	Staff-led seated exercise class in arts and crafts room
11.00-12.15	Falls Prevention Exercise Group run by NHS-employed postural stability instructors in conservatory (for people referred by NHS and registered attenders)
12:15-13:15	Lunch (3 courses: soup, hot fish/meat/vegetarian option or choice of salads or baked potato, and hot dessert. Specific dietary needs catered for on request. 5-week menu rota displayed.)
13:30-14:30	Memory exercises in the meeting room with kitchenette (e.g. focused card games, reminiscence activities)
13:30-14:00	Refreshments (including biscuits) served from refreshment trolley by kitchen staff (wherever attenders are)
14:30-15:00	Healthy Eating session in the meeting room with kitchenette (varied activities e.g. quizzes and cooking)
14:30 & 15:30	Transport arrived. Staff collected attenders from rooms, assisted them to get ready and attenders left with escorts.
Available on request	Blood pressure checks. Computer tablets.
Available through local links	Free internet/computer access at the online centre. Hairdresser visited fortnightly. District nurse visited daily to administer one attender's insulin injections. Blood tests and changing dressings could be arranged on an individual basis, an arrangement set up by the centre's manager so that attenders did not miss their attendance days for health appointments. Weekly Primary Care Falls Service falls prevention exercise group (by referral only). During fieldwork: - an optician visited to check an attender's new reading glasses were satisfactory after being unable to contact her at home. - an NHS Rehabilitation Team visited to assess an attender who was progressing from a walker to a stick after a long hospital stay.

Table 7: *DCV1: Activity and group entertainment. The Research Day and Model As Noted During the Visit Period*

DCV1	**10:30-15:00 Operational Time: 4.5 hours**
10:30-11:00	Arrival, tea/coffee/biscuits, lunch information, sale of fundraising raffle tickets
11:00-12:00	Whole group activity (e.g. 1950s reminiscence talk, exercises with a physiotherapist, arts and crafts, dance performances, singalong, musical bingo)
12:00-13:00	Lunch (2 courses: set menu)
13:10-13:30	Church service (optional extra)
13:30-15:00	Informal small group activities (card games, dominoes or triangular dominoes and colouring books/magazines/word-searches)
14:15-14:30	Refreshments at tables (including biscuits or sweets)
14:30-15:00	Transport arrived and attenders got ready to leave.
Also available	Weekly short worship service in the adjoining church. Trained volunteers ran a monthly hearing aid maintenance clinic. 'Message in a Bottle' kits[4] were given to new attenders, to be used by emergency services visiting their homes.

[4] A small plastic stickered container with medication and contact details for use in emergencies is stored in the fridge door and a sticker placed beside the front door'; emergency services are familiar with these kits.

Table 8: *DCV2: Group activity – centre-based and beyond. The Research Day and Model As Noted During the Visit Period*

DCV2	**10:00-15:00 Operational Time: 5 hours**
10:00-11:00	Arrival, refreshments/toast, lunch orders, sweet shop, tombola
11:00-12:00	Whole group activity (e.g. themed group or individual quizzes, charades, floor hoopla, discussion about local places).
12:15-13:15	Lunch (2 courses: 3 hot meal options, including vegetarian, or salad selections, with a choice of hot dessert, yoghurt, fruit or cheese and biscuits)
13:30/14:00-14:45	Whole group activity (staff- or externally-led) (e.g. themed poetry reading and discussion, yoga, musical performance, musical bingo, talks, outside trips)
14:15-14:30	Refreshments (including biscuits or sweets)
14:45-15:00	Transport arrived and attenders were helped to get ready to leave.
Available on request	A staff member was trained to file and polish nails (charged at £2.50) and, as a hairdresser, also gave haircuts for a donation to the centre (usually £5). Shower. Two attenders regularly visited the library. One used the co-located advice service after staff arranged appointments
Available through local links	Self-employed chiropodist visited fortnightly, providing discounted treatment. Optician visited twice yearly. District nurse visits individually arranged. More regularly, the centre hosted a local charity-operated Monthly Hearing Aid Clinic (open to local residents of the area and attenders), Self-employed masseuse (six-weekly for attender and external bookings). Visiting artisan who sold jewellery. LA-employed Community Warden visited occasionally to check if attenders had concerns needing addressing. Provider website stated eye tests are also available on request.

