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Day Care Services for Older People with Dementia in the North West of England

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Discussion Paper M061
July 2004

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1 EXECUTIVE SUMMARY

1.1 Introduction

National bodies have been established to monitor and improve standards of residential and nursing home care, as well as domiciliary care providers, against a nationally agreed set of criteria. Similar organisations have not however been established in respect of day care and no detailed guidance relating to the development of such standards is specified in the National Service Framework for Older People (Department of Health, 2001a).

The current study was one of a series of studies undertaken to identify and describe specialist dementia services in the North West of England.

This study had three aims:

- To identify and describe day care services that had a specialist focus on dementia care in the North West of England
- To assess the quality of care provided in these facilities
- To compare the type and quality of care provided by day centres and day hospitals

It was intended that the information obtained in meeting these aims would assist in service development in the region.

1.2 Method

One hundred and four specialist day care services for people with dementia in the North West of England (identified by key personnel in the NHS Trusts, Health Authorities, Social Services Departments and voluntary organisations) were each sent a questionnaire. The questionnaire was structured according to three main themes: service delivery; user-centred practice and organisation of care (see Appendix 1) and was developed by the authors around recent policy guidance and published research findings. Seventy nine (76 per cent) services returned a completed questionnaire and there were no exclusions. Data was analysed using SPSS version 10.1.

1.3 Key findings

1.3.1 Description of day care services

- Most local authority areas provided both day centres and day hospitals, although this was not always the case in some of the smaller authorities

- A low proportion of people with dementia appeared to be attending day care services in the North West. We estimated that just three per cent of people with dementia were in contact with day care services

- It was estimated that there are 1.51 – 2.01 day care places per 1000 population aged over 65 in the North West of England. This estimate is lower than the recommended provision of two to three places first advocated by the DHSS in 1970 (DHSS, 1970), and lower than the national average estimate of 2.6 day

hospital places per 1000 population aged over 65 (Audini et al., 2001)

- Despite the low estimates of overall day care places many services had spare capacity. At the time of the survey the mean occupancy rate was 100 per cent in only three areas, yet almost a third of services reported operated a waiting list.

- Thirty eight per cent of facilities described their services as solely for people with dementia. However a much greater proportion (72 per cent) of services reported that all their attendees had dementia. The mean proportion of total day care places specifically designated for people with dementia was 71 per cent (IQR 46 per cent-100 per cent). The mean number of day care places specifically designated for people with dementia per day was 19 (IQR 10-30).

- There was little evidence that services were targeted on the most dependent - of those attendees with dementia, 54 per cent were rated as having mild or moderate dementia, and 46 per cent as severe.

- People with dementia from ethnic minority backgrounds were marginally under-represented in the overall sample. Once outliers were removed from the sample, 2.5 per cent of attendees were reported to be from an ethnic minority background, a slightly lower figure than for the population over 65 coming from an ethnic minority. This masked wide variation between individual local authorities. In addition, cultural traditions did not frequently feature in standardised assessment forms.

- The majority (mean 81 per cent) of people with dementia attended day services for three days or less. Most services (66 per cent) reported offering clients some degree of flexibility in attending for special reasons other than their allocated days.

1.3.2 Service quality

- A distinct lack of service availability on evenings and weekends was also apparent. Only ten facilities (13 per cent) provided evening care and 20 (25 per cent) provided weekend care.

- Services tended to have one member of staff for every three to four users. However, day hospitals tended to have a greater number of and variety of professionally qualified staff groups.

- Only 37 per cent of day care staff were reported to have had recent (in the last two years) training for caring for people with dementia.

- The level of integration in day care services was generally low.

- More than half of respondents considered their transport arrangements to be ineffective.

- Not all respondents (72 per cent) reported completing an assessment form on

people with dementia in the first three months of referral. Fifty-eight (77 per cent) of facilities reported that they made a care plan for each service user as a result of an assessment. Our assessment of these documents showed that on the whole care plan documents were of a poor quality.

- Most services (72 per cent) considered that the care they offered was tailored towards the needs of the individual, but less than half (46 per cent) utilised memory/life story wallets. Day centres tended to have less access to occupational therapy, speech therapy and reality orientation and memory training than day hospitals. Many facilities in general operated from buildings which were not specifically designed or adapted for people with dementia. Almost 70 per cent of facilities in general did not have specially designed gardens and almost 80 percent of facilities in general did not have specially designed buildings.

- Less than half of services had formal carer support arrangements and this was reflected in a lack of specific arrangements for carers such as recording carer needs on assessment forms and providing specialist training in dementia care to carers.

1.3.3 Day hospitals and day centres – a comparison

- Day centres had a greater number of total places compared to day hospitals (1170 versus 891) but a similar number of places per facility (mean 26 versus 30). However, day hospitals had a greater number of designated dementia places (788 versus 629) and more per facility (mean 27 versus 15). Designated dementia places in day centres were more likely to be occupied at the time of the survey than those in day hospitals (mean 87 per cent versus 77 per cent). The total number of service users with dementia was distributed fairly evenly between the two types of services (1232 versus 1190) although capacity was higher in day hospitals (mean 40 versus 27).

- There was evidence to suggest a greater degree of targeting on people with dementia in day hospitals.

1.3.4 User-centred practice

- Day hospitals scored higher than day centres on most of the items relating to user-centred practice. Day hospitals were more likely to use systematic assessment and care planning practices than day centres. Day hospitals were more likely to produce a care plan for each service user, and on average these were likely to be of higher quality than those produced by day centres. Overall levels of training provided to care staff was similar in both services.

- Day hospitals in the present study adopted significantly more rehabilitative approaches for people with dementia than day centres.

- Day hospitals reported significantly more building design features that facilitate choice and effective dementia care for the individual than day centres.
- Day hospitals were more likely than day centres to be responsive to the needs

of carers through adopting proactive practices (for example, greater levels of support to carers and increased carer involvement in reviews).

1.3.5 Organisation of care

- Day centres were predominantly local authority-funded, whilst the funding source for day hospitals was almost always solely the NHS. Day centres tended to report funding arrangements lasting for one to five years, whilst day hospitals tended to report a higher degree of security, with longer term arrangements lasting for in excess of five years. Local authorities are required to charge for services, and most day centres (80 per cent) did so.

- A significantly higher proportion of day hospital staff than day centre staff were professionally qualified.

- Transport arrangements were reported to be more effective in day centres than day hospitals.

1.4 Conclusions

- The number of day care places appeared to be low in relation to the needs of the population, although there appeared to be some spare capacity in those services included in the study.

- More services need to be provided outside the normal hours to include evenings and weekends. Further resources are required to extend opening hours, increase staff and make improvements to buildings

- Improving access and engagement of people with severe dementia, particularly in day hospitals and ethnic minority groups should be a priority

- More buildings need to be specifically designed or adapted for people with dementia.

- Many staff (and consequently users) would also benefit from training with regard to caring for people with dementia.

- More efficient and flexible methods of transport should also be considered.

- Facilities should adopt more comprehensive assessment and care planning procedures and documentation along with life story wallets.

- Proactive policies to support carers (for example, allocation of staff time specifically to develop carer support groups) need to be extended so they can continue to care for highly dependent people with dementia.

- Day care services offered by day hospitals and day centres appear to be distinct and complementary rather than overlapping, with day hospitals offering clinical and medical expertise and day centres focusing on the provision of social support.

2 INTRODUCTION

Dementia is one of the four specific disorders identified in the National Service Framework for Older People (NSFOP) (Department of Health, 2001a) and is one of the greatest challenges to health and social services, affecting about one in 10 people over the age of 65 and about one in four over the age of 85. In the United Kingdom, about 800,000 people suffer from the disorder and the estimated costs in the United Kingdom are about £6 billion per annum, constituting a significant proportion of the total cost of care for elderly people. Around half of this accounted for in terms of direct spending by the NHS and social services authorities (Audit Commission, 2000). In addition, the prevalence of dementia is linked to increasing age, so as the number of older people in the population continues to rise, it is likely that the future costs of dementia care will increase considerably (Kirby et al., 1998).

As dementia is a progressive disease, the care pathway for each individual and their carers requires a wide range of services (Spicker and Gordon, 1997). Equally, as people's conditions become more serious, they need more help, usually from specialist services (Audit Commission, 2000; 2002). The variety and number of statutory and non-statutory agencies involved in any one geographical area can be overwhelming to those attempting to co-ordinate service provision and service development and, indeed, even more so to those receiving it, particularly carers. Along with residential care, nursing care and hospital based services, a range of community based mental health services are required, including day care, domiciliary care and out-patient provision (Department of Health, 2001a).

Services for older people with dementia have developed significantly since the community care reforms introduced in the United Kingdom in 1993. There is, however, little evidence of local systematic development of total service approaches. In certain areas, innovative services have been introduced as a result of local initiatives driven by individuals in purchaser or provider settings. Evidence of this variation is provided by a national survey of old age mental health services in England (Challis et al., 2002). The study demonstrated a high degree of variability between regions in relation to specialist dementia services as identified by old age psychiatrists. Within the North West region a smaller proportion of authorities provided specialist dementia services (33 per cent) compared with the overall national provision (46 per cent).

The NHS and local councils are expected to develop a range of specialist services to meet the needs of older people with mental health problems (Department of Health, 2001a). At the same time, the NHS and Social Care Regional Offices are also responsible for monitoring and reviewing variations in mental health service provision for older people across localities, in order to highlight areas for improvement, as well as areas where variations need to be reduced (Department of Health, 2001a). Furthermore, government guidance recently recommended that agencies in each local authority area review local day provision for older people with mental health problems (Audit Commission, 2002). In the light of these requirements it is clear that research undertaking the mapping of specialist day care services is critical to inform service development.

Service mapping is a developing concept which has expanded in recent years. There have been a number of recent mapping studies which have identified and described specialist services (Challis et al., 2002; Cunningham-Burley et al., 2002; Johnson et al., 2000; Ebrahim and Redfern, 1999; Wrought, 1993) but none have focused on specialist day care services for older people with dementia. There are clearly methodological challenges inherent in attempts to focus on services for dementia alone. Indeed, only 21 per cent of health authorities could readily identify their spending on dementia care (Alzheimer's Disease Society, 1997).

Although many commentators acknowledge the importance and existence of specialist dementia services, very few offer a formal definition of what constitutes such a service. Likewise, services themselves may be unable to accurately define organisational structures and processes that are specific to this client group, as distinct from other mental health problems. In this survey of day care services a broad definition of specialist dementia services was used to overcome these difficulties.

2.1 Specialism

Specialist services are more likely to develop the expertise needed to care for people with dementia. Without the provision of specialist dementia services, there is a heavier reliance on general provision for older people. In their joint review of specialist services for older people with mental health problems, the Royal College of Psychiatrists and the Royal College of Physicians (RCP and RCP, 1998) noted that there were few services with specific responsibilities for people with dementia. A recent study (Hughes et al., 2001) found that less than half of old age services in social services departments in England provided specialist dementia services in conjunction with health trusts, and that this was available throughout the authority in just over a third. Although policy directives have favoured the provision of specialist services (Wagner, 1988; Audit Commission, 2000), most people with dementia are cared for in mixed settings (Marshall, 1999) and a recent survey by the Royal College of Psychiatrists found that the majority (76 per cent) of old age psychiatric day hospitals operated a mixed organic/functional service (Audini et al., 2001) rather than one that concentrated specifically on people with diagnosed dementia. Specialist help for people with dementia and their carers has been described as patchy and often uncoordinated (Audit Commission, 2000; 2002). The evidence supporting specialist provision for the care of older people with dementia, as opposed to care provision through mainstream old age services is still the subject of debate. Marshall called for more research to assess when segregation is useful and noted:

> "We know far too little about the relative impact of separate versus general policies, and indeed formal policies may have little to do with service development on the ground unless users are skilled in demanding implementation." (Marshall, 1999 p.94)

Further research, which is beyond the scope of the report, is needed to evaluate whether the development of specialism or specific aspects of specialist provision can provide a more beneficial mode of care for people with dementia. It is also important to identify these beneficial aspects and to address the extent to which they can be incorporated into non-specialist services in order to benefit users with dementia

(Netten, 1993). However, a critical forerunner to the effectiveness of service systems is a precise map of the services already in existence.

2.2 Day hospitals and day centres

Current policy in England has emphasised the importance of caring for highly dependent older people for as long as possible at home (Sutherland, 1999), suggesting that a high proportion of people with dementia should be receiving care from day care facilities. However, accurate estimates of the numbers of older people receiving day care were difficult to ascertain. According to the Report of Findings from the second year of Referrals, Assessments and Packages of Care for Adults (RAP, Department of Health, 2003) there were 151,000 people aged over 65 years receiving day care services in England in 2001-2002, of which 9,900 had dementia. This figure was based upon users of social services day centres, and did not include NHS day hospitals. Hospital activity statistics for Old Age Psychiatry estimated that there were 28,960 regular, registered day care attendees in England in 2001 (HAS, Department of Health, 2003). However, this figure was not specifically for people with dementia and would have included those with a variety of mental health problems. Kavanagh et al., (1995) estimated that 12 per cent of people with advanced cognitive impairment in private households in England received day care services, which equated to 3729 individuals. The present study found that of the older people in the North West of England receiving day care service provision, approximately half received the service from the NHS, and approximately half from social services. If these proportions were assumed to be an accurate reflection of day care service provision in England as a whole, then one would expect the total number of people with dementia attending day care services in England to be approximately double the number of service users identified by the RAP (Department of Health, 2003), therefore being in the region of 20,000.

Day hospitals originated in the mid 1970s as a cost effective alternative to traditional in-patient care and have a long tradition excellence and innovation in the care of people with dementia, and in raising awareness of dementia (Ardern, 1999). Ironically, it has been suggested that day hospitals are now under threat because they are considered an expensive luxury (Arden, 1999). The situation remains unclear, however, as while recent evidence has suggested an increase in the number of old psychiatric day hospitals places (Audini et al., 2001), the same study found that shortages of day care facilities and the number of day hospitals places available were the main concerns of hospital staff.

Day care can incorporate a range of services provided outside the home and the use of day care as respite is an established provision for people with dementia (Mountain and Godfrey, 1995). Many commentators have noted the need for clear aims and objectives, and for services to be targeted at those most in need (Department of Health, 1992). Others have suggested that contact with day care services may help to ease the transition of an older person into institutionalisation, through providing an ‘intermediate’ level of care (Currie et al., 1995; Gilleard et al., 1984). Day care facilities designed especially for people with dementia and their carers is a relatively new phenomenon (Cunningham and Kesterton, 1997). Modern psycho-geriatric day hospitals are NHS run and tend to have three main functions: assessment, treatment and rehabilitation (Arie, 1986). Day centres, however, are provided either directly by

social services departments or by other organisations, often voluntary bodies, acting on their behalf. In contrast to day hospital provision, local authorities operate a changing policy in respect of the service and associated transport. The relationship between the two types of day care is still regarded as ambiguous however (Audini et al., 2001). Collier and Baldwin (1999) compared the prevalence of difficult behaviours in confused older people attending both types of facility. Their study highlighted, albeit indirectly, differences in the methods of operation of the two types of facility. Day hospitals focused on assessment and throughput, and day centres on social support. Others (for example Ball, 1993; Fasey, 1994) who have questioned the differences have suggested that cheaper day centre care could be substituted for that provided by day hospitals (Currie et al., 1995).

2.3 Developing measurable standards of care

The quality of a service is the degree to which it conforms to preset standards of care (Gray 1997). The health care activities which indicate the rate of progress towards an objective are called process measures (Donabedian, 1982), for which ideally there should be good evidence of effectiveness. However, evidence-based process measures are not readily available for many health and social care services, including dementia care. Some interpretation of the literature therefore has to be made. It is recognised that the outcomes experienced by users are a function of: staff resources; how a facility operates; and how it is managed (Davies and Knapp, 1981; Netten, 1993). Many day care staff are unqualified (Audini et al., 2001), and may be volunteers, emphasising the importance of recruiting, training and supporting staff in this environment. The implementation of the 'new culture' and models of dementia care (Kitwood and Benson, 1997) has proved difficult and the challenges of providing appropriate care for older people remain. It is in this context the current study attempts to define and measure appropriate care for older people with dementia in day care and day hospital settings.

3 AIMS

This study had three aims at its inception, first to provide a map of day care services that had a specialist focus on dementia care in the North West of England. Second, to make an assessment of the quality of care provided in these facilities. Third, to compare the type and quality of care provided by day centres and day hospitals. It is hoped that the information obtained in meeting these aims will assist in service development in the region.

4 METHOD

The current study, which identifies day care services that had a specialist focus on dementia care is one of a series of studies undertaken to identify and describe specialist dementia services in the North West of England. The others focused on long term care, home care and professional teams involved in the care of people with dementia and are reported separately. In all four studies a broad definition of services was adopted: services or resources which are provided exclusively, or which have part of them dedicated specifically, for older people with dementia and/or their informal carers (Audit Commission, 2000). Thus, it encapsulated both those formally diagnosed with dementia, and also those who could be described as 'confused'.

There were two phases to the data collection:

4.1 Phase one: data collection - identification of day care services in the North West of England

Specialist dementia services were initially identified by means of a screening questionnaire sent to key personnel in the NHS Trusts, Health Authorities, Social Services Departments and voluntary organisations in the North West of England. Targeted respondents were asked to identify existing day services on a short postal questionnaire. The services identified were entered onto a Microsoft Access database and checked for duplicate entries. The accuracy of the results were also checked by local health and social care professionals including those attending three local conferences on dementia care (around 200 local delegates*).* Adjustments to the database were made as they became apparent.

4.2 Phase two: data collection from specialist dementia services in the North West of England

A questionnaire was developed by the research team as no suitable measures for the evaluation of services were identified through a review of the literature. In particular, none were identified that related to the provision of effective day care. Questions were related to indicators of good practice on a range of themes to capture the construct of the 'new culture of dementia care' (Kitwood and Benson, 1997), and data was collected within a conceptual framework to reflect the health service evaluation criteria of Donabedian (1982), namely, structure, process and outcome. 'Structure' refers to the resources used in the provision of care, 'process' refers to the activities that constitute care, and 'outcomes' are the consequences of the care provided. These outcomes may be considered broadly as of two types. "Intermediate outcomes" are "part way accomplishments on the road to desired outcomes" (Weiss, 1998). "Final outcomes" represent the effect of care upon an individual, an effect valued in its own right, such as an improvement in well-being (Challis, 1981; Davies and Knapp, 1981). As final outcomes are rarely of use in measuring quality (Gray, 1997), outcomes in the present study were necessarily intermediate markers of progress, reflecting the patterns of service output, for example the number of places per service. Respondents were also asked for information relating to the organisational context; service type; availability; access; capacity; utilisation and whether or not they were aware of any

gaps in local services for people with dementia. At the end of the questionnaire, each respondent was invited to assess their level of confidence in completing the questionnaire to provide us with a check on the reliability of the data.

Each of the specialist dementia services identified in the initial phase were asked to complete the postal questionnaire designed to ascertain the service configuration, resources and patterns of service. This is detailed at Appendix 1. Data was collected at the end of 2002. A researcher contacted non-respondents by telephone; an additional questionnaire was sent if required. This method proved particularly effective at increasing the response rate, especially to identify, by name, the most appropriate person to complete the questionnaire.

4.3 Standards of care

A series of standards or measures of quality were developed to provide criteria by which services could be assessed. These were recorded under the four themes (identified in bold) shown in Table 4.1. Quality issues were identified through a selective literature review, which identified key themes. In the measurement of basic service characteristics, many questions were structured in such a way that respondents were required to tick boxes or leave them blank. For example, in estimating the percentage of users in their facility who suffered from dementia or were confused, the provision of percentage categories allowed for easier and more reliable responses than requesting an exact percentage. To reduce the chances of social desirability bias, the questionnaire was not structured according to each standard.

The measurement of each of the standards developed consisted of a combination of individual descriptive data (for example, relatives/carers routinely invited to reviews) and composite variables (for example, carer involvement practices). The latter were more comprehensive, being derived from multiple items and indicators within a standard. Following data collection, composite variables were calculated through assigning positively answered items within a standard one point and summing the items to compute a composite score. Explanations of these are found within the results section.

Table 4.1: Standards of care

Service configuration and standard of care data [a]	Related Tables and Figures			
	Table	Page number	Figure in Appendix III	Page number
Service structure				
Activity rates - number places/attendees	5.12	30	1.ii	A12
			1.iii	A13
			1.iv	A13
Integration of services	6.27-6.28		3.vi	A21
Funding/funding continuity	5.22	42	3.i	A19
Personnel	5.23	43	3.ii	A19
			3.iii	A20
Care process				
Assessment	6.3-6.4	52	2.i	A15
	6.5-6.9	53-54		
Care plans	6.10-6.14	55-57	2.ii	A15
Rehabilitation potential (stimulating activities)	6.17-6.18	59-60	2.iii	A16
Equity of access to services for ethnic minorities	5.20-5.21	40-41	3.v	A21
	6.29-6.30	70		
Service content				
Service specialism/ targeted at people with dementia	5.16-5.19	37-39	1.v	A14
Promotion of early intervention	-	-	-	-
Prevention	-	-	-	-
Equity of access to specialist input	-	-	-	-
Flexibility and around the clock services	5.10-5.11	28-29	1.i	A12
	5.12-5.13	30-31		
	6.2	51		
Crisis response/ emergency access	-	-	-	-
Independence - good practice & building design	6.21-6.22	63-64	2.v	A17
Transport	6.25-6.26	67	2.viii	A18
Service quality				
Privacy	-	-	-	-
Individuality	6.23-6.24	65-66	2.iv	A16
Specialist dementia care training for staff	6.31-6.32	71	3.iv	A20
Carer involvement (& respite)	6.19-6.20	62	2.vii	A18
Care worker good practice	6.15-6.16	58	2.vi	A17
Quality assurance	-	-	-	-

4.4 Analysis

Data was entered and analysed using SPSS version 10.1. Differences in the characteristics of service types were explored using descriptive statistics. Statistical comparisons on basic service characteristics were made by examining the distribution

of the data using chi square (χ^2). Statistical tests were all conducted at the 5 per cent level. Variations between service types on composite variables were summarised using mean values, and statistical comparisons were made using t-tests. Grouping variables are usually shown in table columns for cross tabulations and in table rows when comparing means. Missing data was recoded as negative where this assumption had face validity, for example, where there was no response to a question requiring a tick for a positive response. Where this assumption was not reasonable the sample size was reduced for the purpose of analysis.

4.5 Structure of report

The results of this study are presented in two main sections. The first part of the results relates to Aims 1 and 2 of the study and explores the characteristics of the sample (e.g. service location and service capacity) in the different service types (day centres, day hospitals, resource centres, inpatient wards, residential/nursing homes). The second section relates to Aim 3 of the study and combines key service characteristics from the first to form composite variables upon which the two major service types only (day centres and day hospitals) are contrasted. The discussion then draws on both key service characteristics and composite variables in order to describe the provision of day care services in the North West in terms of the three themes described above (service delivery, user-centred practice and organisation of care).

To address variations between local authority areas in North West England, the standards of care for day care facilities in North West England are presented in graphical format in Appendix 3. Where appropriate the reader is referred to the relevant figures. The number of services included in the study, and the levels of service capacity in each local authority area are also detailed in the main body of the report (Tables 5.2 and 5.14, respectively).

5 RESULTS I – SERVICE CHARACTERISTICS

5.1 The sample

From an initial sample of 104 day care facilities, 79 (76 per cent) completed and returned the day care questionnaire. Only one refusal was made. The response rate is detailed in Table 5.1. It varied across the 21 local authorities of the North West, ranging from 50 per cent to 100 per cent. The latter was achieved in nine of the 22 authorities. No day care services for people with dementia were identified in St Helens during the initial identification/screening phase.

Table 5.1: Number of respondents and response rate for each local authority area in the North West of England

Local authority	Respondents	
	n	%
Cumbria (12)	9	75.0
Bolton (3)	3	100.0
Bury (2)	2	100.0
Manchester (13)	9	69.2
Oldham (7)	5	71.4
Rochdale (1)	1	100.0
Salford (2)	2	100.0
Stockport (4)	3	75.0
Tameside (3)	3	100.0
Trafford (2)	2	100.0
Wigan (5)	3	60.0
Knowsley (4)	2	50.0
Liverpool (6)	4	66.7
Sefton (4)	2	50.0
St Helens	-	-
Wirral (4)	4	100.0
Cheshire (9)	6	66.7
Halton (1)	1	100.0
Warrington (2)	1	50.0
Lancashire (11)	9	81.8
Blackburn with Darwen (5)	5	100.0
Blackpool (4)	3	75.0
Total (104)	79	76.0

5.2 Service description and organisational context

Table 5.2 specifies the types of day care services identified in North West England. Day centres (38) and day hospitals (30) were the most commonly reported type of provision. People in the early stages of dementia can be accommodated within a generic day centre, but as dementia progresses, it may be more appropriate to attend a dementia specific or dementia focused day centre. People with more complex dementia and those in need of medical supervision or treatment may require care in a day hospital. Three services offered day care within either residential or nursing

homes, and one service offered day care within an inpatient service. Seven respondents described their services as resource centres.

In the second section of the report, services were recoded to allow the most meaningful comparison possible to be made between the main service types, day centres and day hospitals. This resulted in the seven resource centres being recoded as day centres if no nursing or medical staff were employed within the resource centres, or if services were not funded by the health service. The remaining service types, three residential nursing homes and one inpatient ward, were then excluded from the analysis as the numbers were too small for a meaningful statistical comparison to be conducted, and it was not considered that recoding into another service type could be justified. The process thus created two groups, day centres, n(45) and day hospitals, n(30). Instances of recoding are indicated when relevant.

Table 5.2: Types of day care facilities included in the survey in each local authority area in the North West of England

Local authority	Type of facility					Total
	Day centre	Day hospital	Resource centre	Residential/ nursing home	In-patient ward	
Cumbria	7	2	-	-	-	-
Bolton	1	1	1	-	-	3
Bury	1	1	-	-	-	2
Manchester	3	4	2	-	-	9
Oldham	3	1	1	-	-	5
Rochdale	-	1	-	-	-	1
Salford	-	2	-	-	-	2
Stockport	2	1	-	-	-	3
Tameside	1	2	-	-	-	3
Trafford	1	1	-	-	-	2
Wigan	2	1	-	-	-	3
Knowsley	2	-	-	-	-	2
Liverpool	-	3	-	1	-	4
Sefton	-	2	-	-	-	2
St Helens	-	-	-	-	-	0
Wirral	-	1	2	-	1	4
Cheshire	6	-	-	-	-	6
Halton	-	1	-	-	-	1
Warrington	-	1	-	-	-	1
Lancashire	4	2	1	2	-	9
Blackburn with Darwen	3	2	-	-	-	5
Blackpool	2	1	-	3	-	3
Total	38	30	7		1	79

Source Question: 6: Which of the following best describes your facility?

Table 5.2 also shows the spread of different types of unit by local authority. Most provided both day centres and day hospitals, although this was not always evident in some of the smaller authorities. For example, in Cheshire and in Knowsley, a number of day centres were identified, but no day hospitals, resource centres,

residential/nursing homes or inpatient wards. Conversely, in Liverpool, three day hospitals and one residential/nursing home were identified, but no day centres.

Table 5.3: Sectors in which services operate: services with single sector management (n=76)

	Local authority (%)	NHS (%)	Voluntary (%)	Private (%)	Other (%)
Day centre (37)	15 (41)	-	14 (38)	-	-
Day hospital (29)	-	26 (90)	-	-	-
Resource centre (7)	4 (57)	-	1 (14)	-	1 (14)
In-patient ward (1)	-	1 (100)	-	-	-
Residential/nursing home (2)	1(50)	-	-	1 (50)	-

Source Question: 5: Within which sector does your service operate?

Table 5.3 illustrates the sectors in which identified services operated, split by service type. As would be expected, the majority of day hospitals (26) and no day centres operated solely within the NHS sector (χ^2=47.445, df=1, p<.001). Conversely, almost half of the day centres and no day hospitals operated solely within the local authority sector (χ^2=21.589, df=1, p<.001). Similarly, 14 day centres and no day hospitals operated solely within the voluntary sector (χ^2=12.794, df=1, p<.001). The majority of resource centres (4) operated solely within the local authority sector. There was a small amount of missing data which resulted in revised sample sizes in Tables 5.3 and 5.4. These are noted in Table 5.3 and apply equally to Table 5.4.

Table 5.4: Sectors in which services operate: joint managed services

	Local authority and NHS n (%)	Local authority and voluntary n (%)	NHS and voluntary n (%)	Voluntary and other n (%)	Local authority, NHS and voluntary n (%)
Day centre	6 (16)	1 (3)	-	1 (3)	-
Day hospital	2 (7)	0	1 (3)	-	-
Resource centre	-	0	-	-	1 (14)
In-patient ward	-	0	-	-	-
Residential/ nursing home	-	-	-	-	-

Source Question: 5: Within which sector does your service operate?

Table 5.4 shows the breakdown of services with joint areas of operation. There were six (16 per cent) day centres with joint Local Authority and NHS operation compared with two (seven per cent) day hospitals. Only one service, a resource centre, reported joint management arrangements in more than two sectors (Local Authority, NHS and Voluntary). The funding arrangements were similar to those found nationally by the Royal College of Psychiatrists in their national survey of day care (2001) which found that 92 per cent of day hospitals were funded wholly by the NHS. This compared with 93 per cent in the current study and reinforced the validity of the study findings in this respect.

5.3 Service users

There is debate regarding whether the care needs of people with dementia can be successfully provided to older people with a functional mental illness in a single service setting. Shulman (1981) argued the case for separate staff orientation and treatment regimes for the functionally ill, whilst others have described successful implementation of integrated services (Smith and Cantley, 1985). The study assessed the extent to which facilities for older people with dementia in North West England were targeted by exploring a number of variables: the approximate proportion of people with dementia; the number of places specifically designated for people with dementia and whether or not the service was provided soley for people with dementia.

Respondents were asked to estimate the percentage of their users who suffered from dementia or were confused (Table 5.5). In this context emphasis was placed on the presenting pattern of needs of the older person, rather than a diagnosis of dementia (Spicker and Gordon, 1997, p.49).

Table 5.5: Percentage of users who suffer from dementia or are confused by type of facility

Type of facility	Percentage of users who suffer from dementia or are confused				
	1-20% n (%)	21-40% n (%)	41-60% n (%)	61-80% n (%)	81-100% n (%)
Day centre	4 (11)	2 (5)	6 (16)	4 (11)	22 (58)
Day hospital n (%)	-	3 (10)	10 (33)	5 (17)	12 (40)
Resource centre	2 (29)	1 (14)	1 (14)	1 (14)	2 (29)
In-patient ward	-	-	-	-	1 (100)
Residential/nursing home	-	-	1 (33)	1 (33)	1 (33)
Total	6 (8)	6 (8%)	18 (23)	11(13)	38 (48)

Source Question: 1: Please estimate the approximate percentage of your users who suffer from dementia (though they might not have a diagnosis of dementia) or are confused

Overall, around half (48 per cent) of the day care provision surveyed cared predominantly (>80 per cent) for users with dementia. A greater proportion of day centres cared predominantly for people with dementia (58 per cent), compared to less than half (40 per cent) of day hospitals, although the difference was not statistically significant. The data suggested that day centres might be better targeted than other types of provision, as a greater proportion of day centres (47 per cent) compared with day hospitals (25 per cent) described their services as solely for people with dementia. Again however, the difference was not statistically significant. Just over one third of all services included in the survey were solely for people with dementia (38 per cent).

The total day care places, total day care places designated for people with dementia and total service users with dementia by service type are shown in Table 5.6.

Table 5.6: Total number of service users with dementia by service type

Type of facility	Total number of service users with dementia (mean)
Day centre	1021 (26.9)
Day hospital	1190 (39.7)
Resource centre	211 (30.1)
In-patient ward	2 (2)
Residential/nursing home	62 (20.7)

Source Question: 16: What is the total number of service users currently on your register of attendees?

Table 5.6 shows the total number of service users with dementia by service type. There were significantly more service users with dementia in day hospitals than day centres (mean 39.67 [s.d 26.32] vs 26.87 [sd = 21.76], t=-2.415, df=66, p<.05). The figures were broadly similar to those found in the recent nationwide survey of day hospitals conducted by the Royal College of Psychiatrists which reported a mean of 34 patients suffering with organic disorders attending each day hospital (Audini et al., 2001).

Early intervention is encouraged by new policy directives. The NSFOP promoted 'early recognition and management of mental health problems, through effective communication between agencies and an understanding of when and how to refer older people onto appropriate services at the correct time', and through introduction of the single assessment process. Existing evidence however suggests inconsistency and confusion in routine assessments for older people (for example Trickey et al., 2000). If government policies are being effectively implemented, it would be expected that day care services should be receiving a large proportion of referrals regarding those people in the early stages of dementia, with individuals experiencing more severe levels of decline being referred on to clinically orientated day hospitals. This pattern was noted by Levin et al (1989) who found that people with mild/moderate levels of dementia were more likely to attend day centres than day hospitals.

Respondents were asked to estimate the percentage of service users suffering from either mild/moderate or severe dementia. It was not essential that service users had a diagnosis of dementia. Table 5.7 shows the mean percentages for both levels of severity, analysed by service type.

Table 5.7: Approximate proportions of mild/moderate and severe levels of cognitive impairment for those with dementia by service type

	% mild or moderate dementia mean (s.d.)	% severe dementia mean (s.d.)
Day centre (38)	58.9 (28.2)	41.1 (28.2)
Day hospital (30)	58.1 (26.1)	41.8 (28.2)
Resource centre (7)	45.1 (15.8)	54.9 (15.8)
In-patient ward (1)	-	100 (-)
Residential/nursing home (3)	50 (0)	50 (0)
All facilities (79)	56.1 (26.7)	43.9 (26.8)

Source Question: 3: Thinking about the people who suffer from dementia, please estimate the percentage of those who suffer from…?

The data could be interpreted as both an indication of whether services are targeted on the most dependent and as evidence of early intervention. There was however little evidence of either occurring in practice. In contrast to the findings of Levin et al., (1989), the relative proportions of mild/moderate and severe dementia were very similar for both day hospitals and day centres, suggesting that patients with the most severe dementia were being not necessarily being directed towards clinically orientated day hospitals. The overall mean proportions were skewed by the presence of the single inpatient ward in which 100 per cent of service users were experiencing severe levels of dementia. Without this unit, the overall proportions were 56 per cent mild or moderate, and 44 per cent severe.

5.3.1 Services provided

Finch and Orrell (1999) espoused the importance of an agreed purpose and an agreed philosophy in the development of standards in services for older people with mental health problems. Their guidance for day hospitals placed emphasis on assessment and treatment, and the ability both to respond to acute referrals and offer intensive packages of care.

Table 5.8 shows the primary and secondary functions of day care facilities in North West England. The most common primary function was that of Social support, reflecting the fact that day centres comprised the majority of the sample.

Table 5.8: Primary functions/services provided by day care facilities in the North West of England

Function	Primary function		Secondary function	
	n	%	n	%
Social support	63	80	15	19
Monitor users physical and mental health	52	66	7	9
Assessment	50	64	19	24
Respite for carers	49	62	13	17
Reminiscence/life story	42	53	23	29
Occupational therapy	37	47	9	11
Physical exercise	37	47	32	41
Information to carers	37	47	14	18
Reality orientation	37	47	23	30
Nursing care	27	34	8	12
Bathing	19	24	31	39
Physiotherapy	15	19	19	24
Outreach to other services	14	18	12	15
Outreach home based	11	14	20	25
Sitting service	11	14	4	5
Speech therapy	6	8	16	20
Dental services	1	1	12	15

Source Question: 9: Which of the following do you provide…?

To capture the difference in provision between day hospitals and day centres, data relating to their primary function was analysed. This is detailed in Table 5.9.

Table 5.9: Primary functions of day centres and day hospitals

Function	Day centre n (%)	Day hospital n (%)	Statistical significance
Social support	41 (91)	19 (63)	χ^2 =6.63, df=1, p<.01
Monitor users physical and mental health	25 (56)	24 (80)	χ^2 =5.45, df=1, p<.05
Assessment	17 (39)	30(100)	χ^2 =23.40, df=1, p<.001
Respite for carers	31 (69)	14 (47)	n/s
Reminiscence/life story	25 (56)	15 (50)	n/s
Occupational therapy	10 (23)	26 (87)	χ^2=28.87, df=1, p<.001
Physical exercise	24 (55)	11 (37)	n/s
Information to carers	19 (42)	18 (60)	n/s
Reality orientation	20 (44)	15 (50)	n/s
Nursing care	2 (5)	24 (80)	χ^2=38.82, df=1, p<.001
Bathing	12 (27)	5 (17)	n/s
Physiotherapy	2 (5)	12 (40)	χ^2=15.14, df=1, p<.001
Outreach to other services	9 (21)	5 (17)	n/s
Outreach home based	7 (16)	4 (13)	n/s
Sitting service	10 (23)	1 (3)	χ^2=4.77, df=1, p<.05
Speech therapy	0	6 (20)	χ^2=8.34, df=1, p<.01
Dental services	0	0	n/s

Source Question: 9: Which of the following do you provide…?

As expected, whilst the most common primary function for the sample as a whole was that of social support (91 per cent), the most common primary for function for day hospitals was assessment (100 per cent). This suggests two distinct functions for the two major day care service types. There were significant differences between day centres and day hospitals on the following primary functions: social support; monitoring users physical and mental health; assessment; occupational therapy; nursing care; physiotherapy; sitting service and speech therapy. Day hospitals tended to indicate that their primary functions were clinically orientated (monitoring users physical and mental health; assessment; occupational therapy; nursing care; physiotherapy; speech therapy) whilst day centres tended to indicate that their primary functions were care orientated (social support; respite for carers). These differences supported previous work which has suggested differences in the methods of operation of the two types of facility, with the focus being on assessment and throughput in the day hospital and social support in the day care services (Collier and Baldwin, 1999; Ardern, 1999).

5.3.2 Service times and flexibility (Potential for respite and prevention of admission into long-term care)

In keeping with the emphasis on an individualised provision of care for people with dementia, opening times should be flexible. Although the respite function of day care facilities is of course dependent on the availability of services, the limited availability of provision has been criticised (Murphy, 1985). It is expected that lengthening the period when services are available to include evenings, nights and weekends would further reduce distress in carers (Finch and Orrell, 1999), although unequivocal evidence has

yet to be provided (Warrington and Eagles, 1995). Uptake difficulties have also been recorded (Cox, 1997) but comprehensive provision available during evenings, nights and weekends might provide more relief as the time of service provision is important to service users and their carers. Campell and Travis (1999) found that morning or afternoon time periods appeared to be the times when spousal caregivers needed most assistance. They also noted that more than half of the caregivers in their sample reported having no respite time during the weekend.

Table 5.10: Proportion of day care facilities open during morning, afternoon and evening in the North West of England

Day	Morning		Afternoon		Evening (after 6pm)	
	n	%	n	%	n	%
Monday	63	82.3	63	82.3	5	8.9
Tuesday	57	74.4	57	74.7	5	7.7
Wednesday	60	78.2	60	78.5	5	8.9
Thursday	56	73.4	60	78.5	8	12.7
Friday	62	80.8	62	80.8	4	6.4
Saturday	18	24.4	18	24.4	4	7.6
Sunday	16	21.8	16	21.8	4	6.4

Source Question: 22: On which days of the week and at what time is this service available for people with dementia?

Day care has often been referred to as 'middle of the day' care. This was supported by the current data. Overall only 10 facilities (13 per cent) provided evening care and 20 (25 per cent) provided weekend care. The majority of services were offered on weekday mornings and afternoons. Start times varied between 07.30 and 13.30 and finished between 15.00 and 22.00. The mean number of days per week that facilities were open for was 4.4 days (day centres: 4.5; day hospitals: 3.7; resource centres: 5.5; in-patient ward: 5; residential/nursing home: 7). Differences in the number of hours open per week between service types were not statistically significant.

Table 5.11: Facilities available during evenings and weekends by local authority area in the North West of England

Local authority	Number of services open	
	At least 1 evening per week	At some time over the weekend
Cumbria	-	3
Bolton	-	1
Bury	-	1
Manchester	1	1
Oldham	-	-
Rochdale	-	-
Salford	-	-
Stockport	-	-
Tameside	1	2
Trafford	-	1
Wigan	-	2
Knowsley	1	-
Liverpool	-	1
Sefton	-	-
Wirral	1	1
Cheshire	3	3
Halton	-	-
Warrington	1	1
Lancashire	2	2
Blackburn with Darwen	-	1
Blackpool	-	-
St Helens	-	-
Total	10	20

Source Question: 22: On which days of the week and at what time is this service available for people with dementia?

The limited availability of weekend and evening day care facilities in North West England is illustrated in Table 5.11. Of the 22 local authorities included in the study, only eight (one third) possessed any day care facilities that opened for at least one evening per week. Similarly, services which opened at least once over the course of a weekend were identified in only 13 (60 per cent) of local authorities in the North West.

Almost a third of services (30 per cent) operated a waiting list. A higher proportion of day centres had a waiting list compared with day hospitals (39 per cent compared with 20 per cent), and two of the seven (29 per cent) resource centres operated a waiting list. When the data was recoded into two groups, day centres and day hospitals, this difference was statistically significant (χ^2=3.870, df=1, p<.05). The current length of the waiting list ranged from 1 month (mode) to 9 months. There were no significant differences between service types in terms of waiting list length.

Thirteen respondents (17 per cent), all of which were day hospitals (χ^2=24.504, df=4, p<.001), provided services for limited time periods. This was less than 6 months for most of these services (10) and ranged from 2 to 12 months. In contrast, day centres,

resource centres, care homes and the in patient ward offered an open-ended commitment to attend.

Respondents were asked if users could attend the service for special reasons, other than on their allocated days. Two thirds of respondents (52) reported that this was possible. However, a quarter of services did not offer this degree of flexibility (27). Many of these provided suggestions as to how the flexibility of their services could be improved. Most stated that they required more resources in terms of further funding (4); extra staff or volunteers (3); extended opening hours/days (4); a telephone service/outreach (2) or improvements to the building (1). There were no significant differences between service types.

5.3.3 Service availability

Table 5.12: Total day care places, designated day care places for people with dementia and total service users with dementia by service type

Service type	Total day care places (mean)[1]	Designated day care places for people with dementia (mean)[2]	Total service users with dementia (mean)
Day centre	743 (19.6)	487 (13.5)	1021 (26.9)
Day hospital	891 (29.7)	788 (27.1)	1190 (39.7)
Resource centre	427 (61.0)	142 (20.3)	211 (30.1)
In-patient ward	6 (6.0)	6 (6.0)	2 (2)
Residential/nursing home	21 (7.0)	21 (7.0)	62 (20.7)
All facilities	2088	1444	2486 (31.5)

[1] Analysis of variance: F=6.5 df 4, 74 p<.001
[2] Analysis of variance: F=5.46 df 4, 71 p<.001

Source: Question 12: How many day care places are there (in total) per day?; 13: How many day care places are specifically designated for people with dementia per day?; 17: What is the total number of service users with dementia currently on your register of attendees?

Analysis of the total number of day care places by service type revealed that resource centres generally had a higher capacity than day centres and day hospitals (F=10.942 df 2, 72 p<.001). This difference may be partly attributable to two large resource centres with 150 places each. A significant difference was also found between the service types in the total number of designated people with dementia places per day (F=8.767 df 2, 69 p<.001), with day hospitals providing more designated day care places than day centres (27 compared with 14). Although the number of service users with dementia did not significantly differ when all service groups were compared (using analysis of variance), day hospitals were providing a service to a larger number of users with dementia compared with day centres (t=-2.188 df 73 p<.05).

Table 5.13: Number of days per week attended by service users with dementia: proportion attending by service type and overall mean proportion

Service type	Number of days attended per week						
	1 day	2 days	3 days	4 days	5 days	6 days	7 days
Day centre	31.2	34.3	19.6	5.6	5.7	1.3	2.3
Day hospital	31.3	37.9	16.1	5.6	9.7	0	0
Resource centre	9.0	30.2	22.2	4.3	2.7	1.9	0
In-patient ward	5.0	0	0	0	95.0	0	0
Residential/nursing home	25.0	27.7	8.3	0	5.3	0	26.7
Mean (all services)	29.0	34.7	17.7	5.2	8.2	0.8	2.2
Statistical significance	n/s	n/s	n/s	n/s	[a]	n/s	[b]

[a] χ^2=120.22 df=60, p<.001 [b] χ^2=28.29 df=16, p<.05

Source Question: 18: Of all your service users with dementia what proportion currently attend…?

Capturing the intensity of the services provided to people with dementia was difficult when utilising a survey method of data collection. Nevertheless, the majority (mean 81 per cent) of people with dementia attended day services for three days or less. High intensity service attendance (four days or more) was less likely (mean 16 per cent). This was comparable with previous literature where typically clients have been reported to attend day care two to three days per week for approximately five hours each day (Zarit et al, 1999).

Table 5.13 shows the variation in the number of days attended at day care facilities per week. There was significant variation between service types for those attending for five (χ^2=120.22, df=60, p<.001) and seven (χ^2=28.29, df=16, p<.05) days per week, although clearly this variation was explained by a minority of cases in the sample. One in-patient ward was offering a five day per week service, and likewise, the three residential/nursing homes offering a seven day service to approximately one quarter of their clients. This contrasted with both day centres and day hospitals, in which the majority of people with dementia attended one or two days per week, and resource centres, in which the majority of people with dementia attended two or three days per week. Relative to each other, day centres and day hospitals reported a similar proportion of people with dementia attending on all days, but it was notable that whilst day centres reported a small proportion of clients attending for six or seven days per week, day hospitals did not report this level of service.