8. Charges to attenders

Full finance details, including individual payment methods, were not provided. Centres charging systems, attendance, meal and transport charges varied (see Table 9). Voluntary sector centre charges were lower, having been subsidised by grants, contracts and fundraising.

Table 9: *Charging and Payment Details*

Day Centre	Daily Charge to Attenders	Transport	Meal / Refreshments	Payment
DCHA	£38.94	Organised/paid without day centre involvement.	£6 (£3.50 first 4 weeks - subsidised). Refreshments £1 (unused funds, administered by attender committee, are used for extras, e.g. entertainment, parties.)	LA invoiced self-funding attenders in arrears. Refreshments payable on day.
DCLA	£25 'Drop-in' clients (without assessed needs): £2.00 for a maximum of half a day's attendance.	Only for people with assessed needs (and personal budgets). Not chargeable.	£4.10. 20p tea, 25p coffee.	LA invoiced self-funding attenders in arrears.
DCV1	£1 plus annual membership fee (£24).	£3.50	£4.50 lunch and 3 sets of tea/coffee/biscuits	Membership payable 6-monthly. Subscription/lunch payable on day.
DCV2	£12 inclusive of lunch and transport		35p breakfast toast	Payable on day. Monthly invoices in arrears by individual arrangement.

9. Narrative of an observed typical day and the variety of activities available

We now provide narrative descriptions of ‘typical days’ and fuller details of the variety of activities taking place at each centre.

A day at DCHA: Choice, activity and socialisation

Escorts and drivers of LA accessible minibuses, each carrying fewer attenders than their capacity, helped attenders enter their day centres.

Attenders greeted each other and staff when they arrived, and staff hung coats up. Some attenders chatted with each other or staff before refreshments were served; most had toast. Staff collected hot drink preferences and lunch choices. Some attenders brought fruit to eat instead of biscuits.

During morning group activities, which staff reminded attenders about, staff laid tables for lunch and set up a refreshment area. A few attenders brought their own lunch which staff stored in the fridge and later heated up as necessary. One brought a side-salad to eat with her meal. Waits for lunch to be served were sometimes long.

Timetabled art and led singalong sessions were usually themed. The activity leader shared facts about songs’ meanings, the singers or asked attenders about the songs and any associated memories. A musical theatre production and an afternoon tea replaced afternoon activities on two fieldwork days. The television was on all day for those wishing to watch it. Table tennis, pool and table games could be requested. Instead of joining the activities, one attender preferred to sit alone and knit, do crosswords or watch sport on an iPad. A visually impaired attender spent the morning in the recreational area, occasionally chatting with staff, but joined in afternoon activities and chatted with co-attenders. The sole man, who was severely cognitively impaired, spent most of the day at the dining table, sometimes looking at the newspaper, correspondence he had brought or napping. He played dominoes with staff once, table tennis with staff once, joined the singalong once and visibly enjoyed the theatre production.

Music was a big part of this centre; a large speaker in the recreational lounge played 1950s, 1960s or reggae music all day relatively loudly. Some attenders sung along and some danced leaning on their walkers en-route to afternoon refreshments. The manager was the focus of some risqué song-based banter one week. Most attenders interacted with each other and staff throughout the day, some calling across the room to greet others, asking how they were or making jokes. Afternoon activities were accompanied by much conversation. Fixed seating arrangements were not allowed after these were noted to cause conflict. Attenders clamoured if afternoon refreshments were delayed. Biscuits were offered from tins and served with tongs; items baked in the morning were shared. Throughout the day, staff circulated with jugs of water. The Day Care Coordinator was warmly welcomed when she regularly appeared.