Respondents were also asked the proportion of service users with dementia who also were in receipt of home care. A mean of 46 per cent of people with dementia were also in receipt of a home care service. This did not differ significantly between the type of day care facility.

5.4 Capacity

5.4.1 Rates per 1000 population over 65 in the North West of England

To assess the availability of specialist service provision in particular geographical areas, the number of places per facility, the number of specifically designated places for people with dementia and the total number of service users with dementia were measured. Using this data along with population statistics we inferred the proportion

of total estimated population with dementia attending services and the rate per 1000 of designated dementia places per day (Table 5.14).

Dementia prevalence rates[1] were combined with population figures for each of the local authority areas in North West England and data relating to the availability of day care places from the current study (Table 5.14). The most recent population figures available were obtained from KIGS (Department of Health, 2002) (column 1). The total number of day care places per day (column 2), the number of day care places per day designated for people with dementia (column 3), the occupied day care places per day (column 5), the total number of service users (column 6) and the total number of service users with dementia (column 7) were derived from data obtained in the present study. The recorded number of designated day care places per day (column 3) was adjusted upwards according to the response rate for each local authority area to form an estimate of the total number of places that would have been expected had a 100 per cent response rate been achieved (column 4). The estimated population with dementia (column 8) was calculated as a proportion (9.3 per cent) of the total population as described previously (see Appendix 3). By combining this figure with the total number of service users with dementia identified by the present study, the proportion of people with dementia who were attending day care services was estimated (column 11). Day care places specially designated for people with dementia were calculated both as a percentage of the estimated number of people with dementia (column 9), and per 1000 population aged over 65 years (column 13). Again, these were adjusted upwards to estimate the figure that would have been expected had a 100 per cent response rate been achieved (columns 10 and 14). These findings are detailed in Table 5.14.

[1] *Although estimates of the prevalence of cognitive impairment vary considerably by the classification system used (Erkinjuntti et al., 1997), the figure employed to estimate the number of dementia cases within each local authority in North West England, was 9.3 per cent of the population aged 65 and over, which was derived from Hofman et al., (1991) (see Appendix 2).*

Table 5.14. Designated day care places per day – rates per 1000 population over 65 years in the North West of England

Local authority	Population over 65 years	Total day care places per day	Designated dementia day care places per day (recorded)	Designated dementia day care places per day (estimated)	Occupied dementia day care places today	Total number of service users	Total number of service users with dementia	Estimated population with dementia (9.3%)	Total designated dementia day care places as a percentage of people with dementia (recorded)	Total designated dementia day care places as a percentage of people with dementia (estimated)	Proportion of total estimated population with dementia attending day care services (%)	Percentage of non-responders	Designated dementia day care places per day - recorded rate per 1000 population (aged 65+)	Designated dementia day care places per day - estimated rate per 1000 population (aged 65+)
Column Key	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Cumbria	88,141	102	97	129	71	277	144	8197	1.18	1.57	1.76%	25	1.10	1.38
Bolton	39,314	88	14	14	14	248	137	3656	0.38	0.38	3.75%	0	0.36	0.36
Bury	26,177	85	85	85	78	155	105	2434	3.49	3.49	4.31%	0	3.25	3.25
Manchester	56,797	381	218	315	170	966	346	5282	4.13	5.96	6.55%	30.8	3.83	5.01
Oldham	30,908	117	70	98	75	279	130	2874	2.44	3.41	4.52%	28.6	2.26	2.91
Rochdale	29,338	32	30	30	24	65	56	2728	1.10	1.10	2.06%	0	1.02	1.02
Salford	36,302	60	60	60	40	81	81	3376	1.78	1.78	2.40%	0	1.65	1.65
Stockport	47,878	63	59	79	49	114	74	4453	1.32	1.77	1.66%	25	1.23	1.54
Tameside	32,310	83	83	83	70	93	70	3005	2.76	2.76	2.33%	0	2.57	2.57
Trafford	34,945	60	30	30	17	190	73	3250	0.92	0.92	2.25%	0	0.86	0.86
Wigan	43,439	65	40	67	43	83	56	4040	0.99	1.66	1.39%	40	0.92	1.29
Knowsley	21,034	42	22	44	21	81	19	1956	1.12	2.25	0.98%	50	1.06	1.59
Liverpool	67,387	130	130	150	107	295	234	6267	2.07	2.85	3.73%	33.3	1.93	2.89
Sefton	54,405	70	70	140	50	160	97	5060	1.38	2.77	1.92%	50	1.29	2.57
Wirral	57,384	82	82	82	61	168	155	5337	1.54	1.54	2.90%	0	1.43	1.90
Cheshire	108,936	146	96	144	85	189	189	10131	0.95	1.42	1.86%	33.3	0.88	1.32
Halton	15,452	20	20	20	20	100	60	1437	1.39	1.39	4.18%	0	1.29	1.29
Warrington	26,771	20	20	40	16	110	40	2490	0.80	1.61	1.61%	50	0.75	1.49
Lancashire	187590	291	147	180	84	400	205	17446	0.84	1.03	1.18%	18.2	0.78	0.96
Blackburn with Darwen	18759	115	43	43	57	279	149	1745	2.46	2.46	8.54%	0	2.29	3.83
Blackpool	28,752	36	28	37	31	113	66	2674	1.05	1.38	2.47%	25	0.97	1.29
St Helens	27,024	-	-	-	-	-	-	2513	-	-	-		-	-
Total	1,079,043	2088	1444	1870	1219	4447	2486	100351	-	-	-	-	-	-
Mean	49,047	99.4	68.8	89	58.0	211.8	118.4	4778.6	1.62	2.07	2.96	24	1.51	2.01

Source Questions: 12: How many day care places are there (in total) per day? 13: How many day care places are specifically designated for people with dementia per day? 14: How many day care places designated for people with dementia are currently occupied today? (or please complete on the next day when people with dementia would usually attend); 16: What is the total number of service users currently on your register of attendees?; 17: What is the total number of service users with dementia currently on your register of attendees?

See overleaf for how figures were calculated.

Column	Description	Source/Formula
1	Population over 65 years	KIGS (DOH, 2002)
2	Total day care places per day	Questionnaire
3	Designated dementia day care places per day (recorded)	Questionnaire
4	Designated dementia day care places per day (estimated)	Column 3/(100 – column 12) x 100
5	Occupied dementia day care places today	Questionnaire
6	Total number of service users	Questionnaire
7	Total number of service users with dementia	Questionnaire
8	Estimated population with dementia (9.3%)	Column 1 x 9.3%
9	Total designated dementia day care places as a percentage of people with dementia (recorded)	Column 3/column 8 x 100
10	Total designated dementia day care places as a percentage of people with dementia (estimated)	Column 4/column 8 x 100
11	Proportion of total estimated population with dementia attending day care services (%)	Column 7/column 8 x 100
12	Percentage of non-responders	Percentage of non-responders (see Table 5.1)
13	Designated dementia day care places per day - recorded rate per 1000 population (aged 65+)	Column 3/column 1 x 1000
14	Designated dementia day care places per day - estimated rate per 1000 population (aged 65+)	Column 4/column 1 x 1000

Table 5.14 shows that access to services and service provision varied considerably across different local authority areas in North West England. The number of day care places per facility ranged from five to 150 with a mean of 26.4 places. The total places in North West England was 2088 and for each area this ranged from 20 in Warrington and Halton to 381 in Manchester, reflecting in part at least differences in the geographical size and population density of each local authority region.

High levels of targeting, as measured by examining the relative proportions of the total number of day care places to the number of specially designated places for people with dementia, were evident in many areas such as Bury, Salford, Tameside, Liverpool, Sefton, Wirral, Halton and Warrington. Lower levels of targeting were evident in areas such as Bolton and Knowsley.

The proportion of the population with dementia attending day care services can be interpreted as a proxy measure of the accessibility of day care services in the region. Blackburn with Darwen and Manchester scored highly in this domain, whilst the data suggested that services might be less accessible in areas such as Knowsley and Wigan.

The estimated rate of designated day care places per day per 1000 population provides an indication of the level of provision per person in local authority areas. The highest levels of provision were found in Manchester, Blackburn with Darwen, Oldham and Liverpool. Lower levels were found in areas such as Bolton, Trafford and

Lancashire. The overall (mean) level per 1000 population over 65 years of 1.51 – 2.01 was lower than the recommended provision of 2 – 3 places per 1000 population aged over 65 first advocated by the DHSS in 1970 (DHSS, 1970). It was higher than estimates made in 1980 (0.82/1000) (Wattis et al., 1981) and 1985 (1.2/1000) (Wattis, 1988), and comparable with the 1995 estimate of 1.5 places per 1000 population aged over 65 (combined rate for organic and functional illness, Wattis et al., 1999). Our projected rate of 2.01 however suggested that the true rate was likely to be higher than this, and suggested a continuing trend for an increase in available places. The result compared favorably with the results of the national survey conducted by the Royal College of Psychiatrists (Audini et al., 2001), who found an overall national mean of 2.6 places per 1000 aged over 65 (although they found a considerable degree of regional variation, from 1.43 in Northern Ireland to 3.26 in Wales).

5.4.2 Occupancy rates

The mean occupancy rate at the time of data collection for specifically designated dementia places was 83 per cent. This rate was significantly higher for day centres than for day hospitals (87 per cent compared with 77 per cent, $t=2.22$, $df=57$, $p<.05$), suggesting that the day centre resources may be operating closer to their capacity than day hospitals. Sixteen of the 22 local authority areas in North West England had occupancy rates of over 80 per cent (Table 5.15). The occupancy rate ranged from 57 per cent (Trafford) to 100 per cent (Bolton, Halton, Blackburn with Darwen). Data was missing from nine respondents.

Table 5.15: Occupancy rates for specifically designated places by local authority area in the North West of England

	Number of facilities	Occupancy rate for specifically designated places
Cumbria	9	80%
Bolton	2	100%
Bury	2	92%
Manchester	8	80%
Oldham	3	88%
Rochdale	1	80%
Salford	2	70%
Stockport	3	90%
Tameside	3	88%
Trafford	1	57%
Wigan	2	83%
Knowsley	2	88%
Liverpool	4	86%
Sefton	2	72%
Wirral	4	69%
Cheshire	6	83%
Halton	1	100%
Warrington	1	80%
Lancashire	8	65%
Blackburn with Darwen	3	100%
Blackpool	3	87%
Total	70	Mean: 83%

Source Questions: 13: How many day care places are specifically designated for people with dementia per day?; 14: How many day care places designated for people with dementia are currently occupied today?

5.5 Service specialism

Specialist services are more likely to develop the expertise needed to care for people with dementia. It would also seem likely that specialist care for people with dementia may be greater in facilities which are solely provided for this group and in those with places specifically designated for people with dementia.

The mean number of day care places specifically designated for people with dementia per day was 19 (IQR 10-30). The mean proportion of total day care places specifically designated for people with dementia was 71 per cent (IQR 46 per cent-100 per cent).

There are varying degrees of providing a separate service for people with dementia: separate days, separate building or part of building, and sole provision. A high proportion of specialist day care services in North West England (75 per cent) were either described as solely for people with dementia or all their attendees were reported to have dementia.

Table 5.16: Indicators of providing a separate day care service for people with dementia – frequency of occurrence in services in the North West of England

	n	%
All service attendees have dementia	57	72
Service is provided solely for those with dementia	30	38
Either the service is solely for people with dementia *or* all attendees have dementia	59	75
People with dementia attend on separate days	25	32
People with dementia attend in a separate part of building	5	6
People with dementia attend in a separate building	1	1

Numbers do not add up to 100 per cent as respondents may have chosen more than one category

Source Questions: 12: How many day care places are there (in total) per day? 13: How many day care places are specifically designated for people with dementia per day? 15: If this service is for older people with a range of mental health problems, are people with dementia seen…?

Table 5.16 reveals that just over a third of facilities (38 per cent) described their services as solely for people with dementia. However a much greater proportion (72 per cent) of respondents reported that all their attendees had dementia. Where the service was for older people with a range of mental health problems, people with dementia were more likely to use day hospital facilities on separate days (57 per cent) compared to those using day centres (16 per cent)(χ^2 =12.515; df=1 p<0.001).

Table 5.17: Proportion of facilities providing solely for people with dementia *or* all attendees have dementia by service type

Type of service	Solely for people with dementia n (%)	Solely for people with dementia *or* all attendees have dementia n (%)
Day centre (37)	18 (47)	28 (74)
Day hospital (29)	8 (27)	23 (77)
Resource centre (7)	2 (29)	4 (57)
In-patient ward (1)	1 (100)	1 (100)
Residential/nursing home (2)	1 (33)	3 (100)

Source Questions: 12: How many day care places are there (in total) per day? 13: How many day care places are specifically designated for people with dementia per day? 15e: Service is solely for people with dementia.

Almost half of day centres were described as solely for people with dementia. This contrasted with about a quarter of day hospitals and resource centres. Much greater proportions of services either described their services as solely for people with dementia or all their attendees had dementia. The difference in the relative proportions of day centres (74 per cent) and day hospitals (77 per cent) which provided a service solely for people with dementia or all their attendees had dementia, was not statistically significant. However, the fact that almost half of day centres (47 per cent) compared to just over a quarter (27 per cent) of day hospitals described their service as solely for people with dementia suggested that resources in these services might be more tailored for this client group, rather than to people with other mental health problems.

Service specialism for people with dementia was also measured through the degree of involvement the service had with other specialist staff groups.

Table 5.18: Number of organisations/agencies routinely making referrals to each service type

Organisations/agencies which routinely make referrals to each service	Day centre n (%)	Day hospital n (%)	Resource centre n (%)	Residential/ nursing home n (%)	In-patient ward n (%)
Community mental health teams	20 (53)	13 (43)	3 (43)	2 (67)	0
Community psychiatric nurses	20 (53)	18 (60)	4 (57)	1 (33)	0
Social workers/care managers	32 (84)	11 (37)	6 (86)	3 (100)	0
Consultant psychiatrists	12 (32)	25 (83)	4 (57)	1 (33)	0
Residential/nursing homes	0	1 (3.3)	1 (14)	0	0
Occupational therapists	7 (18)	10 (33)	0	0	0
General practitioners	6 (16)	8 (27)	2 (29)	1 (33)	0
Clinical psychologists	2 (5)	1 (3)	0	0	0

Source Question: 34: We are also interested in how many care staff work in this service in the course of a week on a sessional basis. In the table below please provide details on the total number of actual staff for each staff group in addition to the total number of sessions.

Notably, 32 of 38 (84 per cent) of day centres received regular referrals from social workers/care managers. This contrasted sharply with the rate for day hospitals, 11 of 30 services, 37 per cent. Additionally, 25 of 30 (83 per cent) of day hospitals received regular referrals form consultant psychiatrists. This contrasted with just 32 per cent of day centres. The discrepancy highlighted two factors: that day centres may tend to provide 'social' care whilst day hospitals are generally more clinically orientated; and a possible tendency for NHS staff to refer to NHS resources, whilst social services staff tended to refer to the resources of their own department. The single inpatient ward in the sample did not indicate that any of these organisations/agencies made referrals to their service.

Table 5.19: Mean number of each professional/staff group working for each service type on a sessional basis and percentage of each service type with each professional staff group working in them on a sessional basis

	Day centre *Mean (%)*	Day hospital *Mean (%)*	Resource centre *Mean (%)*	Residential/ nursing home *Mean (%)*	In-patient ward *Mean (%)*
Occupational therapists	0.05 (5)	1.27 (67)	0.14 (14)	-	1 (100)
Assistant occupational therapists	-	1.47 (70)	-	-	1 (100)
Physiotherapists	-	0.77 (53)	-	0.33 (33)	1 (100)
Assistant physiotherapists	-	0.67 (43)	-	-	-
Speech therapists	-	0.10 (10)	-	-	1 (100)
Clinical psychologists	-	0.23 (23)	-	-	-
Activity staff	0.39 (24)	0.03 (3)	0.43 (14)	-	-
Trained volunteers/ paid helpers	3.29 (42)	0.40 (20)	1.43 (14)	-	-
Consultant psychiatrists	-	1.27 (67)	-	-	1 (100)

Source Question: 34: We are also interested in how many care staff work in this service in the course of a week on a sessional basis. In the table below please provide details on the total number of actual staff for each staff group in addition to the total number of sessions.

Another indicator of service specialism for people with dementia was the number of different specialist staff groups that worked for the service on a sessional basis. Again, day hospitals emerged as having a greater degree of clinical input than the other services included in the study. All of the specialist staff groups could be found in day hospitals, in particular occupational therapists (mean 1.27 staff per unit, present in 67 per cent of units), consultant psychiatrists (mean 1.27 staff per unit, present in 67 of units) and physiotherapists (mean 0.77 staff per unit, present in 54 per cent of units). This contrasted with day centres, in which only occupational therapists, activity staff, and trained volunteers/helpers contributed to the care regime.

These results contrasted with those reported by the Royal College of Psychiatrist's national survey (Audini et al., 2001) in which an overall mean of 19 per cent of day hospitals were found to have no occupational therapy input (compared to 33.3 per cent in the present study) and 56 per cent had no psychology sessions (compared to 77 per cent in the present study). The lower levels found in the current study are likely to reflect the high variability between regions reported by the former.

5.6 Ethnicity – equity of service provision

One of the principles of the NHS Plan is that the NHS will respond to different needs of different populations (standard 2; Department of Health 2000). The NSFOP also notes that older people from black and minority ethnic groups can be particularly disadvantaged (Department of Health, 2001a) and they are likely to suffer more discrimination in accessing services (Department of Health, 1998; Patel and Mirza, 1998). In an effort to assess whether or not all sectors of the population are being

allowed access to services it is important to understand the relationship between socio-demographic factors. In the context of this study, the prevalence of minority ethnic groups and service provision/activity rates are of particular interest.

The proportion of older people from black and minority ethnic communities is small, but the population of individuals from ethnic minority backgrounds as a whole is growing (Department of Health, 2000). It is estimated that the total black and ethnic minority population of Great Britain is just over three million (5.5 per cent of the total population, Department of Health, 2001a). Ethnic minority groups in the North West of England make up four per cent of the population (Census, 2001), although this figure masks large variations within the region. There are some rural counties with very low ethnic minority populations whilst in a number of metropolitan boroughs ethnic minorities represent over 10 per cent of the total population (Ratcliffe, 1996). Just four per cent of the British population from ethnic minority groups are over 65 years of age (Patel et al., 1998), which equates to just 11030, or one per cent of the total population over 65 years of age in the North West region. It would be therefore be expected that there are approximately 1200 people (9.3 per cent, from Hoffman at al., 1991) from ethnic minority groups with dementia in the North West of England at the present time.

Table 5.20: Numbers of current users from ethnic minority groups in day care facilities in each local authority area in the North West of England

Local authority	Day care facilities n	Ethnic minority users n	Percentage of population over 65 from ethnic minority groups (Census, 2001)* n
Cumbria	9	0	0.9
Bolton	3	1	5.0
Bury	2	5	3.5
Manchester	9	466	9.2
Oldham	5	0	5.4
Rochdale	1	0	5.3
Salford	2	3	2.3
Stockport	3	2	2.6
Tameside	3	5	3.6
Trafford	2	3	4.5
Wigan	3	0	1.0
Knowsley	2	0	1.3
Liverpool	4	8	3.2
Sefton	2	5	1.3
St Helens	0	-	0.9
Wirral	4	1	1.4
Cheshire	6	1	1.5
Halton	1	0	1.0
Warrington	1	2	1.4
Lancashire	9	3	2.3
Blackburn with Darwen	5	43	7.1
Blackpool	3	0	1.2
Total	79	548	2.7

Source Question: 27: How many of your current users are from ethnic minority groups?
* excludes Irish

Less than a third of facilities (25) reported providing day care for users from ethnic minority groups. Of those facilities, the numbers ranged from one to 466 representing 548 users in total. This translated to 12 per cent (548/ 4365) of all service users (on register of attendees) in this North West sample from ethnic minority groups. Thus, when compared with 2001 census data, which reported that four per cent of the population of the North West as a whole is from an ethnic minority background, our data suggested at first glance that ethnic minorities might not be under-represented in services for people with dementia in North West England. However, with a single service removed, the Indian Senior Citizens Centre in Manchester, the figure fell to 2.5 per cent (94/3915). Given that the population from ethnic minorities age 65 years and over stood at 2.7 per cent for the North West as a whole, the spread of the data (ignoring the impact of one 'outlying' centre), just falls short of this, suggesting that people from ethnic minority backgrounds were marginally under-represented across the region. Local authorities with the highest proportion of people from ethnic minority backgrounds tended to also have more day care service facilities and users from ethnic minorities.

Services may not always be accessible or appropriate for older people from ethnic minority communities due to many factors including culturally biased assessment techniques leading to under-diagnosis and assumptions regarding the capacity for relatives to act as primary caregivers (Department of Health, 2001a). Special arrangements and culturally appropriate service provision are examined in Table 5.21.

Table 5.21: Special arrangements for people from ethnic minority groups

	Facilities with users from ethnic minority groups (n=25) n (%)	Facilities without users from ethnic minority groups (n=54) n (%)
Food - diet/storage/preparation/cooking	21 (84)	34 (63)
Religious observation/spirituality	13 (52)	17 (32)
Personal care	10 (40)	19 (35)
Language resources	16 (64)	15 (28)
Of those who completed an assessment	*n=18*	*n=37*
Familiar cultural traditions are assessed	11 (61)	12 (32)

Source Questions: 27: How many of you current users are from ethnic minority groups?; 28: Whether or not you currently have any users from ethnic minority groups have you made any of the following special arrangements for people from ethnic minority groups?

Although only a third of facilities provided services to people from ethnic minorities, many more reported facilities to make special arrangements for people from ethnic minority groups. There was however a trend towards a higher proportion of facilities with users from ethnic minority groups reporting making special arrangements for these groups. This was statistically significant on the provision of language resources (translated leaflets and interpreter services, for example). Of the facilities which completed an assessment form, with or without users from ethnic minorities, less than half (42 per cent) collected information on resident's cultural traditions. This suggests that culturally appropriate services are not being provided in a systematic and planned manner. This is consistent with previous literature (Department of Health, 1998; Patel and Mirza, 1998) which has noted that the specific needs of people from diverse cultural groups were often not properly addressed in the assessment process.

5.7 Funding

The funding sources/management arrangements for services have been described in Tables 5.3 and 5.4. The security of the funding arrangements and whether or not service users could be charged for their attendance were also investigated.

Table 5.22: Funding security and charging by day care service type

	Day centre n (%)	Day hospital n (%)	Resource centre n (%)	In-patient ward n (%)	Residential/ nursing home n (%)
Security of funding arrangements:					
Not known/none	16 (42)	17 (57)	3 (43)	1 (100)	2 (67)
Up to 1 year	9 (24)	3 (10)	2 (29)	-	-
1-5 years	12 (32)	2 (7)	-	-	1 (33)
> 5 years	1 (3)	8 (27)	2 (29)	-	-
Service users can be charged for attendance	30 (80)	-	5 (74)	-	2 (67)
Mean % users with dementia who are charged for their attendance	84	-	84	-	50

Source Questions: 13: How many day care places are specifically designated for people with dementia per day? 30: Is your service currently funded for...? 31: Can service users be charged for attendance of this service? If yes, how many of your current service users with dementia are charged?

Interestingly, the security of funding arrangements was either unclear or unknown for around half of each of the main service types (day centres 16, day hospitals 17, resource centres 3). Although nearly one third (12) of day centres reported funding arrangements reaching for between one and five years, this contrasted with just two of day hospitals. However, day hospitals reported the highest levels of longer term finding, with approximately one quarter (8) reporting secured funding for over five years. This contrasted with day centres for which only one had this level of funding security. The differences in security of funding arrangements between day centres and day hospitals were statistically significant (χ^2=14.882, df=3, p<0.01). Appendix 3 includes a comparison of the security of funding arrangements in each local authority area.

With regard to the practice of charging users for attendance, unsurprisingly a significant difference emerged between services. For day centres, 30 services could charge users, and within these a mean of 83.5 per cent of users were charged. As expected, there were no day hospitals in the study that charged users for attendance (χ^2=45.221, df=4, p<.001). As with day centres, five resource centres charged users for attendance, and within these services, 84 per cent of service users did actually pay for the service.

5.8 Personnel

It is clearly of great importance that units are properly staffed (Finch and Orrell, 1999) and that personnel have adequate skills to provide an acceptable level of care to service users. The difficulties of providing daycare to older people with dementia are well reported (Hasselkus, 1997; Gwyther, 1989) as are the ethical dilemmas challenged by the cognitive impairment and dependency of users (Moody, 1992; Kitwood, 1990). A breakdown of staff from different professional groups is detailed in Table 5.23.

Table 5.23: Mean levels of employment of care staff from different professional groups by day care service type

Types of staff working in facilities	Day centre (n=38)	Day hospital (n=30)	Resource centre (n=7)	In-patient ward (n=1)	Residential /nursing home (n=3)
Nurse (qualified)	8 (21%)	27 (90%)	0	1 (100%)	1 (33%)
Nursing staff (unqualified/ support workers)	6 (16%)	26 (87%)	0	1 (100%)	1 (33%)
Social work staff (qualified)	5 (13%)	0	4 (67%)	0	1 (33%)
Social care staff (non-nursing)	31 (82%)	2 (7%)	7 (100%)	0	3 (100%)

Source Question 33: We are interested in how many care staff work in this service in the course of a week. In the table below please provide details on the total number of actual staff for each staff group in addition to the total number of whole time equivalent staff.

Again, Table 5.23 reflects the trend for day centres to provide socially orientated care using unqualified non-nursing staff (in 31 of 38 units, 82 per cent) whilst day hospitals reported employing qualified nursing staff much more frequently (in 27 of 30 units, 90 per cent). Thirty one day centres (82 per cent) reported the employment of unqualified nursing staff, whereas 27 day hospitals (90 per cent) reported employing qualified nursing staff. A similar trend was noted in Table 5.19, in which the proportions of different staff groups working for each service type on a sessional basis were described.

The importance of adequate levels of staffing has been noted by many authors. A higher staff-to-client ratio is necessary as the number of clients with dementia increases (Cherry and Rafkin, 1988), and the quality of care and active participation in activities and occupations is determined by the presence of a caregiver (Perrin, 2000). In accordance with the literature, the study found that proportion of care staff usually in the unit to day care places per day was significantly correlated with the proportion of people with dementia on the register of attendees (correlation coefficient 0.399 $p<.001$). However, scarcity of funding inevitably means that reliance shifts from qualified to lower-paid care staff or unpaid staff such as volunteers. The issue of professionally qualified staff groups was therefore investigated further. Table 5.24 contrasts the mean numbers of professionally qualified staff for each service type.

Analysis of variance was not possible due to the numbers in the smaller groups. However, there was a significant difference between the mean number of different professionally qualified groups of staff employed in day centres (0.60) and day

hospitals (6.83) (t=-9.930, df=66, p<.001, see Table 5.24). Not surprisingly, more qualified staff were employed in day hospitals, in accordance with the 'higher-intensity' of this type of service (Collier and Baldwin, 1999) and similar to the more productive day hospitals described by Kitchen et al., (2002). The resultant higher concentration of resources has been debated by many (for example Currie et al., 1995; Fasey, 1994; Murphy, 1994).

Table 5.24: Mean number of qualified care staff per facility by service type

Type of facility	n	Mean	Standard deviation
Day centre	37	0.60	1.19
Day hospital	29	6.83	3.63
Resource centre	7	0.86	0.69
In-patient ward	1	12.0	3.79
Residential/nursing home	2	2.67	3.98

Source Question 33: We are interested in how many care staff work in this service in the course of a week. In the table below please provide details on the total number of actual staff for each staff group in addition to the total number of whole time equivalent staff.

Table 5.25: Mean number of unqualified care staff per facility by service type

Type of facility	n	Mean	Standard deviation
Day centre	38	9.68	7.96
Day hospital	30	6.00	3.11
Resource centre	7	14.33	10.31
In-patient ward	1	16.00	7.02
Residential/nursing home	3	13.00	7.93

Source Questions 33: We are interested in how many care staff work in this service in the course of a week. In the table below please provide details on the total number of actual staff for each staff group in addition to the total number of whole time equivalent staff; 34: We are also interested in how many care staff work in this service in the course of a week on a sessional basis. In the table below please provide details on the total number of actual staff for each staff group in addition to the total number of sessions.

Table 5.25 contrasts the mean number of unqualified care staff for each service type. Again, analysis of variance was not possible due to the low numbers in some groups. However, a direct comparison between day centres and day hospitals revealed that day centres employed significantly more unqualified care staff than day hospitals (t=2.393, df=66, p<.05). This finding was consistent with the previous result, that day hospitals employed significantly more qualified staff than day centres.

Thus, as would be expected, the percentages of total professionally qualified staff employed by day centres was low (6.2 per cent) compared to that in day hospitals (47.7 per cent) (t=-10.945, df=66, p<.001). However, overall there were no statistically significant differences in the total number of staff employed each week in day centres and day hospitals (mean number of staff = 10.29 (day centre,), 12.83 (day hospital) t=-1.409, df=66, p=.163), or the rate of care staff usually in the unit to day care places per day (0.29 (day centre), 0.24 (day hospital), [i.e. between three and four day care places to each member of staff], t=1.571, df=61, p=.121).

Table 5.26: Mean number of different professionally qualified groups per unit by day care facility type

Type of facility	n	Mean	Standard deviation
Day centre	38	0.26	0.60
Day hospital	30	1.27	1.20
Resource centre	7	0.57	0.53
In-patient ward	1	4.00	-
Residential/nursing home	3	0.67	0.56

Source Questions 33: We are interested in how many care staff work in this service in the course of a week. In the table below please provide details on the total number of actual staff for each staff group in addition to the total number of whole time equivalent staff; 34: We are also interested in how many care staff work in this service in the course of a week on a sessional basis. In the table below please provide details on the total number of actual staff for each staff group in addition to the total number of sessions.

Table 5.26 shows the mean number of different professionally qualified groups for each type of day care service. The mean number was significantly higher in day hospitals than in day centres ($t=-4.491$, $df=66$, $p<.001$), suggesting that day hospitals also employed a significantly greater variety of different professionally qualified staff than day centres.

5.8.1 Training

Training is given significant priority in the National Service Framework for Older People (Department of Health, 2001a) and the NHS Plan (Department of Health, 2000). However, unlike residential and nursing care and domiciliary care, there have been no minimum standards set for the training of day care staff. Staff knowledge and abilities have been found to be among some of the strongest predictors of stress reduction in dementia staff, and low staff turnover has been associated with more dementia specific training (Grant et al., 1996). Whilst respondents were asked the proportion of care staff in each of the facilities which have undergone specific training for caring for people with dementia in the past two years, the study did not address the quality of training that has taken place.

Clearly it is not the volume of training that is vital, but the effectiveness of the learning approach (Skog et al., 2001). Indeed, the evidence of effectiveness of training in dementia care is primarily anecdotal (Beck et al., 1999).

Respondents were asked whether new staff on the unit received an induction, and if this was the case, whether the induction included a specific component which focused on caring for people with dementia. Table 5.27 shows the breakdown of responses by service type.

Table 5.27: Proportion of staff receiving an induction with a specific dementia care component by service type

Type of facility	n	%
Day centre	24	63
Day hospital	17	57
Resource centre	3	43
In-patient ward	1	100
Residential/nursing home	2	67

Source Questions: 36: Do new staff receive an induction? If yes, is there a specific component of this induction which focuses on caring for people with dementia?

The provision of induction for new staff which included a specific component focusing on caring for people with dementia was present in almost two thirds of units as a whole (51 in total). A slightly higher proportion was found in day centres than day hospitals which probably reflected the higher proportions of unqualified staff employed by this service type. The differences between service types were not however statistically significant.

Table 5.28: Proportion of care staff who had attended specific training for caring for people with dementia (in-house or external) in the last 2 years by service type

Type of facility	n	Mean proportion	Standard deviation
Day centre	28	0.57	0.26
Day hospital	18	0.42	0.21
Resource centre	5	0.60	0.44
In-patient ward	1	0.21	0.21
Residential/nursing home	3	0.44	0.18

Source Question: 37: Have any of the care staff in this facility undergone any specific training for caring for people with dementia (in-house or external), in addition to any induction, in the past 2 years?

Table 5.28 shows the proportion of care staff in different day care service types who have received specific training for caring for people with dementia. The overall mean proportion for day care services as a whole was 45 per cent. This ranged from 21 per cent (in-patient ward) to 60 per cent (resource centre). However, due to the low numbers in each of these groups the two extreme means should be interpreted with caution. Interestingly, a significantly higher proportion of staff in day centres had received specific training with regard to caring for people with dementia ($t=20.52$, $df=44$, $p<.05$). This difference may reflect day centres providing additional training to unqualified staff, of whom there were a significantly higher proportion in day centres compared to day hospitals.

5.8.2 Provision of training to other agencies

Finally, an analysis of the provision of training to other agencies from the different types of day care service was undertaken. The results of this analysis can be found in Table 5.29.

Table 5.29: Mean levels of provision of training to other agencies by service type

Day care service	Residential/ nursing homes	Primary health care teams	Social services departments	Community mental health teams	Carers	Mean
Day centres	3 (8.1%)	2 (5.4%)	5 (13.5%)	3 (8.1%)	8 (21.6%)	0.68
Day hospitals	10 (33.3%)	-	6 (20%)	1 (3.3%)	14 (46.6%)	1.23
Resource centres	1 (14.3%)	-	-	-	1 (14.3%)	0.29
In-patient wards	-	-	-	-	-	-
Residential/ Nursing homes	1 (33.3%)	-	-	-	-	0.33

Source Question: 38: Do any of your staff provide specialist training in dementia care to any of the following…?

Table 5.29 shows the breakdown of training provided to other agencies by each type of day care service. Notably, day hospitals provided a considerable amount of training. In particular, 46.6 per cent of day hospitals provided training for carers, one third of day hospitals provided training to residential/nursing homes, and 20 per cent provided training to social services departments. Day centres also provided training to a wide range of other services, especially carers (21.6 per cent). The overall proportion of day centres providing training was lower than that of day hospitals, although not significantly so ($t=1.8$, $df=45$, $p=.079$).

6 RESULTS II – STANDARDS OF CARE

This section will concentrate on the aggregation of key variables from section one into composite variables. These reflect the overall performance of the major day care service types on a number of standards of care. These have been summarised previously (Table 4.1).

The data is presented in the following format. First, each factor contributing to the overall composite score is first presented in order of the frequency of its occurrence in day care services as a whole. This allows the overall proportion of day care facilities providing the individual services in question to be assessed. Second, the same variables are presented as a direct contrast between the two major day care service types, with the relative overall performances of each service type on the composite variable contrasted at the bottom of the table. This allows both the overall performance of each day care service type to be assessed for each theme (the composite score), and also, when an overall difference is found, for the contribution to this difference of each individual factor comprising the theme to be identified.

In this section of the report, services were recoded to allow the most meaningful comparison possible to be made between the main service types, day centres and day hospitals. Resource centres were recoded as day centres, for the purposes of data analysis, if they fulfilled two criteria. First, no nursing or medical staff were employed within centres and second, the facility was financed from a source other than the NHS. All seven resource centres met these criteria and were therefore reclassified as day centres. The remaining services, residential nursing homes (3) and inpatient ward (1) were then excluded from the analysis as the numbers were too small for a meaningful statistical comparison to be conducted. Thus the comparisons in this section of the report were conducted between day centres (45) and day hospitals (30) only.

6.1 Reliability

The internal consistency of the scales was examined using Cronbach's Alpha. Alpha is an index of reliability associated with variation in the underlying construct, measuring how well a set of items fit together to form a summated scale, where the scale or 'construct' is the hypothetical variable that is being measured (Hatcher, 1994). Thus, it is of particular relevance to summated scales as it provides an indication of the validity of the construct (for example rehabilitation potential) through examining inter-item correlations. If inter-item correlations are found to be high, then this provides evidence that the separate items comprising the scale are measuring aspects of the same domain. If a construct is considered to be valid, then theoretically it would also elicit consistent and reliable responses even if questions were replaced with other, similar questions (Santos, 1999). The Alpha co-efficient ranges in value from 0 to 1, with a higher score indicating greater reliability. Nunally (1978) suggested that 0.7 was an acceptable cut-off, but lower thresholds have been used in the literature (Santos, 1999). Table 6.1 shows the Alpha co-efficient for each of the composite variables used in the present study.

Table 6.1: Internal reliability of the questionnaire (Cronbach's Alpha)

	Alpha score
Service flexibility (5 items)	0.24
Assessment (6 items)	0.55
Quality of care plans (9 items)	0.92
Rehabilitation (11 items)	0.68
Care worker good practice (3 items)	0.34
Carer involvement (9 items)	0.67
Building design (9 items)	0.67
Individuality (5 items)	0.55
Service integration (15 items)	0.71
Equity of service delivery for people from ethnic minorities (5 items)	0.80
Training (2 items)	0.50
Mean	0.63

The mean Alpha score across the twelve themes was 0.63, suggesting an acceptable overall degree of reliability inherent within the measurement of care standards in the present study, and the reliability was in line with the thresholds utilised by recent literature (Santos, 1999). Only two themes presented with low reliability (service flexibility and care worker good practice). These results were however informative in themselves as they illustrated inconsistency in services with regard to the practice of factors comprising each standard. Although the lower scores found on some of the composites indicated a lack of association between the separate items within them, the scores were unlikely to be high as the possession of one attribute does not mean a service would be any more likely to possess one of the other attributes. In addition, regardless of the alpha coefficient, the greater the number of attributes found within each composite would indicate a greater likelihood of a better quality of care. These results are discussed further in the relevant sections.

6.2 Service delivery

6.2.1 Service flexibility

Day care services should be appropriate, flexible and responsive, with a range of facilities for both dementia and functional disorder (Finch and Orrell, 1999, Standard 3.2). To assess the levels of 'flexibility' of services in our sample, a composite variable with five components was constructed. These were: whether a service was open at some point on the weekend; if it was open for at least one evening per week; whether it allowed users to attend for special reasons other than on allocated days; if there was a waiting list and whether the service was time limited. This produced a score from zero to five for each respondent. Only one service did not possess any of these items, with the vast majority reporting two (37 per cent) or three (34 per cent). Only four services possessed all five requirements.

Table 6.2: Service flexibility: comparison of day hospitals and day centres

	Day centre (n=45) (%)		Day hospital (n=30) (%)		Statistical significance
Service opens on the weekend	15	(33)	2	(7)	X^2=7.30, df=1, p<.01
Service opens in the evening	7	(16)	1	(3)	ns
Service users can attend on un-allocated days for special reasons	28	(62)	21	(70)	ns
Service does not have a waiting list	28	(62)	25	(83)	X^2=3.87, df=1, p<.05
Service is not time limited	45	(100)	17	(57)	X^2=23.59, df=1, p<.001
Service flexibility score – mean (standard deviation)	2.73	(0.99)	2.20	(0.96)	t=2.32, df=73, p<.05

Source Questions: 20: Does your service have a waiting list? If yes, how long is the current waiting list? 21: Does this facility provide services for a limited time period? If yes, what is the maximum time period? 22: On which days of the week and at what time is this service available to people with dementia? 24: Can users attend this service, for special reasons, other than on their allocated days?

A comparison of day centres and day hospitals was undertaken, which revealed that day centres were significantly more flexible than day hospitals (t=2.317, df=73, p=<.05). Table 6.2 shows that the variation between service types was primarily found in the non-time limited nature of day centres, their capacity to open on weekends, and the fact that a smaller proportion of day centres operated a waiting list. The low alpha score (0.24) for this standard of care suggested that services which scored on one variable (for example weekend opening) were not necessarily any more likely to score on others (for example evening opening). This suggested that services may have tended to offer one set of opening hours or the other. The alpha score also reflected some polarity within service types (for example day hospitals were significantly more likely to operate a waiting list, and also significantly less likely to exist in a time limited capacity).

6.3 User centred practice

There are a number of dimensions by which the construct of the 'new culture of dementia care' (Kitwood and Benson, 1997) has been addressed. These are: assessment; care planning; care worker good practice; rehabilitation potential; carer involvement; independence encouraged by building design features and good practice; practices which promote individuality and choice; and equity of service delivery/access to services for ethnic minorities.

6.3.1 Assessment

The effective assessment and management of an older persons care is essential (Audit Commission, 2000). Each individual should receive a comprehensive assessment to identify his or her needs, strengths and abilities, weaknesses and personal characteristics (Alzheimer Society of Canada, 1992). Assessment is widely recognised as pivotal to the practice of health and social care in the community. The NSFOP (Department of Health, 2001a) recently defined assessment as, "A process whereby the needs of an individual are identified and their impact on daily living and quality of life is evaluated." It is also important in the determination of eligibility; the decision to enter care homes; periodic review and linkage between assessment and

care planning (Challis et al., 1996; Stewart et al., 1999). Standard 2 of the NSFOP describes a single assessment process for health and social care needs, including an individual care plan which should be used by all agencies for managing the care and treatment of older people including those with mental health problems.

Table 6.3: Systematic assessment and care planning practices in day care facilities in the North West of England

	n	%
Care plan for each service user made as a result of assessment	62	79
Operates a key worker/named nurse system	60	76
Relatives/carers routinely invited to reviews	60	76
Assessment form completed in 3 months of referral for people with dementia	57	72
Operates within the CPA policies and procedures	47	59
3 monthly or more, planned review of each service user	33	59

Source Questions: 39: Do you operate within the CPA policies and procedures? 40: Do you have a key worker/named nurse system in operation? 41: Do you complete an assessment form on people with dementia in the first three months of referral? 43: Do you make a care plan for each service user as a result of this assessment? 45: Do you have a planned review of each service user? 46: Do you routinely invite relatives/carers to your reviews?

Table 6.4: Systematic assessment and care planning practices: comparison of day centres and day hospitals

	Day centre (n=45)		Day hospital (n=30)		Statistical significance
Operates a key worker/named nurse system	26	(58)	30	(100)	χ^2=14.81 df1 p<.0001
Assessment form completed in 3 months of referral for people with dementia	26	(58)	29	(97)	χ^2=12.00 df1 p<.001
Care plan for each service user made	29	(64)	29	(97)	χ^2=8.90 df1 p<.001
Operates within the CPA policies and procedures	18	(40)	26	(87)	χ^2=14.30 df1 p<.0001
Relatives/carers routinely invited to reviews	31	(69)	26	(87)	n/s
3 monthly or more, planned review of each service user	16	(53)	14	(64)	n/s
Care panning practices – mean score (standard deviation)	3.2	(1.7)	5.2	(0.8)	t=5.52 df 73 p<.001

Source Questions: 39: Do you operate within the CPA policies and procedures? 40: Do you have a key worker/named nurse system in operation? 41: Do you complete an assessment form on people with dementia in the first three months of referral? 43: Do you make a care plan for each service user as a result of this assessment? 45: Do you have a planned review of each service user? 46: Do you routinely invite relatives/carers to your reviews?

The six items listed in Table 6.3 were aggregated to produce a composite score of systematic assessment and care planning practices (maximum score 6). The mean score of all services (n=75) was four. Systematic assessment and care planning practices were significantly higher in the day hospitals (5.2 vs 3.2 t=-5.522 df 73 p<.001). These results corresponded to the primary function of these facilities (Tables 5.8 – 5.9) and concur with previous research (Collier and Baldwin, 1999) where day hospitals have reported their primary function to be that of assessment.

Most, but not all respondents (57; 72 per cent) reported completing an assessment form on people with dementia in the first three months of referral. The composition of these assessments was explored further. Respondents were asked either to tick those items specified in their assessment forms or to return the proforma with their completed questionnaire. Of the respondents reporting the completion of an assessment, 34 (61 per cent) returned blank copies of assessment forms. Researchers rated the presence or absence of pre-defined items in four broad assessment domains, as categorised by Stewart et al., (1999):

- functional domains
- cognitive, mood and psycho-social domains
- social environment domains
- clinico-medical domains

Twelve (22 per cent) of these respondents did not report recording any of the 16 listed items. None of the facilities collected all 16 items and only one collected 15 items. The mean number of items was 8.4 items. The following tables show the proportions of items systematically collected.

Table 6.5: Assessment in day care facilities in the North West of England: Cognitive mood and psycho-social domain (n=57)

	n	%
Daily routine/preferences	24	42
Depression/anxiety/mood state	38	67
Cognitive patterns	42	74

Source Question: 42: Does your assessment form specify the following…?

Of services that completed an assessment in the first three months 13 (23 per cent) did not collect any of the three items in the cognitive, mood and psycho-social domain. Twenty one (37 per cent) reported collecting all three items.

Table 6.6: Assessment in day care facilities in the North West of England: Social environment domain (n=57)

	n	%
Social/recreational activity	30	53
Religious observance	23	40
Participation in assessment	7	12
Carer needs/support given	21	37
Familiar cultural traditions	8	14

Source Question: 42: Does your assessment form specify the following…?

Only one facility collected all five items in the social environment domain. Cultural traditions was the least likely item to be collected. Almost half (46 per cent) of the respondents collected two or three of these items, however 19 (33 per cent) collected none.

Table 6.7: Assessment in day care facilities in the North West of England: Clinico - medical domain (n=57)

	n	%
Teeth and nutrition	37	65
Medication	38	67
Disease/health conditions	33	58
Skin and footcare	10	18

Source Question: 42: Does your assessment form specify the following…?

Only 8 (14 per cent) respondents collected all 4 clinical and medical items (Table 6.7). Twenty six per cent (15) collected none of these items.

Table 6.8: Assessment in day care facilities in the North West of England: Functional domain (n=57)

	n	%
Continence	39	68
Mobility and ADL	42	74
Communication/hearing patterns	40	73
Vision patterns	34	60

Source Question: 42: Does your assessment form specify the following…?

Just over half (31, 54 per cent) of respondents collected all four functional assessment items (Table 6.8), but there were still 25 per cent (14) of facilities which failed to collect any.