Reduced mobility and disabilities meant staff were constantly assisting attenders to stand up from their chairs, taking them to and from the toilet or activities, handing them their bags, helping them organise their money, supporting the visually-impaired attender to know where

her drink and biscuits were, and assisting her to feel part of the activities. Staff took protected lunch breaks behind closed doors.

A day at DCLA: Choice and company

Escorts and drivers of LA accessible minibuses, none filled to capacity, helped attenders go into the day centre from their minibuses. A handful of attenders organised their own transport.

Attenders greeted each other on arrival after they, or staff, hung their coats up on coat-stands in the dining room. Attenders tended to sit at regular tables. Background music of varying genres played from a small speaker beside the kitchen for most of the day. A staff member noted lunch choices in the morning. The volunteer circulated, chatting, and ran small errands locally for attenders. Staff circulated reminding people individually that activities would begin, about ten minutes beforehand. Throughout the day, staff circulated chatting with attenders and assisting as needed. Activities started and ended at scheduled times. Programming incorporated time for movement between rooms and toilet visits.

This relaxed day was loosely structured around timetabled group activities. Those not joining in with these remained in the main dining room to chat, play dominoes, cards or Scrabble, do jigsaws, read the newspaper, use tablet computers to, for example, follow foreign news or listen to music. Some watched television in the television room while others sat in the quiet room. A pool/snooker table and a table tennis table were available. Blood pressure checks and computers/tablets were available on request on any day. Timetabled staff-run activities on other days included crafts (including knitting), quizzes, singing, relaxation, tai chi, seated exercises, bingo, Scrabble competition and other board games, discussion group, music appreciation, circle dancing (for attenders with dementia only), Stroke Group, manicures on request. Externally-led activities on other days included chair-based exercises, pet therapy (fortnightly), art, reading group. A hairdresser visited fortnightly.

Lunch tables were set during the morning activity, including water jugs. Non-slip silicone mats kept plates in place for those needing them and there was adapted cutlery and crockery. Some attenders were given plastic aprons. Attenders helped each other open condiment packets. Staff assisted attenders with more advanced dementia, all seated at one table, and others needing help to eat. Lunch was unrushed and afternoon activities did not start immediately. After lunch, around five attenders went to the television room; some spent the whole afternoon there while others joined activities. One had a short nap in the quiet room before joining an activity. Once, when activities were cancelled (a continence ‘accident’ required several staff), people gathered together and played cards.

Before attenders arrived, staff discussed the day’s plans and shared attender updates. After attenders had left, they held a de-brief to share any observations, concerns or evaluations of how the day had been. Staff breaks were sometimes cut short if there was a staff shortage.

A day at DCV1: Activity and group entertainment

The provider's volunteer car driver service was used by most attenders. Each driver was assigned one or two attenders whom they collected from their front door, accompanied into the centre and ensured they arrived home safely. Some attenders used local community transport organised by the provider.

After being greeted and having their coats taken by volunteers, attenders took their usual place in the semi-circle. Walking sticks and frames, trip-hazards, were stored out of the way; volunteers usually reacted quickly when attenders appeared to want these (e.g. to go to the toilet). Two people were given cushions from the cupboard. Attenders chatted to their neighbours. Volunteers chatted with people as they arrived. A volunteer circulated with the refreshment trolley and another offered biscuits from a tin. Another volunteer showed the day's menu, written on a big chalkboard, to everyone individually. Raffle tickets were sold fortnightly to fundraise. Prizes (mostly sweets, biscuits, tinned food, cards or toiletries), donated by attenders and volunteers, were displayed on a trolley. About ten minutes before the whole-group activity, the manager or assistant manager officially welcomed everyone, made announcements (e.g. upcoming events, deaths, birthdays – happy birthday was sung) and explained the day's organised group activity. The raffle was then called; winners walked to the trolley to select their prize and volunteers took the trolley to the less mobile.