Table 6.9: Overall levels of assessment: comparison of day centres and day hospitals

Service type	Day centre (n=45)	Day hospital (n=30)	Statistical significance
Cognitive, mood and psycho-social domain	0.80	2.33	t=-6.47, df=73, p<.001
Clinico-medical domain	0.91	2.77	t=-6.33, df=73, p<.001
Functional domain	1.31	3.33	t=-5.46, df=73, p<.001
Social environment domain	0.53	2.37	t=-7.24, df=73, p<.001
Assessment score	3.65	10.80	t=-7.03, df=73, p<.001

Source Question: 42: Does your assessment form specify the following…?

Table 6.9, which compares day hospitals and day centres on the breadth and quality of their assessment procedures, illustrates very clearly that day hospitals performed better than day centres in all respects on the assessment variables measured. Differences between the service type on all six assessment variables was statistically significant. This was a clear demonstration of the apparent emphasis placed on clinically related care in day hospital services.

6.3.2 Care Planning

Standard 7 of the national minimum standards (Department of Health, 2001b) stated that a service user plan of care should be generated from a comprehensive assessment for each service user. This provides the basis of the care to be delivered. The care plan should be intricately linked to the original assessment and cannot be considered adequate if the initial assessment is incomplete. In an environment which provides care to the older person with dementia, care plans which carry information on the individual's personal preferences and lifestyle are of great importance as the patient may not always be able to express his or her own wishes (Wallum, 1995). The care plan was a foundation of the community care reforms, but they do not include a standardised, routine data set for the monitoring of care plans (Kerrison and Pollock, 2001). The new framework requires that a care plan is completed for each service user, but there are no arrangements for collecting standardised information on the care plans. Thus determining the level of care needed, the level of care provided, and whether needs have been met might not be feasible.

> "Care planning is a process based on an assessment of an individual's assessed need that involves determining the level and type of support to meet those needs, and the objectives and potential outcomes that can be achieved" (NSFOP, Department of Health, 2001a)

Analysis was based on a few variables reflecting core data.

Fifty-eight (77.3 per cent) facilities reported that they made a care plan for each service user as a result of an assessment. Of these 46.5 per cent (27) returned blank copies of care plan forms. Table 6.10 summarises the contents of these care plans.

Table 6.10: Contents of care plans in day care facilities in the North West of England (n=27)

Description of:	n	%
Need or problem	19	70
Goals/outcome	18	72
Intervention		
- in general	12	48
- action required	5	23
- when or how often	4	18
- by whom	5	23

Source: Care plans

The care plan is the end point of the assessment of the individual (Department of Health, 2001b). Care must then be delivered in accordance with the service user's plan for that individual. Thus the plan becomes the yardstick for judging whether appropriate care is delivered to the individual resident. It is a dynamic document which will change as regular assessment of the user reveals changing needs. Thus it is important that documents are comprehensive in nature. Most of the documents had a space allocated to describe the particular need or problem (78 per cent) and provided a category to outline the objectives, goals or potential outcomes (74 per cent) but not all specified a space for reporting the level and type of support to meet the needs of the user (48 per cent). Mostly this was in general terms, rather than clearly specifying what

needs to be done (23 per cent), when or how often (18 per cent) and by whom (23 per cent).

Although poor documentation does not necessarily imply poor practice, it is reasonable to assume that clarity in writing might reflect clarity in the purpose and direction of care (Griffiths and Hutchings, 1999). A third of all documents (39 per cent) were found to be insufficient in length to write a comprehensive care plan (mode length: one page) and a half (50 per cent) were deemed by the researchers to be presented in an inaccessible style. For the process to work effectively, staff must be adequately trained and skilled in documenting care plans (Mueller et al., 2001; Webb and Pontin, 1997). No care plans were returned with instructions for the person completing the form.

We also noted that a space for signatures on care plans was not always present for when the problem was identified (44 per cent) or actioned (51 per cent) and only eight per cent of care plans clearly showed a space for the service users signature or category to say they had been consulted. None provided a space for the carer's signature or a category indicating that they had been consulted.

From the above data we derived two composite scores on the quality of care planning documents. The first score consisted of the presence of three items specified in the NSFOP: description of need; specified level and type of support to meet those needs and specified objectives or potential outcomes to be achieved. These are shown for the sample as a whole in Table 6.11, and split between day centres and day hospitals in Table 6.12.

Table 6.11: Presence of items specified in the NSFOP on care plans in day care facilities in the North West of England (n=27)

	n	%
Description of problem	21	78
Specified place on form for support required	20	74
Specified objectives	14	52

Source: Care plans

Table 6.12: Presence of items specified in the NSFOP on care plans: Comparison of day centres and day hospitals

	Day centre n=13		Day hospital n=14		Statistical significance
	n	%	n	%	
Description of problem	7	54	12	86	ns
Specified place on form for support required	3	23	9	64	χ^2=4.89, df=1, p<.05*
Specified objectives	8	62	10	71	ns
Mean total composite score (sd)	1.3 (1.3)		2.4 (1.0)		t=-2.45, df=25, p<.05

* Exact sig, 2-sided
Source: Care plans

Care plans returned by day hospitals were of significantly higher quality than those from day centres (2.4 vs 1.3, p<.05). However, irrespective of service type, only 27 per cent of respondents have at least one of these three key domains.

The second composite variable, intended to describe the overall quality of the care plan, consisted of the previous three factors detailed in 6.10 and 6.11 and also whether the form was based on an assessment of need; a date category for the assessment; a date for the review; space for a signature when a problem is identified; and actioned; and adequate space on the form. These are shown for the sample as a whole in Table 6.13, and split between day centres and day hospitals in Table 6.14.

Table 6.13: Overall Quality of care plans in day care facilities in the North West of England

	n	%
Space for signature when care plan actioned	14	52
Date category-identification	14	52
Review date	12	44
Space for signature when problem identified	10	37
Inadequate space on form	10	37
Based on an assessment of need	6	22

Source: Care plans

Table 6.14: Overall quality of care plans: comparison of day centres and day hospitals

	Day centre *n=13*		Day hospital *n=14*		Statistical significance
	n	%	n	%	
Based on an assessment of need	2	14.3	4	30.8	ns
Date category-identification	4	28.6	10	76.9	χ^2=6.31, df=1, p<.05*
Review date	3	21.4	9	69.2	χ^2=6.24, df=1, p<.05*
Space for signature when problem identified	2	14.3	8	61.5	χ^2=6.45, df=1, p<.05*
Space for signature when cp actioned	4	28.6	10	76.9	χ^2=6.31, df=1, p<.05*
Inadequate space on form	4	28.6	6	46.2	ns
Overall quality of care plan composite mean score (sd)	2.6 (2.7)		6.0 (1.6)		T=-3.96, df 25 p<.001

* Exact sig, 2-sided
Source: Care plans

Again, the documents returned by the day hospitals scored higher than those returned by the day centres, indicating a higher overall standard of quality (mean score 6.00 [day hospital] vs 2.6 [day centre]; t=-3.958, df 25 p<.001).

6.3.3 Care worker good practice

The extent to which care worker good practice was present within day care services was examined. This was achieved by means of a composite variable examining whether: new staff receive an induction with component on dementia care; existing care staff have received specific training for caring for people with dementia; and whether a key worker system was in operation at the service.

Table 6.15: Factors contributing to care worker good practice in day care facilities in the North West of England

	n	%
Key worker system in operation	56	75
Existing care staff have received specific training in caring for people with dementia	56	75
New staff receive an induction with a component on people with dementia care	44	59

Source Questions: 36: Do new staff receive an induction? If yes, is there a specific component of this induction which focuses on caring for people with dementia? 37: Have any of the care staff in this facility undergone any specific training for caring for people with dementia (in-house or external), in addition to any induction, in the past 2 years? 40: Do you have a key worker/named nurse system in operation?

Table 6.16: Factors contributing to care worker good practice: comparison of day centres and day hospitals

Item	Day centre (%)	Day hospital (%)	Statistical significance
New staff receive an induction with a component on people with dementia care	27 (60)	17 (57)	ns
Existing care staff have received specific training in caring for people with dementia	35 (78)	21 (70)	ns
Key worker system in operation	26 (58)	30 (100)	X^2=16.96, df=1, p<.001
Care worker good practice score - mean (sd)	1.97 (0.94)	2.26 (0.78)	Ns

Source Questions: 36: Do new staff receive an induction? If yes, is there a specific component of this induction which focuses on caring for people with dementia? 37: Have any of the care staff in this facility undergone any specific training for caring for people with dementia (in-house or external), in addition to any induction, in the past 2 years? 40: Do you have a key worker/named nurse system in operation?

Performance was generally high for most services on this dimension. Whilst four services possessed none of these factors, 75 per cent of services possessed either two or three and 40 per cent had all three criteria in place. Further analysis contrasting the overall performance of day hospitals and day centres revealed no significant differences between the service types in care worker good practice, although day hospitals were significantly more likely to have a key worker system in operation.

The theme generated a low alpha score (0.34) which suggested that services possessing one of the variables comprising the theme were not necessarily any more likely to possess another. Thus, a service which for example provided an induction with a component on dementia care was not necessarily any more likely to offer specific training for dementia care or a key worker system. As such, the validity of the theme as a summated scale may have been lower than the other standards and the overall composite score may not have adequately addressed the theme to which it was intended to refer. The lack of significant differences between service types and the finding that 75 per cent of services possessed either two or three of the items comprising the scale also suggested that the discriminant validity of the scale may not have been adequate. Nevertheless, in descriptive terms the value of the information provided by individual items would not be compromised by the low alpha score.

6.3.4 Rehabilitation potential

Measurement of the concept of rehabilitation and independence is difficult when addressing the needs of those with a degenerating condition (Perrin, 1997). A number of factors have been highlighted as important for the well-being of people with dementia: flexibility, responsiveness, a variety of stimulating activities for users and access to specialist input (Finch and Orrell, 1999). Indeed, through the practice of person-centred care, activity and occupation are now seen as central to promoting well-being for people with dementia. Reality orientation and memory training has showed promise in improving both cognition and behaviour (Floyd and Scogin, 1997; Spector et al., 2000). There is however insufficient evidence to support the use of validation therapy, reminiscence therapy, music therapy (Contributors to the Cochrane Collaboration and the Campbell Collaboration, 2000). Nevertheless, all these factors were measured together with other factors likely to aid rehabilitation.

It was expected that significant differences would be found between day centres and day hospitals, as although geriatric day hospitals have several functions, rehabilitation has historically been regarded as the most important (RCP, 1994).

Table 6.17: Factors expected to promote rehabilitation for people with dementia in day care facilities in the North West of England

	n	%
Specialist input from three or more professional groups (visits or personnel)	54	68
Memory/life story work	54	68
Reality orientation boards	43	54
Occupational therapy - primary function	37	47
Physical exercise - primary function	37	47
Reminiscence room/area	34	43
Snoezelen/sensory rooms	26	33
Specially designed garden	24	30
Specially designed building	16	20
Physiotherapy - primary function	15	19
Speech therapy - primary function	6	8

Source Questions: 9: Which of the following do you provide? 33: We are interested in how many care staff work in this service in the course of a week. In the table below please provide details on the total number of actual staff for each staff group in addition to the total number of whole time equivalent staff; 34: We are also interested in how many care staff work in this service in the course of a week on a sessional basis. In the table below please provide details on the total number of actual staff for each staff group in addition to the total number of sessions; 52: Does your facility employ any of the following methods or approaches in the care of people with dementia; 53: Does your building have any of the following special design features for people with dementia…?

Table 6.18: Factors expected to promote rehabilitation potential for people with dementia in day care facilities: comparison of day centres and day hospitals

	Day centre	Day hospital	Statistical significance
	n=45	n=30	
Occupational therapy*	10 (23)	26 (87)	X^2=26.69 df1 p<.001
Reality orientation boards	17 (38)	24 (80)	X^2=11.30 df1 p<.001
Memory/life story work	29 (64)	22 (73)	ns
Specialist input from three or more professional groups (visits or personnel)	23 (51)	19 (63)	ns
Snoezelen/sensory rooms	6 (13)	19 (63)	X^2=18.06 df1 p<.001
Reminiscence room/ area	15 (33)	18 (60)	X^2=4.17 df1 p<.05
Physiotherapy*	2 (5)	12 (40)	X^2=12.40 df1 p<.001
Physical exercise*	24 (53)	11 (37)	ns
Specially designed garden	12 (27)	11 (37)	ns
Specially designed building	6 (13)	9 (30)	ns
Speech therapy*	-	6 (20)	X^2=1.08 df1 p<.01
Rehabilitation score – mean (standard deviation)	3.2(2.1)	5.9 (2.1)	t=5.46 df 73 p<.001

* primary function

Source Questions: 9: Which of the following do you provide? 33: We are interested in how many care staff work in this service in the course of a week. In the table below please provide details on the total number of actual staff for each staff group in addition to the total number of whole time equivalent staff; 34: We are also interested in how many care staff work in this service in the course of a week on a sessional basis. In the table below please provide details on the total number of actual staff for each staff group in addition to the total number of sessions; 52: Does your facility employ any of the following methods or approaches in the care of people with dementia; 53: Does your building have any of the following special design features for people with dementia…?

The items were aggregated to produce a composite score of rehabilitation practices upon which it was possible to contrast the performance of day centre and day hospitals. As expected, it was found that day hospitals offered significantly more factors that encouraged rehabilitation potential than day centres (mean scores: 6.13 vs 3.22, t=-5.851, df=73, p<.001). This difference was apparent on many of the individual items, with the presence of reality orientation boards, snoezelen/sensory rooms, reminiscence room/area, and physiotherapy, occupational therapy and speech therapy (as primary functions) having occurred significantly more often in day hospitals than in day centres.

6.3.5 Carer involvement

Quality standards for carer support services were proposed as part of the implementation of the National Strategy for Carers (Department of Health, 1999), and are being developed as part of the modernisation of health and social services and local government. These include standards with the ongoing care charter, National Service Frameworks and standards for local authority support to carers, assessment, and short breaks which are already in place for social services inspections. One of the aims of the strategy is to assist relevant authorities and funding bodies to ensure that existing services, including day care services, provide an acceptable quality of help to carers.

Given that unpaid informal care is vital in supporting people with dementia who live in the community (O'Connor et al., 1989) and forms a major part of the total costs of dementia care (Wimo et al., 1997; Kirchner et al., 2000), it is essential that services address the needs of carers. Many carers of older people with dementia are themselves elderly - up to 60 per cent are husbands or wives (Levin et al., 1994). Service quality is also of particular relevance to carers of older people with dementia as it can have a significant impact on their ability to continue caring (Levin, 1997). People with dementia often show resistance to new environments which may challenge their failing cognitive abilities and cause distress. Caregivers can also feel ambivalent or resistant about using day services, and, for the person with dementia, this can make the process of adaptation to a new environment more difficult. Preparation and support of the carer is therefore paramount in fostering effective services for all parties concerned (Cherry and Rafkin, 1988).

Evidence relating to the impact of day care on carers is mixed (Gaugler et al., 2003): Larger-scale randomized studies such as Lawton et al., (1989); Montgomery and Borgatta (1989); Hendrick et al., (1993) and Newcomer at al., (1999) have reported negligible impacts of day care on the psychological well-being and negative appraisals of carers. Studies reporting positive outcomes (for example Gottlieb and Johnson, 1995; Kosloski and Montgomery, 1995; Cox, 1997) have generally been smaller and more prone to selection bias, but have also focused on carers who have utilised day care facilities more, and thus received a greater 'dose' (Gaugler et al., 2003). A recent study of 400 carers again found conflicting results: day provision was associated with decreased feelings of 'role overload'. However, a subgroup of non-users (for whom the daily living dependencies of the person with dementia had worsened) actually reported greater reductions of worry and strain than their service-using counterparts (Gaugler et al., 2003). The picture therefore remains unclear.

The employment of professionals with a specific brief to develop support networks and services for carers should ensure that their needs are addressed (Benson, 1987), promote appropriate service development, and facilitate the take up of services (Mountain and Godfrey, 1995). The value of flexibility with regard to the needs of carers has been espoused for example by Cunningham and Kestererton's (1995) implicit recognition of the need for 'prime carers to lead less restricted lives' in the 'new culture of dementia care'. Help for carers is one of the best ways of helping the people they are caring for and cannot be seen in isolation from help for the person for whom they are caring (Department of Health, 1999). Services can make a large impact on the ability of carers of older people with dementia to continue caring (Levin, 1997), and a number of techniques for achieving greater autonomy for relatives of people with dementia who are carers have been identified (Marshall 1999).

Levin et al., (1989) found no difference in the value carers placed on day centres and day hospitals. However, the degree to which day care services regard the carer as a priority has been found to differ (Carter, 1981). Differences in carer involvement practices between the two service types were examined and, on the whole, the data revealed that day hospitals were more likely to adopt proactive practices for carers.

Table 6.19: Carer involvement practices in day care facilities in the North West of England

	n (%)
Relatives/carers routinely invited to reviews	60 (76)
Relatives/carers often attend reviews	40 (51)
Formal arrangements for carer support	39 (49)
Information to assist in caring process for carers is a primary function of resource	37 (47)
Carer needs/support recorded on assessment form	34 (43)
Staff time allocated to support the development of self-help/support groups	34 (43)
Staff provide specialist training in dementia care to carers	23 (29)
Respite for carers is s primary function of resource	49 (62)
Relatives frequently sent/given copies of care plans	11 (14)

Source Questions: 9: Which of the following do you provide…? 38: Do any of your staff provide specialist training in dementia care to any of the following…?,42: Does your assessment form specify the following…? 44: Do you send copies of care plans to relatives? 46: Do you routinely invite relatives/carers to your reviews? 47: Do relatives /carers attend reviews? 48: Do you have any formal arrangements or resources for providing support for close relatives/friends of users with dementia, in addition to respite care (detailed in Q.9)? 49: Is staff time allocated to support the development of self-help/ support groups for carers?

Table 6.19 shows the extent to which proactive policies for carers were adopted by day care services in North West England. Notably, just over three quarters of services routinely invited relatives to reviews, and relatives attended approximately half of these. The provision of respite for carers was a primary function of almost two thirds (62 per cent) of services.

A comparison was made between day centres and day hospitals on these variables, which were also aggregated to produce a composite score of practices which were considered proactive to carer involvement. This allowed an overall comparison to be made between these service types shown in Table 6.20.

Table 6.20: Carer involvement practices: comparison of day centres and day hospitals

	Day centre n=45	Day hospital n=30	Statistical significance
Relatives/carers routinely invited to reviews	31 (69)	26 (87)	ns
Relatives/carers often attend reviews	15 (33)	23 (77)	X^2=11.84 df1 p<.001
Formal arrangements for carer support	19 (42)	19 (63)	ns
Information to assist in caring process for carers is a primary function of resource	19 (42)	18 (60)	ns
Carer needs/support recorded on assessment form	16 (36)	17 (57)	ns
Staff time allocated to support the development of self-help/support groups	17 (38)	15 (50)	ns
Staff provide specialist training in dementia care to carers	9 (20)	14 (47)	X^2=4.83 df=1 p<.05
Respite for carers is a primary function of resource	31 (69)	14 (47)	X^2=3.70, df=1, p=.054
Relatives frequently sent/given copies of care plans	4 (9)	7 (23)	ns
Carer involvement score –mean (standard deviation)	3.6 (2.3)	5.2 (1.8)	t=3.03 df 73 p<.01

Source Questions: 9: Which of the following do you provide…? 38: Do any of your staff provide specialist training in dementia care to any of the following…?,42: Does your assessment form specify the following…? 44: Do you send

copies of care plans to relatives? 46: Do you routinely invite relatives/carers to your reviews? 47: Do relatives /carers attend reviews? 48: Do you have any formal arrangements or resources for providing support for close relatives/friends of users with dementia, in addition to respite care (detailed in Q.9)? 49: Is staff time allocated to support the development of self-help/ support groups for carers?

Day hospitals (mean score: 5.2) scored significantly higher than the day centres (mean score: 3.6) on this measure (t=-3.03 df=73 p<.01). Thus it was possible to conclude that day hospitals in a general sense were more sympathetic to carer needs than day centres. It was notable however that in contrast to this trend, more day centres (69 per cent) than day hospitals (47 per cent) provided respite for carers as a primary function, although this just failed to reach statistical significance (χ^2 = 3.704, df=1, p=.054).

6.3.6 Promoting independence by building design

The physical environment can have a significant impact on the type of care provided by facilities. Although it is possible that excellent care be provided in a poor environment, more appropriate surroundings have been shown to be related to greater well being in people with dementia (Netten, 1993) encouraging independence and choice. In relation to design, it is helpful to view dementia as a disability characterised by impaired memory, impaired reasoning, impaired ability to learn, high levels of stress and an acute sensitivity to the social and built environment (Marshall and Cox, 1998). Most buildings are based on the disease model of dementia, with the inevitability of decline as the main focus (Marshall and Cox, 1998). By not providing a day care environment conducive to rehabilitation, people with dementia have been further disabled and consequently prevented from flourishing (Cunningham and Kesterton, 1997). Day care facilities should be appropriate and informal, safe, non-threatening and have adequate amenities (Finch and Orrell, 1999). Furthermore, buildings should be appropriately designed, and facilities and equipment should be appropriate for people with dementia. There should also be an opportunity to separate people with functional and with organic disorders.

The incidence of building design features which were appropriate for the facilitation of care for people with dementia through encouraging independence and choice in service users was explored in the questionnaire. Table 6.21 shows the availability of these features in North West England.

Table 6.21: Building design features which encourage independence and choice in day care facilities in the North West of England

	n	%
Signposting or aids to visual access	39	49
Enclosed secure outside space	43	54
Combination code door locks	39	49
Reminiscence room/area	34	43
Snoezelen/sensory room	26	33
Specially designed garden	24	30
Specially designed building	16	20
Enhanced lighting	13	17
Colour coded doors	11	15

Source Question: 53: Does your building have any of the following special design features for people with dementia…?

Specific characteristics of building design, some of which are likely to promote a better environment for people with dementia were reported. A large proportion (44 per cent) of facilities incorporated at least 3 of the above practices (mean 3.1; sd 2.2) which might encourage choice and independence for people with dementia. However, over a quarter of facilities (21; 27 per cent) reported none or only one of above items. Although without direct observation it was difficult to report the exact degree to which the scale and design of these facilities addressed the environmental needs of people with dementia, these results do provide an impression of the types of environments available.

The items in Table 6.21 were summated to form a composite variable upon which day centres and day hospitals could be contrasted. The results of this comparison can be found in Table 6.22.