At lunch time, volunteers helped attenders move across to the lunch tables. Volunteers offered squash and second helpings, if available. Most volunteers sat separately to eat their packed lunch; one or two joined the attenders. Lunch was unrushed yet always finished by 12.45pm. An 'active member' helped volunteers to clear the tables, wiped tablecloths and folded them away with a volunteer. During lunch, volunteers set up three folding trestle tables and moved chairs from the semi-circle. Some attenders remained at the lunch tables chatting. Two or three joined the short worship service in the adjoining church. The kitchen hatch was lowered after lunch and kitchen volunteers kept noise to a minimum.

Afternoon activities took place at three trestle tables. Attenders sat at their preferred one; most sat at the same table every week. The 'conversation volunteer' joined in the card games, assisted by members, and chatted with anyone passing by. There was a low buzz of conversation throughout the afternoon. During the day, manager and/or other staff popped in regularly to ensure everything was going smoothly and ask if any problems needed addressing.

During fieldwork, activities, which almost all attenders joined in, included musical and bird bingo, food sampling, a reminiscence talk about life in the 1950s, exercises with a physiotherapist, seasonal arts and crafts led by the Workers' Education Association, singalong music with guitar accompaniment, a talk about key moments during World War II, a performance by a local amateur dramatic group, a Scottish dancing performance and a special occasion lunch. All except bingo and food sampling were led by visitors. Upcoming activities for quarter following the visit period were chatting after the group holiday, a beetle drive, a childhood games reminiscence session, yoga, a demonstration by a frozen meals provider and talks given by representatives of an armed forces charity, an assistance dogs charity and the local NHS Rapid Response service.

Volunteer drivers tended to arrive early, sitting and chatting while waiting. Some attenders started to get ready to leave immediately they saw them. When attenders started to leave, volunteers and the 'active member' stored the chairs and tables on the stage.

A day at DCV2: Group activity – centre based and beyond

The provider's minibus was used by all but two attenders who used a local hospital volunteer car scheme, booked by the centre's manager. The minibus (driven by agency drivers during fieldwork) was met outside by the manager, staff and the volunteer. The driver briefed staff/manager on any matters arising on the journey while staff and the volunteer chatted with attenders about how they were.

Attenders then took their usual place in the circle of chairs and chatted or browse the selection of magazines placed on the small tables. Some attenders were given cushions and one a footstool. Some brought in things to show each other. Staff/volunteer served refreshments prepared to individual preferences by consulting a laminated list in the kitchen, having first checked attenders' preferences, and toast to those wanting it. One staff member usually joked with an attender about having ensured they had buttered it right up to the edges as they liked it. Biscuits were offered from a plate.

There was plenty of time before the morning activity for chatting and there was much conversation and laughter. Even those who were deaf chatted; one joked that she was her friend's eyes and her friend was her ears. Activity timings were flexible, sometimes interrupted when the manager needed to make an announcement, and punctuated with banter with staff. Staff and the volunteer modified activities to include the attender with advanced dementia, gave her props or sat beside her to explain what was happening. During the morning, the manager read out the following week's lunch options, noting down choices which were delivered to the hospital meals supplier when lunch was collected and insulated boxes returned.

During the morning activity, staff set tables with pale green tablecloths, a small vase of plastic flowers, salt, pepper, cutlery, white paper napkins and transparent plastic tumblers. The activity stopped once lunch arrived to give attenders time to use the toilet. Lunch was leisurely. Some attenders sat with different attenders to the ones they had been beside in the circle. The volunteer offered squash and water from jugs. The visually-impaired attender was supported to know what was on her plate and where. Staff and the volunteer took their own lunch, sitting with attenders if there was space, once the main course was served. Second helpings were offered before dessert was served. Attenders often stayed at the table chatting until 1.30pm. Two attenders regularly visited the adjoining library and one used the co-located advice service after staff arranged appointments. After lunch, staff took the wheelchair-using attender outside so that he could smoke a cigarette. The manager ate lunch after crockery and cutlery had been cleared, the dishwasher loaded, and everyone was seated in the circle.