Table 6.22: Building design features which encourage independence and choice: comparison of day centres and day hospitals

	Day centre n=45	Day hospital n=30	Statistical significance
Combination code door locks	12 (27)	24 (80)	X^2=18.43 df1 p<.001
Signposting or aids to visual access	23 (51)	23 (77)	X^2=3.948 df1 p<.05
Reminiscence room/area	15 (33)	18 (60)	X^2=4.17 df1 p<.05
Snoezelen/sensory room	6 (13)	19 (63)	X^2=18.06 df1 p<.001
Enclosed secure outside space	24 (53)	16 (53)	ns
Specially designed garden	12 (27)	11 (37)	ns
Specially designed building	6 (13)	9 (30)	ns
Enhanced lighting	9 (20)	2 (7)	ns
Colour coded doors	9 (20)	2 (7)	ns
Building design features score – mean (standard deviation)	2.6 (2.1)	4.2 (1.8)	t=3.34 df 73 p<.001

Source Question: 53: Does your building have any of the following special design features for people with dementia…?

Comparison of the mean scores of day hospitals and day centres on this variable revealed that day hospitals reported significantly more special design features than day centres (mean scores: 4.2 vs 2.1; t=3.34 df=73, p<.001). In the sample as a whole, more imaginative methods of promoting visual access were uncommon (for example colour coded doors, which were present in 20 per cent of day centres and 7 per cent of day hospitals). Methods of containing wandering such as combination code door locks are used more frequently, but more so in day hospitals than day centres (80 per cent vs 27 per cent; χ^2 = 18.432 df=1 p<.001).

It is particularly important that users with cognitive impairment are helped to independently navigate within their environment visually, so they are able to see or sense where they are or where they want to go. A greater proportion of day hospitals compared to day centres, employed signposting or aids to visual access (77 per cent vs 51 per cent; Chi square = 3.938 df 1 p<.05).

Although at present there is insufficient high quality evidence to support the use of reminiscence therapy (Spector et al., 2002) there has been some research which

suggests possible benefits (Thorgrimsen et al., 2003; Hopkins, 2003; Greenyer, 2003; Mowatt, 2001). Reminiscence rooms/areas were implemented more frequently in day hospitals (60 per cent vs 33 per cent; χ^2 = 4.169 df=1 p<.05). Similarly, there is insufficient high quality evidence to support the use of Snoezelen or sensory rooms, but some research which suggests benefits (Hope, 1997). Snoezelen or sensory rooms were also implemented more frequently in day hospitals (63 per cent vs 13 per cent; χ^2 =18.063 df 1 p<.001).

6.3.7 Individuality

Cunningham and Kestererton (1997) coined the phrase - 'Demolishing the barriers between 'us' and 'them' in referring to a more humanistic and user-centred approach to day care for people with dementia. This kind of 'personalised' approach can be facilitated in a number of ways, such as the use of memory/life story wallets for people with dementia in day centers, which has been associated with an improvement the quality of conversations (Bourgeois and Mason, 1996). Cunningham and Kesterton's (1997) radical review of day centre services for individuals with dementia suggested that staff should not wear uniforms, which may create a more homely environment.

The incidence of practices encouraging individuality in day care facilities in North West England are presented in Table 6.23.

Table 6.23: Practices encouraging individuality in day care facilities in the North West of England

	n	%
Individualised provision of care	57	72
Two or more special arrangements for people from ethnic minority groups	7	28
Policy of no uniforms for staff	42	53
Memory/life story wallets/files	36	46
Shared meal times for users and staff	29	37

Source Questions: 11: Do you feel your service is able to provide an individualised provision of care to people with dementia? 27: How many of all your current users are from ethnic minority groups? 28: Whether or not you currently have any users from ethnic minority groups have you made any of the following special arrangements for people from ethnic minority groups? 52: Does your facility employ any of the following methods or approaches in the care of people with dementia…?

Most services considered that care was tailored towards the needs of the individual (72 per cent). However, less than half 46 per cent of services utilised memory/life story wallets, or adopted the practice of not having uniforms for staff (53 per cent).

The above practices were aggregated to produce a composite variable allowing an overall contrast of individual care policies to be made between day centres and day hospitals.

Table 6.24: Practices encouraging individuality: comparison of day centres and day hospitals

	Day centre	Day hospital	Statistical significance
	n=45	n=30	
Individualised provision of care	27 (60)	27 (90)	X^2=6.62 df1 p<.01
Memory/life story work	29 (64)	22 (73)	ns
Two or more special arrangements for people from ethnic minority groups	6 (13)	19 (63)	X^2=18.06 df1 p<.0001
Policy of no uniforms for staff	26 (58)	15 (50)	ns
Shared meal times for users and staff	27 (60)	2 (7)	X^2=19.40 df1 p<.0001
Individuality score – mean (standard deviation)	2.0 (1.4)	1.7 (1.1)	ns

Source Questions: 11: Do you feel your service is able to provide an individualised provision of care to people with dementia? 27: How many of all your current users are from ethnic minority groups? 28: Whether or not you currently have any users from ethnic minority groups have you made any of the following special arrangements for people from ethnic minority groups? 52: Does your facility employ any of the following methods or approaches in the care of people with dementia…?

Table 6.24 shows that there were major differences evident between day centres and day hospitals in individual care practices in North West England. Of the five activities assessed, two were found significantly more often in day hospitals than in day centres. These were individualised provision of care (90 per cent vs 60 per cent, χ^2=6.617 df1 p<.01); and two or more special arrangements for people from ethnic minority groups (63 per cent vs 13 per cent, χ^2=18.063 df1 p<.001). Interestingly, the practice of shared meal times for users and staff was found significantly more often in day centres than in day hospitals (60 per cent compared to 2 per cent, χ^2=19.399 df1 p<.001). This result suggested that day centres were tending to offer a informal, 'friendly' service, whilst 'individuality' in a day hospital setting was more likely to reflect individual packages of care and specialist input such as memory/life story work. There was however no significant difference found between overall mean composite score measuring practices encouraging individuality.

6.3.8 Transport

Day care facilities need to be accessible in terms of transport, location and access to people with physical disabilities (Finch and Orrell, 1999). Clearly, arrangements to and from day care should be effective, and should meet the needs of the individual. It has been noted that only when transport is identified as an essential component of respite care, will schemes be fully utilised (Gibbons, 1990). Inadequate transport arrangements may undermine the potential value of some services for older people with dementia, most usually because of their failure to respond to the needs of individual users and carers (Department of Health, 1996). Moreover, transport costs are a major element of total expenditure on day care. Problems with regard to hospital ambulance transport (Audit Commission, 2000) have been noted. Long delays prior to reaching the day hospital for users can be stressful and uncomfortable, especially for people who are confused or physically frail. Problematic transport arrangements also have the knock-on effect of forcing activities to be re-scheduled in order to accommodate unpredictable arrival and departure times.

Less than half of respondents (35, 47 per cent) identified transport to and from the service as being effective in meeting the needs of individuals. However, in only one area did all responding services consistently report problems in transport. Table 6.25 describes the forms of transport used to transport users to and from the service. The most common form of transport reported was by family carers. Predictably, services which relied on hospital transport were more likely to report problems (58 per cent compared with 28 per cent; χ^2=4.964 df=1 p<.05). The use of taxis was also prevalent. They have the potential to be more efficient, flexible, cheaper and have the potential benefit of the driver getting to know individuals and consequently reporting problems to staff.

Table 6.25: Transport to day care facilities in the North West of England

	n	%
Family carers	57	75
Taxi	35	44
Hospital transport	30	38
Local authority transport	27	34
Trained volunteer drivers	15	19
Other methods	15	19
Users arrive or leave by dial a ride	7	9

Source Question: 25: We are interested in how users are transported to and from the service. Do they arrive or leave by the following…?

Table 6.26 contrasts the perceived effectiveness of transport arrangements by responders in day hospitals and day centres.

Table 6.26: Transport to day care facilities: comparison of day centres and day hospitals

	Day centre N=45 (%)	Day hospital N=30 (%)	Statistical significance
Transport arrangements considered effective	27 (60)	8 (27)	X^2=6.75 df1 p<.01

Source Question: 25: We are interested in how users are transported to and from the service. Do they arrive or leave by the following…?

Table 6.26 shows that respondents in day centres were significantly more likely to consider their transport arrangements to be effective in meeting the needs of the individual than those in day hospitals (60 per cent compared with 27 per cent, χ^2=6.752 df1 p<.05). The result concurred with the findings of the Royal College of Psychiatrists national survey of day hospitals (Audini et al., 2001) which reported that the transportation of patients remained a problem for many day hospitals.

6.4 Organisation of care

6.4.1 Service integration

Integration of services for older people is an important element of the government's modernisation agenda (Department of Health, 2001a), as an integrated approach to older people with dementia is considered more likely to produce higher standards of

care and improved outcomes (Audit Commission, 2000). We measured the extent of integration with other services by asking respondents whether their services were closely linked with other services on a number of dimensions.

Table 6.27: Factors indicative of highly integrated services in day care services in the North West of England

	n	%
Joint health/local authority/voluntary sector funding	17	(22)
Service sharing:		
Accommodation with other services	25	(32)
Management with other services	18	(23)
Single telephone number with other services	8	(10)
Single point of referral with other services	7	(9)
Assessment forms with other services	22	(28)
Care plan forms with other services	16	(20)
Client record database system with other services	15	(19)
Case files /filing system with other services	14	(18)
Provision of specialist training in dementia care to other services:		
Residential/nursing homes	15	(19)
Primary health care teams/general practitioners	2	(3)
Social services departments	11	(14)
Community mental health care teams	4	(5)
Carers	23	(29)
Others	10	(13)

Source Questions: 29: We are interested in identifying how services are funded. Please indicate whether the service is funded in part or wholly by any of the following…? 38: Do any of your staff provide specialist training in dementia care to any of the following…? 51: Are you closely linked with any other services by sharing any of the following…?

Despite the limitations in this categorisation of integration, this data does suggest a low level integration between the majority of services. Only 17 per cent of services achieved more than 10 of the indicators, and only 17 (22 per cent) of services were joint-funded. The degree of 'sharing' between services was generally low, with none of the six items being present in more than one third (32 per cent) of services. Similarly, only a small proportion of day care services provided specialist training to other agencies, although 23 (29 per cent) of services provided training to carers.

The items were aggregated in order to form a composite variable assessing the overall degree of integration in day centres and day hospitals. The results of this comparison can be found in Table 6.28.

Table 6.28: Factors indicative of highly integrated services: comparison of day centres and day hospitals

	Day centre n=45	Day hospital n=30	Statistical significance
Services with joint health/local authority/voluntary sector funding	9 (20)	3 (10)	ns
Shared accommodation with other services	14 (31)	10 (33)	ns
Shared management with other services	9 (20)	8 (27)	ns
Shared single telephone number with other services	4 (9)	2 (7)	ns
Shared single point of referral with other services	4 (9)	2 (7)	ns
Shared assessment forms with other services	13 (29)	9 (30)	ns
Shared care plan forms with other services	9 (20)	6 (20)	ns
Shared client record database system with other services	7 (16)	7 (23)	ns
Shared case files/filing system with other services	5 (11)	8 (27)	ns
Provision of people with dementia training to residential/nursing homes	4 (9)	10 (33)	X^2=6.83, df=1, p<.01
Provision of people with dementia training to primary health care teams/general practitioners	2 (4)	-	ns
Provision of people with dementia training to social services departments	5 (11)	6 (20)	ns
Provision of people with dementia training to community mental health care teams	3 (7)	1 (3)	ns
Provision of people with dementia training to carers	9 (20)	14 (47)	X^2=6.02, df=1, p<.05
Provision of people with dementia training to others	1 (2)	6 (20)	ns
Service integration score – mean (standard deviation)	2.38 (2.68)	3.03 (2.15)	ns

Source Questions: 29: We are interested in identifying how services are funded. Please indicate whether the service is funded in part or wholly by any of the following…? 38: Do any of your staff provide specialist training in dementia care to any of the following…? 51: Are you closely linked with any other services by sharing any of the following…?

Table 6.28 shows that the difference in the overall level of integration based on these 15 measures found in day centres and day hospitals was not statistically significant. Day centres were more likely to be in receipt of joint funding arrangements than day hospitals but the difference was not statistically significant. As has been reported previously, day hospitals provided significantly more training to residential/nursing homes, and to carers.

6.4.2 Ethnicity: equity of service provision

To produce a composite variable allowing a comparison of the overall levels of service provision between day centres and day hospitals, five items pertaining to special provision for ethnic minorities were aggregated: food (diet/storage/preparation/cooking); religious observation/spirituality; personal care; language resources; and the assessment of familiar cultural traditions (in those services that completed an assessment).

Table 6.29: Special arrangements for people from ethnic minority groups in day care services in the North West of England

	Facilities with users from ethnic minority groups(n=25) n (%)
Food - diet/storage/preparation/cooking	21 (84)
Language resources	16 (64)
Religious observation/spirituality	13 (52)
Personal care	10 (40)
Of those who completed an assessment	*N=18*
Familiar cultural traditions are assessed	11 (61.1)

Source Questions: 27: How many of all your current users are from ethnic minority groups? 28: Whether or not you currently have any users from ethnic minority groups have you made any of the following special arrangements for people from ethnic minority groups…? 42: Does your assessment form specify the following…?

A comparison of day centres and day hospitals on the above factors can be found in Table 6.30.

Table 6.30: Special arrangements for people from ethnic minority groups: comparison of day centres and day hospitals

	Day centre n=11	Day hospital n=14	Statistical significance
Food - diet/storage/preparation/cooking	10 (91)	11 (79)	ns
Language resources	7 (64)	6 (43)	ns
Religious observation/spirituality	6 (55)	4 (29)	ns
Personal care	6 (55)	10 (71)	ns
Of those who completed an assessment (n=18)	*n=5*	*n=13*	
Familiar cultural traditions are assessed	5 (100)	6 (46)	X^2=4.41, df=1, p=.054
Food - diet/storage/preparation/cooking	0.72 (0.46)	0.71 (0.47)	ns

Source Questions: 27: How many of all your current users are from ethnic minority groups? 28: Whether or not you currently have any users from ethnic minority groups have you made any of the following special arrangements for people from ethnic minority groups…? 42: Does your assessment form specify the following…?

No significant differences were found in the overall levels of equity of service provision for ethnic minority groups between service types (for those services that had clients from ethnic minority backgrounds) [mean 3.00 (day centre) versus 2.64 (day hospital)]. In the case of those who completed an assessment form on new admissions within the first three months of admission, a higher proportion of day centres than day hospitals assessed the cultural traditions of the service user, although the numbers were small (n=5, day centre; n=13, day hospital) and just failed to reach significance.

6.4.3 Training

A composite variable was constructed to assess the overall level of dementia-specific training or induction received by staff in the different day care services. This produced a score from 0-2 for each unit. One point was awarded if staff working at the unit received an induction with a specific component caring for people with dementia. A

second point was awarded if more than 50 per cent of care staff on the unit had attended specific training for caring for people with dementia (in-house or external) in the last two years. The frequencies for these factors can be found in Table 6.31. It was then possible to compare the performance of day care service types on this variable (Table 6.32).

Table 6.31: Frequency of dementia-specific staff training in day care facilities in the North West of England

	n	%
New staff receive an induction with a component on dementia care	44	58
More than 50% of staff attended specific training for caring for people with dementia in the last 2 years	27	36

Source Questions: 33: We are interested in how many care staff work in this service in the course of a week. In the table below please provide details on the total number of actual staff for each staff group in addition to the total number of whole time equivalent staff; 36: Do new staff receive an induction? If yes, is there a specific component of this induction which focuses on caring for people with dementia? 37: Have any of the care staff in this facility undergone any specific training for caring for people with dementia (in-house or external), in addition to any induction, in the past 2 years?

Table 6.32: Dementia-specific staff training: comparison of day centres and day hospitals

Item	Day centre (%)	Day hospital (%)	Statistical significance
New staff receive an induction with a component on dementia care	27 (60)	17 (56.7)	ns
More than 50% of staff attended specific training for caring for people with dementia in the last 2 years	20 (44.4)	7 (23.3)	ns
Mean composite score (sd)	1.46 (0.51)	1.21 (0.42)	ns

Source Questions: 33: We are interested in how many care staff work in this service in the course of a week. In the table below please provide details on the total number of actual staff for each staff group in addition to the total number of whole time equivalent staff; 36: Do new staff receive an induction? If yes, is there a specific component of this induction which focuses on caring for people with dementia? 37: Have any of the care staff in this facility undergone any specific training for caring for people with dementia (in-house or external), in addition to any induction, in the past 2 years?

Table 6.32 shows a breakdown of scores by service type on the composite variable for staff who had either undertaken specific training for caring for people with dementia or received an induction with a specific component relating to caring for this user group. A statistical comparison was conducted between day centres and day hospitals, but no significant difference was found. Nevertheless, there was again a tendency for more training to have been undertaken or received in day centres as opposed to day hospitals, and as before this was likely to have reflected the greater proportions of unqualified staff in day centres.

7 DISCUSSION

The survey aimed to provide a map of specialist day care dementia services in the North West of England, a detailed description of the quality of services and a comparison of both the type and quality of services provided in day hospitals and day centres.

7.1 Specialist day care dementia services in the North West of England

The survey provided clear evidence that specialist day care provision for people with dementia varied considerably between service types and Local Authority areas across the North West of England, in accordance with previous findings from across the country (Audit Commission, 2000). A number of important findings emerged from the data:

The number of day care places per facility ranged from five to 150 with a mean of 27 places. The total number of places in the North West was 2088. This ranged from 20 in Warrington and Halton to 381 in Manchester, sometimes reflecting differences in the geographical size and population density of each local authority region.

The survey suggests that overall the proportion of day care places per population is lower than recommended number of places. The rate of designated day care places per day per 1000 population was estimated to provide an indication of the level of provision per person in local authority areas. Our overall estimates of 1.51 – 2.01 per 1000 population aged over 65 were lower than the recommended provision of two to three places first advocated by the DHSS in 1970 (DHSS, 1970). Bearing in mind that this guidance referred to day hospital places only and is thirty years out of date, our combined estimates (which refer to all types of day care) are substantially lower. More recent estimates of 2.6 day hospital places per 1000 population aged over 65, by the Royal College of Psychiatrists (Audini et al., 2001), may also suggest that our North West figures are well below average, given that they refer to all types of day care. However, our figures, like those from the RCP also found a considerable degree of regional variation with upper estimates ranging from 0.36 to 5.53. The highest levels of provision were found in Manchester, Blackburn with Darwen, Oldham and Liverpool. Lower levels were found in areas such as Lancashire, Bolton and Trafford.

Also in line with a possible shortage of day care places, a low proportion of (estimated) people with dementia appeared to be attending day care services in the North West. We used the proportion of the population with dementia attending day care services as a proxy measure of the accessibility of day care services in the region. According to our estimates, only 3 per cent of people with dementia were in contact with day care services. This ranged from 1 per cent to almost 9 per cent in the 22 local authority areas of the North West (see Table 5.14). Access to services and service provision varied considerably across different local authority areas in the North West. Blackburn with Darwen and Manchester scored highly in this domain, whilst the data suggested that services might be less accessible in areas such as Knowsley and Lancashire.

Despite the low estimates of overall day care places, at the time of the survey the mean occupancy rate was 100 per cent in only three areas (mean 83 per cent - range 57 per cent to 100 per cent) (see Table 5.15). It is possible that day services run below

capacity to encourage a higher level of participation or attendance (Kitchen et al., 2002) or lower occupancy could indicate difficulties in service uptake or engaging people with dementia. It is also worth noting here, that almost a third of services reported operating a waiting list (ranging from one month (mode) to nine months).

Specialist dementia services are more likely to develop the expertise needed to care for people with dementia. It is possible that specialist care for people with dementia may be greater in facilities which provide separate provision for this group, and particularly so in those which are solely provided for people with dementia, and in those with places specifically designated for this group. Just over a third of facilities (38 per cent) described their services as solely for people with dementia. However a much greater proportion (72 per cent) of services reported that all their attendees had dementia. The mean proportion of total day care places specifically designated for people with dementia was 71 per cent (IQR 46 per cent-100 per cent). The mean number of day care places specifically designated for people with dementia per day was 19 (IQR 10-30).

There was little evidence of services targeted on the most dependent - of those attendees with dementia, 54 per cent were rated as having mild or moderate dementia, and 46 per cent as severe.

People with dementia from ethnic minority backgrounds were marginally under-represented in the overall sample. Once outliers were removed from the sample, 2.5 per cent of attendees were reported to be from an ethnic minority background compared with 2.7 per cent of the ethnic minority population over age 65 living in North West England. However this masked wide variation between local authorities. Our results were slightly more encouraging than those of other studies, which suggested that such individuals experience discrimination with regard to accessing day care services (Department of Health, 1998; Patel and Mirza, 1998).

Cultural traditions did not frequently feature in standardised assessment forms, also suggesting that special arrangements for those from ethnic minority backgrounds were not being provided in a systematic and planned manner. This was also consistent with previous literature (Department of Health, 1998; Patel and Mirza, 1998).

The majority (mean 81 per cent) of people with dementia attended day services for three days or less. This was comparable with previous literature where typically clients have been reported to attend day care two to three days per week for approximately five hours each day (Zarit et al., 1999). Most services (66 per cent) reported offering clients some degree of flexibility in attending for special reasons other than their allocated days. Of those that were not able to offer this flexibility, most highlighted the need for extra funding and resources to extent opening times, increase the numbers of staff, extend services to provide outreach and telephone support and make improvements to the building.

A distinct lack of service availability on evenings and weekends was also apparent. Consistent with the reputation of day care services as ‘middle of the day’ care, only ten facilities (13 per cent) provided evening care and 20 (25 per cent) provided weekend

care. The majority of services were offered on weekday mornings and afternoons. Most facilities were open for four days per week.

Appropriately staffed units are essential for providing appropriate day care (Finch and Orrell, 1999; Cherry and Rafkin, 1988). Personnel need to have adequate skills to provide an acceptable level of care to service users. Units tended to have one member of staff for every three to four users. However, day hospitals tended to have a greater number of and variety of professionally qualified staff groups.

Training is given significant priority in the NSFOP (Department of Health, 2001a) and the NHS Plan (Department of Health, 2000). However, unlike residential and nursing care and domicilary care, there have been no minimum standards set for the training of day care staff. This study showed that although 76 per cent *of services* reported that existing staff have received training in caring for people with dementia, only just over a third (37 per cent) of day care staff were reported to have had recent (in the last two years) training for caring for people with dementia. The type, quality and intensity of the training was not investigated but it is clear that the majority of day care staff require training in this area if we are to have a skilled and competent workforce.

Integration with other services was assessed by measuring the extent of close links with other services such as sharing accommodation and assessment procedures with other services and the provision of specialist training in dementia care to external agencies such as primary health care teams and social services departments. The degree of integration between services was generally low (below a third for most of our indicators). An integrated approach to older people with dementia is considered more likely to produce higher standards of care and improved outcomes (Audit Commission, 2000), government policy emphasises this (Department of Health, 2001a).

More than half of respondents considered their transport arrangements to be ineffective. Long delays prior to reaching the day hospital for users can be stressful and uncomfortable undermining the potential value of the service, especially for older people with dementia or the physically frail. More efficient and flexible methods of transport therefore need to be considered. The Audit Commission (2000) recommended that providers of day services monitor the effects of the transport they use and, if there are problems, consider changing to a more flexible arrangement, such as a local taxi service.

Although assessment is widely recognised as pivotal to the practice of health and social care in the community, not all respondents (72 per cent) reported completing an assessment form on people with dementia in the first three months of referral. An individual care plan should be used by all agencies for managing the care and treatment of older people including those with mental health problems (Department of Health, 2001a). Fifty-eight (77 per cent) of facilities reported that they made a care plan for each service user as a result of an assessment. Our assessment of these documents showed that on the whole, care plan documents were of a poor quality and could indicate a need for more comprehensive care plan documents which are accessible and contain clear instructions for completion.

Measuring rehabilitation and independence is difficult when addressing the needs of those with a degenerating condition. Whilst most services (72 per cent) considered

that the care they offered was tailored towards the needs of the individual, less than half (46 per cent) utilised memory/life story wallets, which have been associated with an improvement the quality of conversations (Bourgeois and Mason, 1996). A number of factors have been highlighted as important for the well-being of people with dementia: flexibility, responsiveness, a variety of stimulating activities for users and access to specialist input (Finch & Orrell, 1999). Day centres tended to have less access to occupational therapy, speech therapy and reality orientation and memory training than day hospitals. Many facilities in general operated from buildings which were not specifically designed or adapted for people with dementia. Almost 70 per cent of facilities in general did not have specially designed gardens and almost 80 percent of facilities in general did not have specially designed buildings. By not providing a day care environment conducive to rehabilitation, people with dementia are further disabled and consequently prevented from flourishing (Cunningham and Kesterton, 1997). Buildings should be appropriately designed, and facilities and equipment should be appropriate for people with dementia.

The extent of proactive policies for carers in each facility was assessed. Less than half of services had formal arrangements for carer support and this was reflected in a lack of specific arrangements for carers such as recording carer needs on assessment forms and providing specialist training in dementia care to carers. Given that unpaid informal care is vital in supporting people with dementia who live in the community (O'Connor et al., 1989) and forms a major part of the total costs of dementia care (Wimo et al., 1997; Kirchner et al., 2000), it is vital that services address the needs of carers.

7.2 A comparison of day care facilities: day hospitals compared with day centres

There is debate about whether the services offered by day hospitals and day centres overlap. Data regarding what is actually provided by services is rare and this research gap may have allowed commentators a free reign in this. The study has provided an important addition to the debate about the similarities and differences of day hospital and day centre care for older people with dementia. The results suggest, as have others (Collier and Baldwin, 1999; Murphy, 1994), that day care services offered by day centres and day hospitals are distinct and complementary, rather than overlapping. However, in contrast to the findings of Levin at al (1989), the relative proportions of mild or moderate and severe dementia were very similar for both day hospitals and day centres, suggesting that patients with the most severe dementia were not being directed towards clinically orientated day hospitals in the North West of England.

7.2.1 Service delivery

Day centres had a greater number of total places compared to day hospitals (1170 versus 891) but a similar number of places per facility (mean 26 versus 30). However, day hospitals had a greater number of designated dementia places (788 versus 629) and more per facility (mean 27 versus 15). Designated dementia places in day centres however were more likely to be occupied at the time of the survey than those in day hospitals (mean 87 per cent versus 77 per cent). The total number of service users

with dementia were distributed fairly evenly between the two types of services (1232 versus 1190) although capacity was higher in day hospitals (mean 40 versus 27).

The intensity of the service provided (most older people attended for three days or less) was similar in day hospitals and day centres. This was comparable with previous literature where typically clients have attended day care two to three days per week for about five hours each day (Zarit et al., 1999), but contrasted with other literature (Levin, 1989), which has suggested that day centres provide a less intensive level of care than day hospitals.

7.2.2 User-centred practice

Day hospitals scored higher then day centres on most of the items relating to user-centred practice. Day hospitals were more likely to use systematic assessment and care planning practices than day centres. These results corresponded to the primary function of these facilities (see Tables 5.8 & 5.9) and concurred with previous studies (Collier and Baldwin, 1999) where day hospitals have reported their primary function to be that of assessment. Day hospitals were also more likely to produce a care plan for each service user, and on average these were likely to be of significantly higher quality than those produced by day centres. This reflected, at least in part, the relatively structured environment one might expect in a health care setting. Overall levels of training provided to care staff was similar in both services.

Geriatric day hospitals have several functions but rehabilitation has been regarded as the most important (RCP, 1994). Reflecting this, day hospitals in the present study adopted significantly more rehabilitative approaches for people with dementia than day centres. Such factors included input from a broader range of specialist health professions, and the availability of occupational therapy, physiotherapy, speech therapy, reality orientation and reminiscence and snoezelen rooms. This may reflect advances in dementia care which move away from the mechanistic model of care (routines and tasks) to the development of the social-psychological model of dementia care.

Although overall levels were low, day hospitals reported significantly more building design features that facilitate choice and effective dementia care for the individual than day centres. These included greater use of signposting or other types of aids to visual access, and combination code door locks to provide greater independence to those individuals who might wander. Although the provision of excellent care is possible in a poor environment, more appropriate surroundings have been shown to be related to greater well-being in people with dementia through the encouragement of independence and choice.

While there were no major differences between service types in the provision of ‘individualised’ care to service users, it was found that day hospitals were more likely than day centres to be responsive to the needs of carers through adopting proactive practices (for example, greater levels of support to carers and increased carer involvement in reviews).

7.2.3 Organisation of care

There were fewer differences between the two service types with regard to the funding arrangements and the total number of qualified staff employed. However, almost a half (49 per cent) of respondents were unable to answer the question relating to the former. Day hospitals reported the highest levels of longer term funding, with approximately one quarter (27 per cent) reporting secured funding for over five years. Day centres were predominantly local authority-funded, whilst the funding source for day hospitals was almost always solely the NHS. Day centres tended to report funding arrangements lasting for one to five years, whilst day hospitals tended to report a higher degree of security, with longer term arrangements lasting for in excess of five years. Local authorities are required to charge for services, and most day centres (80 per cent) did so.

The total number of staff employed and the rate of staff to day care places in both services were comparable. However, as expected, a significantly higher proportion of day hospital staff were professionally qualified. Attendance of specialist training in caring for people with dementia on the other hand was slightly more common in day centre staff (but not significantly so). This increased level of training provision could be a direct result of employing fewer professionally qualified staff per week. Whilst Kitchen et al (2002) reported inadequate provision of occupational therapy in day hospitals, this study identified a mean of 1.27 occupational therapists in each day hospital, with occupational therapy sessions conducted in 67 per cent of day hospitals. This contrasted sharply with day centres, where most (95 per cent) did not have access to occupational therapists.

Transport arrangements were reported to be more effective in day centres than day hospitals, which are reliant on hospital transport. This contrasted with the trend for day hospitals to score highly on most of the items relating to user centred practice. This result helped illustrate the way in which day centres appeared to operate as a socially, rather than clinically orientated service (Collier and Baldwin, 1999), providing a complementary but distinct function when compared to day hospitals.

Greater integration between health and social care is both core government policy (Department of Health, 2000; Health Act, 1999) and is vital to ensure that provision meets the range and extent of need (Mountain and Godfrey, 1995). In this study, service integration was assessed through measuring the extent to which day care services shared factors such as accommodation and assessment procedures with other services, and linkages with other services through the provision of specialist training in dementia care to external bodies such as primary health care teams and social services departments. Overall, the results suggested that very few services were integrated.

7.2.4 Social compared with clinically orientated care

A picture emerged from the data in which day centres and day hospitals appeared to provide two distinct, but complementary types of care. Day centres described ‘social support’ as a primary function in over 90 per cent of cases, and regularly received referrals principally from social workers and care managers (84 per cent of services).

The service provided by day centres typically had an emphasis on flexibility of service provision with generally adequate transport arrangements.

Day hospitals tended to be solely NHS funded and experienced lower occupancy rates (77 per cent compared with 87 per cent in day hospitals). They all cited assessment as a primary function and most commonly received clinically orientated referrals, for example from consultant psychiatrists (83 per cent of services). Overall it appeared that day hospitals employed a broad range of qualified staff, and appeared to deliver a relatively high quality of clinically orientated care.

Although no cost analysis was undertaken as part of the present study, it is likely that day hospitals constituted a more expensive operation than day centres. However, they also provided a different service to that of day centres with emphasis placed on assessment, and medical expertise. Interestingly, the data did not concur with previous research suggesting that day centre care could be substituted for that provided by day hospitals (Curran, 1995), as the study found clear differences in the nature of the services they provided.

7.3 Methodological issues and constraints

The response rate achieved by the study was high (76 per cent) suggesting that the results were representative of day care facilities in the North West of England. The data is also likely to be generalisable to other parts of the country: The population aged over 65 years living in the North West of England represents 16 per cent of the population of England aged over 65, and has a similar age group percentage breakdown with England as a whole with 28 per cent aged between 65 and 69, 25 per cent between 70 and 74, 21 per cent between 75 and 79, 14 per cent between 80 and 84, eight per cent between 85 and 90 and four per cent being over the age of 90 (Census, 2001). The 22 local authorities in the North West of England represent 19 per cent of England's local authorities outside London (not including the district councils, which do not provide social care services) (LGA, 2003). The response rate indicated that the questionnaire was acceptable to respondents and compared well with a recent national survey of old age psychiatric day hospitals, which achieved a response rate of 47 per cent (Audini et al., 2001)

Whilst the overall response rate was good, only around a quarter of services responded to the initial mail-out. It was therefore deemed appropriate to adopt more assertive methods to ensure a maximum return rate (Edwards et al., 2001). Non-respondents were systematically targeted by telephone by a researcher, who provided further explanation of the study and sent additional questionnaires if required. This method was also used to clarify missing data.

Low numbers in some service types made certain statistical comparisons difficult in the first section of the report. In particular, while 38 day centres and 30 day hospitals were identified, there were only seven resource centres, three residential/nursing homes and just one in-patient ward. The small numbers would have reduced the power of statistical comparisons between service types. In the second section of the report, the resource centres were analysed along with the day centre group to maximise the validity of the statistical comparisons conducted. Although resource centres may have had some characteristics which were similar to day centres, there

were also important differences (for example they were larger). There may therefore be reasons to justify the reanalysis of the data without this group.

The problem of low group sizes was also apparent when comparing the relative performance of different local authority areas in the North West of England on key variables (Appendix 3). Whilst larger local authority areas had up to nine respondents (for example Lancashire), others (for example Rochdale) had only one. The effect of this was that scores on composite measures in local authority areas with a relatively high number of respondents may reflect a degree of regression to the mean and produce unremarkable scores on composite measures which were balanced out over a variety of different results from individual respondents. In contrast, regions with a relatively low number of respondents would be more likely to produce more extreme scores, as the sample size was small, and therefore less averaging out would be expected to occur (Shaughnessy and Zechmeister, 1990). This effect can be seen for example in the breakdown of total assessment scores by local authority area (Figure 2.1, Appendix 3). The two highest scores, and also the lowest score (14, 13 and 0) were each recorded by local authority areas with just one respondent (Halton, Warrington, and Rochdale, respectively). The three local authority areas with the highest number of respondents (Manchester, n=9, Lancashire, n=9 and Cumbria, n=9) all fell close to the mean (4.5, 6.5 and 8, respectively).

In relation to response rates, it should be noted that we made a number of assumptions in order to complete our calculations relating to our estimates of whether the North West of England as a whole, or individual local authority areas were adequately able to provide day care to people with dementia (see Table 5.14):

- That 9.3 per cent of the population aged over 65 have dementia (Hoffman et al, 1991)
- That non-respondents had a similar capacity to respondents

One of the main constraints of this research was the need to focus on the measurable. Many of the generally accepted principles of good practice or key design features were difficult to adequately assess through a postal questionnaire. Methods such as Dementia Care Mapping (Kitwood and Bredin, 1992), based on a person-centred philosophy of care (Kitwood and Benson, 1997), and self report methods (Mead and Bower, 2000), which measure psychological attributes or rely upon external observation methods, were unsuitable for this large scale survey. Like Sixma and colleagues (2000), a framework was adopted where quality was defined by the degree to which health and social care services met the needs of people with dementia with respect to important standards. Most of the information requested from respondents therefore related to process measures of care. The validity of the composite variables was assessed by contrasting groups (Streiner and Norman 1991). It was hypothesised that practices would differ between day centres and day hospitals. The significant differences found between day hospitals and day centres on many composite measures provided evidence on the validity of the constructs measured in the questionnaire. The internal reliability of our composite variables was assessed using Cronbach's Alpha. Acceptably high Alpha scores were found for 10 of the 12 composites, and the mean Alpha score was 0.63, suggesting that overall reliability was good. The two composites that failed to produce acceptably high Alpha scores (Service Flexibility and Care Worker Good Practice) were discussed in the relevant

sections of the report. One would not however expect very high internal consistency on such measures because higher endorsement of items reflects greater quality of care and the presence of one indicator should not necessarily predict the presence of another.

7.4 Further research

The results have the potential to provide each local authority with a benchmark of the level and quality of care offered. From the results, it is also possible to infer service gaps in particular areas. By estimating the rates of places per 1000 it has been possible to assess whether or not the capacity of services is in accordance with the level of need. Future research could investigate how the presence of day care services may influence the availability and use of other local services by assessing patterns of substitution and complementarity, and balance of care relationships of health and social services, residential care and home based-services.

The current study has assessed the 'quality' of care provided by different day care services. It has not addressed outcomes for service users or carers. As such, the present study has found such a degree of contrast between the two types of day care in terms of the service provided, it is not implausible that outcomes may also differ between them. Indeed, these results suggest that day hospitals may be an expensive alternative to day centres. Yet there are few studies which measure the efficacy of different forms of day care for people with dementia (Warrington and Eagles, 1995). Indeed, a recent review of day hospital care (Forster et al., 1999) excluded studies evaluating day hospital care for patients with dementia. There is still therefore a need for a systematic literature review to assess the evidence to date. Uncontrolled studies have indicated improvements in the mood and behaviour of new attendees at dementia specific day centres (Curran, 1996), and the review by Forster et al., (1999) referred to previously found no overall advantage for day hospital care compared with a range of alternative services. MacDonald et al (1982) however, compared outcomes in different types of day care for the elderly and found evidence of improved levels of dependency in day centres when compared to day hospitals, with no differences between the two in terms of mortality rates or improvements in dementia scores. The picture therefore remains unclear.

7.5 Conclusion

Current policy in England has emphasised the importance of caring for highly dependent older people for as long as possible at home (Sutherland, 1999, CM 4169, 1998; DoH, 2001). In order to assess whether this is actively being implemented and adequately resourced in the North West, we undertook an assessment of day care service provision. The data has a number of possible applications: to help policy makers in developing key performance indicators, to provide benchmarks for future follow-up and monitoring, and to assist service providers in improving services and setting of quality standards in the region.

The comparison of available day care places to estimates of people with dementia, along with the use of waiting lists for many services, indicates that the number of day care places appeared low in relation to the needs of the population. The data also suggest that improving access and engagement of people with severe dementia,

particularly in day hospitals should be a priority. More services need to be provided outside the normal hours to include evenings and weekends, and indeed many services were keen to offer greater flexibility but required further resources to extend opening hours, increase staff and make improvements to buildings. Although a high proportion of services were providing just to people with dementia (74 per cent), most facilities were not specifically designed or adapted for this group. Many staff (and consequently users) would also benefit from training with regard to caring for people with dementia. More efficient and flexible methods of transport should also be considered. Facilities should adopt more comprehensive assessment and care planning procedures and documentation along with life story wallets. Proactive policies to support carers (for example, allocation of staff time specifically to develop carer support groups) need to be extended so they can continue to care for highly dependent people with dementia.

The comparison of the services provided by day centres and day hospitals in this study has provided an important addition to the debate about their similarities and differences. The results suggest that day care services offered by both are distinct and complementary rather than overlapping. As there are no national standards for day care services, providing a clear assessment of quality is complex. However, this report assists by describing the present position in the North West of England against specific standards derived from a review of the literature. Examination of the data can provide an indication of what the current standards of care are and what is achievable. This report and the data which has informed it, provides a key vehicle for identifying and measuring the standard of and access to local specialist dementia services in the North West of England. The results provide essential information to aid the local planning and improvement of service provision. Moreover, they facilitate the completion of the milestone which requires that health and social care systems should have agreed protocols in place for the care and management of older people with mental health problems by 2004 (Department of Health, 2001a). A detailed comparison of actual performance with the available standards can enable a target for quality improvement to be set. The development of key performance indicators will also provide benchmarks for future follow-up and monitoring, and may lend themselves more readily to the setting of quality standards in the region and further afield.

Acknowledgements

This work was undertaken by PSSRU, which receives funding from the Department of Health. The views expressed in the publication are those of the authors and not necessarily those of the Department of Health. The study has been supported by funding from the North West NHS Executive. The authors are grateful to Gill Dunkerley, Irene Pederson and Mandy Bryant for their unfailing persistence to increase the amount and quality of data collected. The opinions expressed are the responsibility of the authors alone.

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APPENDIX 1

For office use only

North West Dementia Centre

(1-5) ☐☐☐☐☐

MAPPING SPECIALIST DEMENTIA SERVICES IN THE NORTH WEST OF ENGLAND

DAY CARE QUESTIONNAIRE

This questionnaire is designed for a range of service providers and not all the questions will be relevant for all services. Please complete as far as possible.

Contact Details

Name of service /facility: .....

(If you are completing this form on services which span more than one site please complete a separate form for each facility)

Address: .....

.....

Postcode ☐☐☐☐ ☐☐☐ (6-12) *(Please ensure each facility has the correct post code)*

Telephone: .....

Fax number: .....

Email address: .....

Your name: .....

Your role: 1= Manager / Officer in charge /deputy manager ☐ (13)
2= Group leader
3= Nurse in charge
4= Staff nurse
5= Administrator
6= Other (please specify)……

☐☐ (14-15)

Does this service provide:

Day care	☐ no ☐ yes	(16)
Residential care	☐ no ☐ yes	(17)
Home care / community support services	☐ no ☐ yes	(18)

If your facility includes services other than day care, we will send you further questionnaire(s).

*** ! REMINDER ! ***

Please send us any documentation relating to your service on the following areas to further inform the North West Dementia Centre's Service Directory

Extra documents enclosed	*(tick box)*
Service information / other publicity material	☐ (19)
Assessment documents	☐ (20)
Care plan form	☐ (21)

PLEASE RETURN COMPLETED FORMS ALONG WITH ANY OTHER DOCUMENTS TO:

North West Dementia Centre,
Personal Social Services Research Unit,
Dover Street Building,
The University of Manchester,
Oxford Road,
Manchester, M13 9PL
by 31st August 2001
(Pre-paid envelope enclosed)

INFORMATION ABOUT YOUR SERVICE

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Service Users

1. Please *estimate* the approximate percentage of your users who suffer from dementia *(though they might not have a diagnosis of dementia)* or are confused:

0 = none
1 = 1-20%
2 = 21-40%
3 = 41-60%
4 = 61-80%
5 = 81-100%

☐ (22)

2. Please indicate the lower age boundary for people with dementia being accepted into your facility:

0= no age boundary
1= 60 years
2= 65 years
3= 70 years
4= 75 years
5= other (please specify) ……

☐ (23)

☐☐ (24-25)

3. Thinking about the people who suffer from dementia, *please estimate* the percentage of those who suffer from:

Mild /moderate cognitive impairment ☐☐☐% (26-28)
Severe cognitive impairment ☐☐☐% (29-31)

4. Does your centre have any of the following for current or potential users of your service?

Leaflets describing the centre & services offered ☐ (32)
Evaluation/ satisfaction questionnaires ☐ (33)
Other material ☐ (34)
(please specify)…….....

☐☐ (35-36)

Please send us any information /publicity material for your facility.

Service description

5. Within which sector does your service operate? *(Tick relevant boxes)*

Local authority ☐ (37)
NHS ☐ (38)
Voluntary ☐ (39)
Private ☐ (40)
Other ☐ (41)
(please specify)……

☐☐ (42-43)

6. Which of the following best describes your facility? ☐ (44)

1= Day centre
2= Day hospital
3= Resource centre
4= In patient ward
5= Residential / nursing home
6= Other (please state) …….