During fieldwork, everyone joined in the team quizzes, mainly using quiz books, that were the usual morning group activity. Team names, chosen by attenders, were usually topical and content varied (general knowledge, brain teasers, mental agility, reminiscence, science and nature and cryptic quizzes of names of sweets and local landmarks). Often these used half the available time and the remainder was filled with one or two shorter (10-15 minutes)

activities such as group crosswords, charades, chair exercises, floor hoopla and poem readings or individual quizzes (e.g. name a place beginning with a letter selected from a tub of letters). One week, places appearing in vintage local postcards were identified and discussed. Another week, the volunteer led a discussion in which attenders shared snippets of information about where they were born, had lived, their first job and the highlight of their lives. Afternoon activities led by visitors included a season-themed poetry reading and discussion, yoga, a consultation-talk by a NHS representative about plans for new NHS buildings, and a musical performance organised by the learning disability day centre for its clients. Where activities were shorter than a whole session, they were supplemented by internally-led quizzes (e.g. throwing an inflatable quiz ball, true or false cards), group crosswords, guessing the object in the bag, charades and I-spy). Staff and volunteer-led afternoon activities included card-making and musical bingo. During the visit period, there was a Bring and Buy Fundraising sale and two outside visits (fish and chips at the seaside and a boat trip). While the fieldwork day was usually quiz day, the programme on the other operational day varied considerably, often with outside speakers or entertainers. Recent activities included falls prevention exercise with a personal trainer, a talk by a Police Community Support Officer, a visit to one of the provider's other day centres, a singing performance and chocolate tasting. The adjoining sensory room was said to be used occasionally. Attenders could also have a shower which happened very rarely, according to the manager.

The hatch and door to the kitchen remained open all day meaning conversation noise sometimes interrupted attenders from hearing the afternoon activity.

At the end of the day, a staff member remained in the room to ensure cash was secure while the manager, the other staff member and volunteer accompanied attenders to and into the minibus. They stood in a line and waved as the minibus left; attenders waved back and some blew kisses.

10. Discussion

We have provided contemporary and rich descriptions of four distinct English day centres for older people. Operational descriptions and narrative accounts of days provide greater depth than other accounts and highlight centres' diverse nature, thus furthering the understanding of these services and providing background for debates about day centres and their optimisation which were newly stimulated by the Covid-19 pandemic.

We have clarified what makes 'the day centre' a multi-faceted intervention that each attender is likely to experience differently due to its complexity and heterogeneity. It incorporates door-to-door accompanied transport to a fixed venue with varying facilities, a meal, refreshments, a group of peers, trained staff/volunteers (some of whom may be older themselves; see Orellana et al., 2021b) who provide both care and emotional, physical and practical support, the opportunity to socialise and participate (or to witness without participating) a variety of structured or unstructured activities or be entertained, group outings, and access to other services or activities local partnership working has facilitated. Contextual data presented here support interpretation of other studies' findings, such as

outcomes for day centre attenders, volunteers and carers, and the service's focus on relationships (e.g. Hagan and Manktelow, 2021, Lunt et al., 2021b, Orellana et al., 2020a, 2021a, 2021b). Unlike Tester's (1989) finding, centres' aims were clearly defined but differed in specificity. Aims addressed English health and social care policy target areas and were consistent with recent literature (Orellana et al., 2020b).

We now comment upon day centres within the context of the Covid pandemic, the potential impact of better understandings of day centres on local working relevant to policy initiatives, and finances.

The Covid-19 pandemic demonstrated how withdrawal of structured social contact can be detrimental (Giebel et al., 2020, Tuijt et al., 2021), and spotlighted a desire for relationship-based public services (Mackenzie, 2021). Increased numbers of people sought support from other social care services due to temporary pandemic-related service closures (Association of Directors of Adult Social Services (ADASS), 2021). One local voluntary sector provider blogged that "*admission to residential care for eight of our [day centre] service users was (….) an ironic indication of the preventative value of day care, which is sometimes viewed as an outdated service*" (Lee, 2020). Another reported re-opening its day centres as early as possible because attenders said they would rather risk infection than be consistently at home (Newton, 2021).

Giebel et al.'s (2020) UK study of carers and people living with dementia, undertaken during the early part of the pandemic, concluded that "*nothing can replace the face-to-face human social interaction and the impact this has on someone's well-being*." Despite some providers maintaining contact with attenders and carers via regular phone calls or internet-based activities, the latter were not always successful particularly for people with dementia living alone or with more advanced dementia (Giebel et al., 2020). Just over half of UK people aged 75 or older were recent internet users in 2020 (ONS, 2021), so attempts at digital remote support may be jeopardised. Many lack internet competence (Hargittai et al., 2019, Age UK London, 2021) and may lack a support person. Many day centre attenders live alone (Lunt, 2018, Orellana et al., 2020a). Numbers of people living alone are increasing, especially among the oldest old (Kempton and Tomlin, 2014). People ageing without children, an increasing group (ONS, 2020), felt extremely isolated with the withdrawal of group activities during the pandemic (Collieson, 2021) and face additional disadvantage as much practical support is from adult offspring (Pickard et al., 2007).

England's day care sector is still not fully operational despite national guidance allowing formally organised support groups for up to 15 people since July 2020, and 30 people from May 2021. In April 2021, estimated commissioned day centre places, for all adults, had reduced to two-thirds when compared with February 2020 places (pre-pandemic) (ADASS, 2021). Operational challenges to re-opening for the not-for-profit sector have included substantial income reductions due to reduced fundraising activity, unavailable volunteers due to Covid-19 vulnerability, and difficulties ensuring Covid-safe environments (Groundwork UK, 2020, Townsend, 2021).

Greater need for voluntary sector services, post-pandemic, has been mooted due to increased isolation and anxiety among older people, reduced physical activity affecting health and wellbeing, and increased carer stress (Groundwork UK, 2020). With residential

care reported as a less attractive option post-Covid (Quilter-Pinner and Sloggett, 2020), alternative options, such as day centres, will increase in importance, particularly given high digital exclusion among older people and because internet-based provision does not enable a change of scene or personal care, something day centre attenders value (Orellana et al., 2020b). Within this context, day centres' suitability to support recovery has been proposed (Lunt et al., 2021b, Green et al., 2021).

Given English LAs' role in shaping the care market (HM Government, 2014) and the efforts to build back better services following the pandemic, there is a need to situate day centres within the current English policy agendas of partnership working, prevention and early intervention and ageing in place (growing older at home with changing needs) (HM Government, 2014), growth in social prescribing (NHS, 2019), and interest in the potential of community assets.

Referral, commissioning, funding or partnership working decisions may be influenced by individual knowledge and pre-held assumptions about specific service types, perhaps derived from professional background. Both in England, and in countries where day centres are integrated into health and care systems, little is known about social care and health professionals' perceptions of day centres, particularly those commonly in contact with older people in need of care and support (e.g. family doctors, nurses, social workers, occupational therapists, social prescribers) (Orellana et al., 2020b). Social prescribing link workers (community navigators), often based in NHS primary care networks, make 'social prescriptions', referrals to, or connect people with social, emotional or practical needs to non-medical interventions (e.g. support services such as day centres – to attend or as a volunteer) (NHS England, 2020). Outcomes measured include individual health and wellbeing improvements, and reduced use of primary and secondary healthcare (Polley et al., 2019). Stakeholder buy-in is key (Fixsen et al., 2020) to this enactment of personalised care and support with demonstrated potential to economically benefit the NHS. This report raises awareness of day centre services.

With partnership working in mind, exploring potential future local collaborations is recommended with a view to enhancing and making more efficient the care and support offered to older people via their day centres. Some examples of additional services or support for attenders resulting from local links have been provided here. Most had been developed by DCLA, something possibly linked with its larger size, flexible, standalone premises, five-day operation and more stable funding. Most LAs want to invest in prevention and new ways of working; these are an important way to deliver savings whilst recognising that statutory funding for local services continues to be problematic (ADASS, 2021).

Under an asset-based approach, day centres can be considered 'anchor institutions' which promote the health and wellbeing of individuals in a local community (Daly and Westwood, 2018). Social prescribers, social care and health professionals, including those who are peripatetic or community-based (e.g. undertaking outreach or medical visits), may wish to make themselves aware of their local day centres, the services they offer and facilities available.

A hindrance may be "difficulties in obtaining accurate information on costs", also experienced by Tester (1989). Day centre finances are complicated, by varied funding

sources, staffing and attendance differences, building ownership, estates costs, and transactions with public sector bodies. This perhaps explains the lack of research about cost-effectiveness (Ellen et al., 2017). The present study and Lunt's (2018) could only report attendance charges, and even these are not often publicly available (Green et al., 2021). Apart from the Personal Social Services Research Unit's annual Unit Costs work, which covers LA day care provision (https://www.pssru.ac.uk/project-pages/unit-costs/), only one English study has reported income streams and financial viability of 12 day centres for people with disabilities while operating as social enterprises (Powell et al., 2019, Powell, 2015). Several finance questions remain unanswered (e.g. cost per hour/day/place/transport for different models of provision).

Further exploration of finances and cost-effectiveness would improve understanding of service provision within the current social care market in which funding and clientele levels fluctuate or are uncertain, and be important in the context of sustainability, reduced commissioning and a need for clarity for individual consumers. Progress in ascertaining costs could enable the use of the Adult Social Care Outcomes Toolkit (ASCOT) (Netten et al., 2012), a cost-utility tool recommended for economic evaluations (Makai et al., 2014, Balamu et al., 2015). Economic evaluation exercises could further improve understandings of day centre benefits with a view to maximising their use and potential.

Limitations and strengths of this research

The research was undertaken at a time of financial cuts and service reviews. Reviews, reduced numbers of centres and lack of publicly available information meant some sub-typologies were not represented, for example, small, entirely volunteer-run day centres without national affiliations and for-profit centres (all of the latter identified specialised in dementia care).

Centres' typological and location diversity helped compensate for the study's limitations which relate to the small number of participating centres in one region and the inclusion of data from the agreed research days; other days may have differed in attender profile, activities and staffing. International comparisons are difficult as models differ between, and within, countries.

Strengths lie in the study's in-depth nature, resulting an in-depth snapshot of one day at each centre, and focus on generalist day centres. Risk of disruption to normal activity and practises was minimised by regular full-day visits which habituated attenders, volunteers and staff to the researcher and led to a trusting rapport.

11. Conclusions

This report has updated the English evidence base about older people's day centres not specialising in the care of older people with dementia by setting out the details of what happens in these services and local links in place. It shows how 'the day centre' is a multi-faceted intervention within a local context encompassing many different planned and unplanned elements. Some may be part of anchor institutions, others offer opportunities for asset-based community development, drawing on mutual aid and volunteering support.

One pandemic legacy is a greater understanding of the need for in-person, face-to-face (relational) contact and the difficulties experienced by certain groups of older people when their supportive relationships delivered via day centres were halted. Given the importance of relationship based public services (Mackenzie, 2021), it may be timely to re-examine the value and broader use made of these services, and their buildings/activities, which have tended to remain invisible to scrutiny due to their smaller scale, exclusion from regulatory frameworks and patchy online presence (Green et al., 2021). Rather than focusing on these as resource-heavy services, consideration could be given to what they do, and could offer - to individuals, their staff and volunteers, the social care sector, the wider community, LAs, the NHS, and the education sector - within the context of a preventive and early intervention approach espoused by policy.

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