☐☐ (45-46)

7. Does this service accept self referrals or referrals from friends, relatives and neighbours?

☐ no ☐ yes (47)

8. Which of the following organisations/ agencies **routinely make referrals** to your service?

Community mental health teams ☐ (48)
Community psychiatric nurses ☐ (49)
Social workers / Care managers ☐ (50)
Consultant psychiatrists ☐ (51)
Residential and nursing home staff ☐ (52)
Occupational therapists ☐ (53)
General practitioners (or other primary care workers) ☐ (54)
Clinical psychologist ☐ (55)
Other (please specify) ☐ (56)
……

☐☐ (57-58)

9. Which of the following do you provide? *(Tick relevant boxes)*

	Primary* function	Secondary function	
Assessment	☐	☐	(59-60)
Reality orientation	☐	☐	(61-62)
Bathing service	☐	☐	(63-64)
Dental services	☐	☐	(65-66)
Nursing care	☐	☐	(67-68)
Physiotherapy	☐	☐	(69-70)
Speech therapy	☐	☐	(71-72)
Occupational therapy	☐	☐	(73-74)
Reminiscence / life story work	☐	☐	(75-76)
Physical exercise	☐	☐	(77-78)

	Primary* function	Secondary function	
Social support	☐	☐	(79-80)
Monitor users physical & mental health	☐	☐	(81-82)
Outreach - home based care	☐	☐	(83-84)
Outreach - to other services	☐	☐	(85-86)
Respite for carers	☐	☐	(87-88)
Information to assist in caring process for carers	☐	☐	(89-90)
Sitting service	☐	☐	(91-92)
Other *(please specify)*…….....….	☐	☐	(93-94)

☐☐ (95-96)

* activities which reflect a prime function of the resource

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10. Activity and occupation are seen as central to promoting well being for older people with mental health problems. If your service provides therapeutic activities (in addition to or including the ones above), please list the four most frequently undertaken

First activity ..... ☐☐ 97-98
Second activity ..... ☐☐ 99-100
Third activity ..... ☐☐ 101-102
Fourth activity ..... ☐☐ 103-104

11. Do you feel your service is able to provide an individualised provision of care to people with dementia?

☐ no ☐ yes (105)

a) How do you think this might be improved? ……. ☐☐ 106-107
…… ☐☐ 108-109

Total capacity / activity

12. How many **day care places** are there **(in total) per day**? ☐☐☐ (110-112)

13. How many **day care places** are specifically designated for **people with dementia per day**?
(Please complete on a day when people with dementia usually attend) ☐☐☐ (113-115)

14. How many **day care places designated for people with dementia** are currently **occupied today**?
(*or please complete on the next day when people with dementia would usually attend)* ☐☐☐ (116-118)

15. If this service is for older people with a range of mental health problems, are people with dementia seen:

On separate days ☐ (119)
In a separate building ☐ (120)
In a separate part of the building ☐ (121)
Other (please specify)…….. ☐ (122)
Not applicable as this service is provided solely for older people with dementia ☐ (123)

☐☐ (124-125)

16. What is the **total number of service users** currently on your register of attendees? ☐☐☐ (126-128)

17. What is the **total number of service users with dementia** currently on your register of attendees?
☐☐☐ (129-131)

18. Of all your **service users with dementia** what proportion currently attend:

1 day per week ☐☐☐% (132-134)
2 days per week ☐☐☐% (135-137)
3 days per week ☐☐☐% (138-140)
4 days per week ☐☐☐% (141-143)
5 days per week ☐☐☐% (144-146)
6 days per week ☐☐☐% (147-149)
7 days per week ☐☐☐% (150-152)

(The numbers you insert should add up to 100%)

19. Of all your **service users with dementia** how many currently **also receive home care**?
☐☐☐ (153-155)

20. Does your service have a waiting list? ☐ no ☐ yes (156)
a) if yes, how long is the current waiting list? ☐☐ *(months)* (157-158)

21. Does this facility provide services for a limited time period? ☐ no ☐ yes (159)
a) if yes, what is the maximum time period? ☐☐ *(months)* (160-161)
(include the assessment period)

22. On which days of the week and at what time is this service available to **people with dementia**?

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	Morning	*Afternoon*	*Evening (after 6pm)*
Monday	☐ (162)	☐ (163)	☐ (164)
Tuesday	☐ (165)	☐ (166)	☐ (167)
Wednesday	☐ (168)	☐ (169)	☐ (170)
Thursday	☐ (171)	☐ (172)	☐ (173)
Friday	☐ (174)	☐ (175)	☐ (176)
Saturday	☐ (177)	☐ (178)	☐ (179)
Sunday	☐ (180)	☐ (181)	☐ (182)

23. On a normal weekday, what time does this service:

a) open ☐☐☐☐ (183-186) b) close ☐☐☐☐ (187-190)

24. Can users attend this service, for special reasons, other than on their allocated days? ☐ no ☐ yes (191)

a) If no, how could the flexibility of your serviced be improved…..…….
…… ☐☐ (192-193)

25. We are interested in how users are transported to and from the service.
Do they arrive or leave by the following:

Hospital transport	☐ (194)	Trained volunteer drivers	☐ (198)
Family carers	☐ (195)	Dial-a-ride	☐ (199)
Taxi	☐ (196)	Other (please specify)……..	☐ (200)
Local authority transport	☐ (197)		

☐☐ (201-202)

26. Do you think transport arrangements to and from the service are effective in meeting the needs of the individual? ☐ no ☐ yes (203)

a) If no, how do you feel this could be improved …….
…… ☐☐ (204-206)

27. How many of all your current users are from ethnic minority groups? ☐☐ (207-208)

28. Whether or not you currently have any users from ethnic minority groups have you made any of the following special arrangements for people from ethnic minority groups? *(tick relevant boxes)*

Religious observation / spirituality *e.g. areas for prayer/ meditation, links with religious & spiritual bodies*	☐ (209)
Language resources *e.g. translated leaflets, interpreter service*	☐ (210)
Food - diet / storage/ preparation /cooking *e.g. catering for specific dietary requirements*	☐ (211)
Personal care *e.g. provision of appropriate washing facilities*	☐ (212)

Funding

29. We are interested in identifying how services are funded. Please indicate whether the service is funded in part or wholly by any of the following:

	All	*Part*		*All*	*Part*
Health authority/ trust	☐ (213)	☐ (214)	Voluntary sector	☐ (217)	☐ (218)
Local authority	☐ (215)	☐ (216)	Other (please specify)……	☐ (219)	☐ (220)

☐☐ (221-222)

30. We are also interested in the security of funding arrangements.
Is your service currently funded for : 1=Up to 1 year 2=One to 5 years 3=More than 5 years ☐ (223)

31. Can service users be charged for attendance of this service? ☐ no ☐ yes (224)

a) If yes, how many of your current service users with dementia are charged? ☐☐☐ (225-227)

Personnel

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32. Which of the following does your facility **receive from outside your service**? *(do not include any of the following professionals who are part of the staff group - see Q 33 & Q34)*

Community psychiatric nurse(s)	☐ (228)	Occupational therapy	☐ (231)
Social worker(s)	☐ (229)	Speech therapy	☐ (232)
Old age psychiatrist outreach clinics	☐ (230)	Physiotherapy	☐ (233)

External training of day care staff provided by any of the above professional groups (please specify training providers)..... ..... ☐ (234)

Other external inputs (please specify)……..... ..... ☐ (237)

☐☐ (235-236)

☐☐ (238-239)

33. We are interested in how many **care staff** work in this service in the course of **a week**. In the table below please provide details on the **total number of actual staff** for each staff group in addition to the **total number of whole time equivalent staff**. ***Please use the example for guidance.***

	Total number of actual staff members *(whole numbers)*	**Total number of whole time equivalent (WTE) staff** *(whole numbers or decimal places)*
Example: **Nurses (qualified)** ***5 part time nurses (0.5 each) + 1 full time***	☐☐	☐☐.☐☐
Nurses (qualified)	☐☐ (240-241)	☐☐.☐☐ (242-246)
Nursing staff (unqualified /support workers)	☐☐ (247-248)	☐☐.☐☐ (249-253)
Social work staff (qualified ie CQSW/ CSS/ NVQ lev 4)	☐☐ (254-255)	☐☐.☐☐ (256-260)
Social care staff (non-nursing)	☐☐ (261-262)	☐☐.☐☐ (263-267)

34. We are also interested in how many **care staff** work in this service **in the course of a week on a sessional basis**. In the table below please provide details on the **total number of actual staff** for each staff group in addition to the **total number of sessions**. ***Please use the example for guidance.***

****(1 session=½ day or approx 4 hrs)***	**Total number of actual staff members** *(whole numbers)*	**Total number of sessions (1 session=½ day or approx 4 hrs)** *(whole numbers or decimal places)*
Example: **Occupational therapists** ***3 individual OTs (two sessions each*)***	☐☐	☐☐.☐☐
Occupational therapists	☐☐ (268-269)	☐☐.☐☐ (270-274)
Occupational therapist helpers	☐☐ (275-276)	☐☐.☐☐ (277-281)
Physiotherapists	☐☐ (282-283)	☐☐.☐☐ (284-288)
Physio- helpers	☐☐ (289-290)	☐☐.☐☐ (291-295)
Speech therapists	☐☐ (296-297)	☐☐.☐☐ (298-302)
Clinical psychologists	☐☐ (303-304)	☐☐.☐☐ (305-309)
Activity staff	☐☐ (310-311)	☐☐.☐☐ (312-316)
Trained volunteer staff or paid helpers	☐☐ (317-318)	☐☐.☐☐ (319-323)
Consultant psychiatrists	☐☐ (324-325)	☐☐.☐☐ (326-330)
Other staff (please specify) ……	☐☐ (331-332)	☐☐.☐☐ (333-337)

☐☐ (338-339)

35. On average how many people usually staff this unit / service at any one time? ☐☐ (340-341)

36. Do new staff receive an induction? ☐ no ☐ yes (342)

a) If yes, is there a specific component of this induction which focuses on caring for people with dementia? ☐ no ☐ yes (343)

37. Have any of **the care staff** in this facility undergone any specific training **for caring for people with dementia** (in-house or external), in addition to any induction, *in the past 2 years*? ☐ no ☐ yes (344)

If yes, how many have had training ☐☐ (345-346)
Please provide details.....
.....

For office use only ☐☐ (347-348)

38. Do any of your staff **provide** specialist training in dementia care to any of the following?

Residential or nursing homes	☐ (349)	Community mental health teams	☐ (352)
Primary health care teams / GPs	☐ (350)	Carers	☐ (353)
Social services departments	☐ (351)	Other (please specify)…….	☐ (354)

☐☐ (355-356)

Person Focused Care

39. Do you operate within the CPA policies and procedures? ☐ no ☐ yes (357)

40. Do you have a key worker / named nurse system in operation? ☐ no ☐ yes (358)

41. Do you complete an assessment form on people with dementia in the first three months of referral? ☐ no ☐ yes (359)

<u>If yes, please send us copies of your assessment forms.</u>

We would prefer you to send copies of your assessment form, but if this is not possible please complete Q42, otherwise go to Q43:

42. Does your assessment form specify the following? *(tick relevant boxes)*

Mobility & ADL	☐ (360)	Continence	☐ (366)	Carer needs /support given	☐ (372)
Daily routine /preferences	☐ (361)	Cognitive patterns	☐ (367)	Disease /health conditions	☐ (373)
Teeth and nutrition	☐ (362)	Depression /anxiety/ /mood state	☐ (368)	Medication	☐ (374)
Skin & foot care	☐ (363)	Social /recreational activity	☐ (369)	Do service users participate in assessments?	☐ (375)
Communication / hearing patterns	☐ (364)	Familiar cultural traditions	☐ (370)		
Vision patterns	☐ (365)	Religious observance	☐ (371)		

43. Do you make a care plan for each service user as a result of this assessment? ☐ no ☐ yes (376)

<u>If yes, please send us a blank copy of a care plan form</u>

44. Do you send copies of care plans to relatives? 1= Routinely 2= Occasionally 3= On request 4= Never ☐ (377)

45. Do you have a planned review of each service user? ☐ no ☐ yes (378)

a) If yes, how often do you undertake this review?

1= Monthly
2= Two monthly
3= Three monthly
4= Every four or five months
5= Six monthly
6= 12 monthly
7= Other (please specify) ……
☐ (379)

☐☐ (380-381)

46. Do you routinely invite relatives / carers to your reviews? ☐ no ☐ yes (382)

47. Do relatives /carers attend reviews?

1= Often
2= Sometimes
3= Rarely
4= Never
☐ (383)

48. Do you have any formal arrangements or resources for providing support for close relatives / friends of users with dementia, in addition to respite care (detailed in Q.9)? ☐ no ☐ yes (384)

If yes, please describe ……..

☐☐ (385-386)

49. Is staff time allocated to support the development of self-help/ support groups for carers?

☐ no ☐ yes (387)

For office use only

50. Do you have contact with other specific dementia services in your area? ☐ no ☐ yes (388)

If yes, please provide details……..

…… (389-390) (391-392)

51. Are you **closely linked with any other services** by sharing any of the following: *(tick relevant boxes)*

Accommodation	☐ (393)	if yes, please specify relevant service(s)……	(394-396)
Management	☐ (397)	if yes, please specify relevant service(s)……	(398-400)
Single telephone number	☐ (401)	if yes, please specify relevant service(s)……	(402-404)
Single point of referral	☐ (405)	if yes, please specify relevant service(s)……	(406-408)
Assessment forms	☐ (409)	if yes, please specify relevant service(s)……	(410-412)
Care plan forms	☐ (413)	if yes, please specify relevant service(s)……	(414-416)
Client record databases system	☐ (417)	if yes, please specify relevant service(s)……	(418-420)
Case files /filing system	☐ (421)	if yes, please specify relevant service(s)……	(422-424)
Other	☐ (425)	if yes, please specify relevant service(s)……	(426-428)

52. Does your facility employ any of the following methods or approaches in the care of people with dementia? *(Tick relevant boxes)*

Memory/life story wallets/ files	☐ (429)	Alarm systems	☐ (434)
Policy of no uniforms for staff	☐ (430)	Tagging devices	☐ (435)
Shared meal times for users and staff	☐ (431)	Special liaison with police service	☐ (436)
Hazard warning symbols	☐ (432)	Other (please describe)	☐ (437)
Reality orientation boards	☐ (433)	……	

(438-439)

53. Does your building have any of the following special design features for people with dementia? *(Tick relevant boxes)*

Specially designed building	☐ (440)	Carpet zoning and guidance	☐ (446)
Specially designed garden	☐ (441)	Colour coded doors	☐ (447)
Enclosed secure outside space	☐ (442)	Combination code door locks	☐ (448)
Snoezelen/sensory rooms	☐ (443)	Enhanced lighting	☐ (449)
Reminiscence room/ area	☐ (444)	Other (please describe)	☐ (450)
Signposting or aids to visual access	☐ (445)	……..	

(451-452)

54. Has your service undergone any service evaluation, monitoring or auditing in the last year?

☐ no ☐ yes (453)

a) If yes, please provide details……..

(454-455)

Finally,

55. How much of the questionnaire did you feel able to answer with confidence?

1= All questions 3= Some questions ☐ (456)

2= Most questions 4= Few questions

OTHER SERVICES & ADDITIONAL COMMENTS

Please add any additional comments you might have in the space provided below if

a) there are any other services provided by your establishment for people with dementia

b) you would like to elaborate on any of the questions you have already answered

c) you would like to raise any other issues.

If necessary, please continue overleaf.

(457-458)

.....

(459-460)

.....

(461-462)

.....

(463-464)

.....

(465-466)

.....

(467-468)

Many thanks for your assistance in completing this form.
(SEE FRONT SHEET FOR RETURN ADDRESS)

APPENDIX 2: DEMENTIA PREVALANCE RATES

Estimates of dementia prevalence rates were derived from work by Hofman et al (1991). This major demographic study pooled 23 datasets of European studies. It is also important to note that estimates from the United Kingdom suggest there will be a 50 per cent increase in the total number of persons age 65 and older with cognitive impairment over the next 25 years (Melzer et al., 1997).

Table A1: Percentage of dementia cases in people over 65yrs by age group

65-69	70-74	75-79	80-84	85-89	90-94	95-99	Total over 65
25/1740	64/1559	125/2203	189/1453	258/1197	115/357	24/69	800/8578
1.4%	4.1%	5.7%	13.0%	21.6%	32.2%	34.7%	9.3%

Source: Hofman et al. (1991)

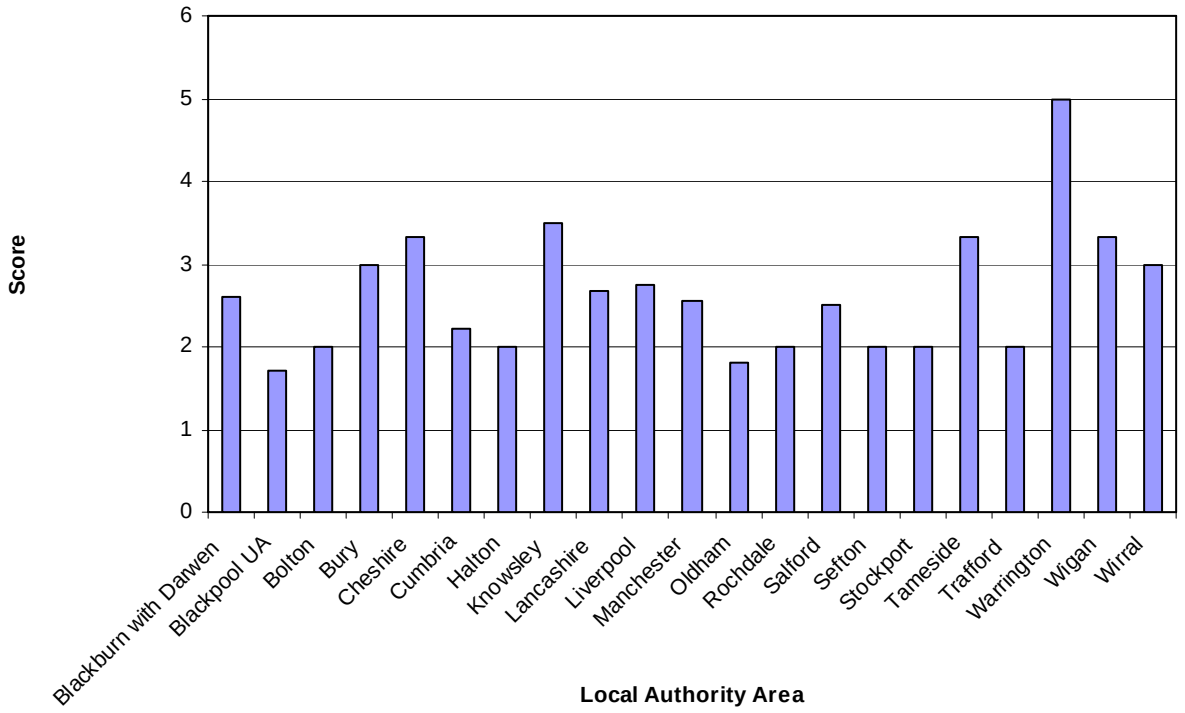
Dementia prevalence rates were combined with population figures for each of the local authority areas in the North West of England, and data relating to the availability of day care places from the current study, in order to obtain estimates of the proportion of the population with dementia attending day care services, and the availability of day care places per 1000 population aged over 65 years.

APPENDIX 3: STANDARDS OF CARE BY LOCAL AUTHORITY AREA

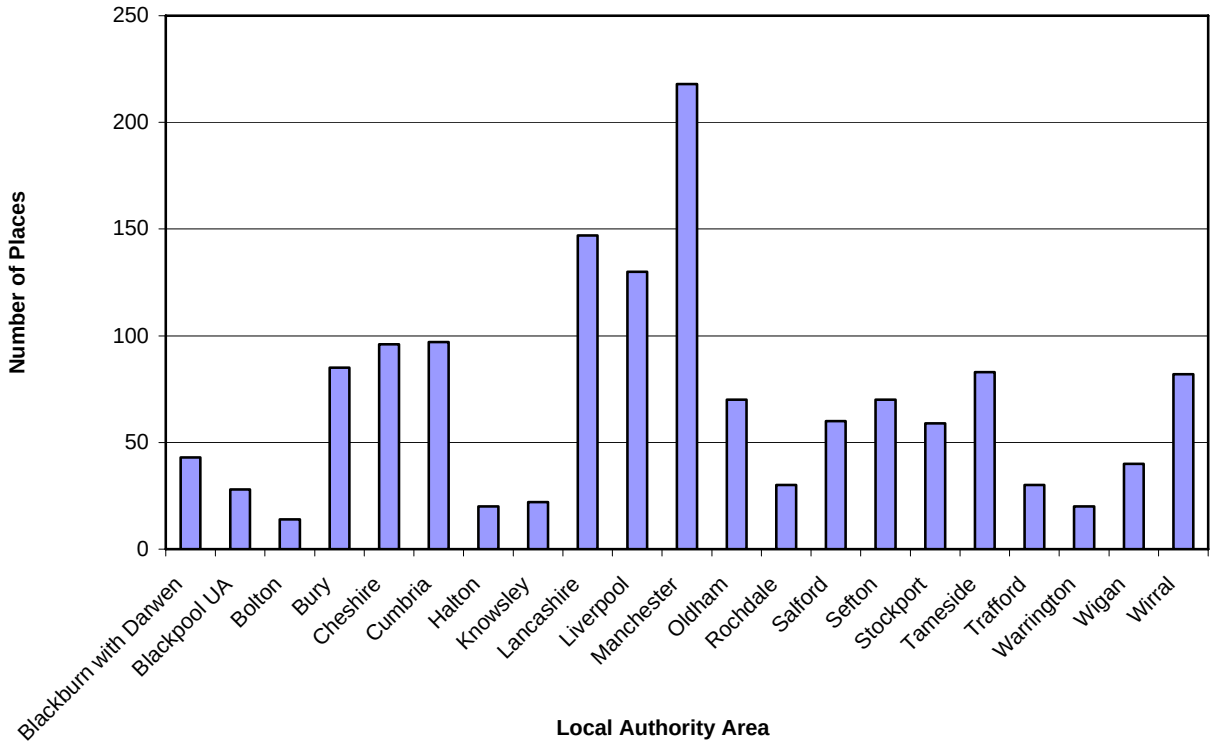
The data was analysed on each of the standards of care measured by the study according to local authority area. The following graphs provide an indication of service provision and regional variations in the North West of England. Splitting the data in such a way was problematic; in some areas (for example Rochdale) there was only one responding day care facility for the region, whilst in others there were up to 9 respondents (Cumbria and Lancashire). These variations in the number of respondents carried implications for the reliability of the data (see 'Methodological issues and constraints' for a discussion of this). One should therefore take the relative number of respondents into consideration when local authority areas are compared.

1. Service delivery

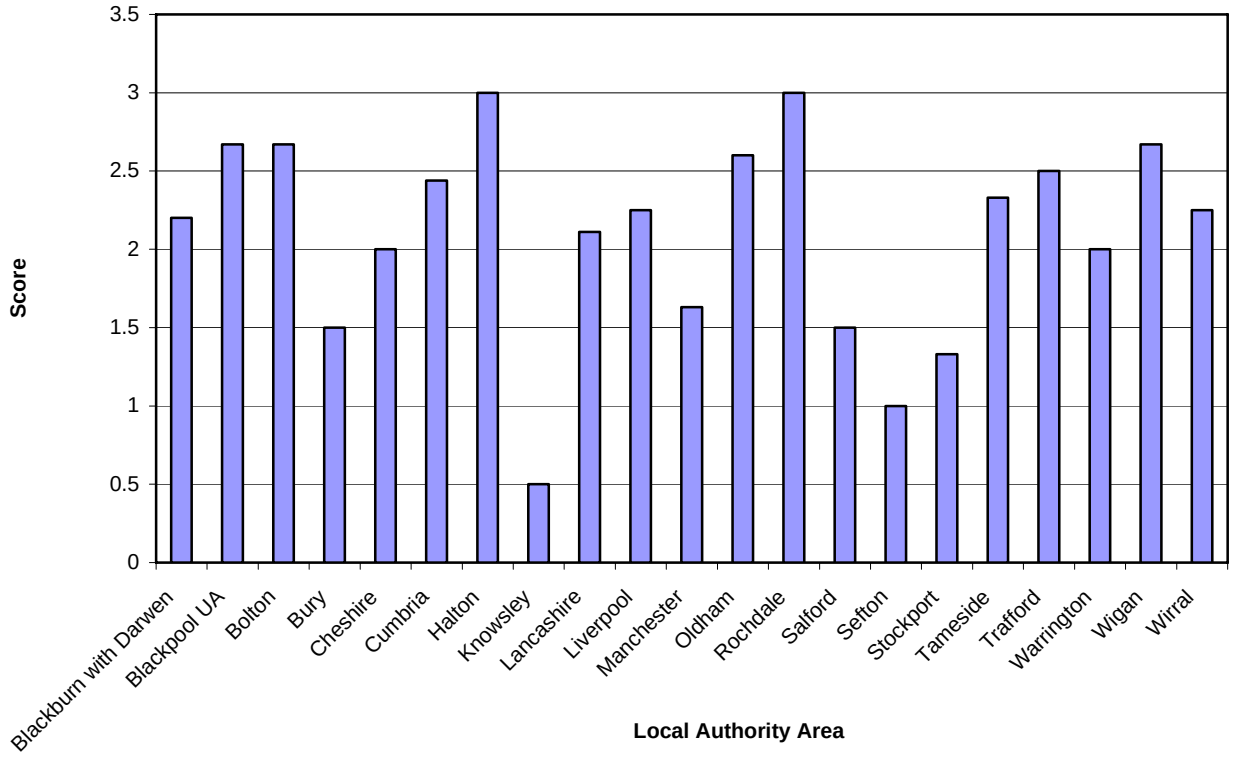
i. Service flexibility mean score (Composite variable)



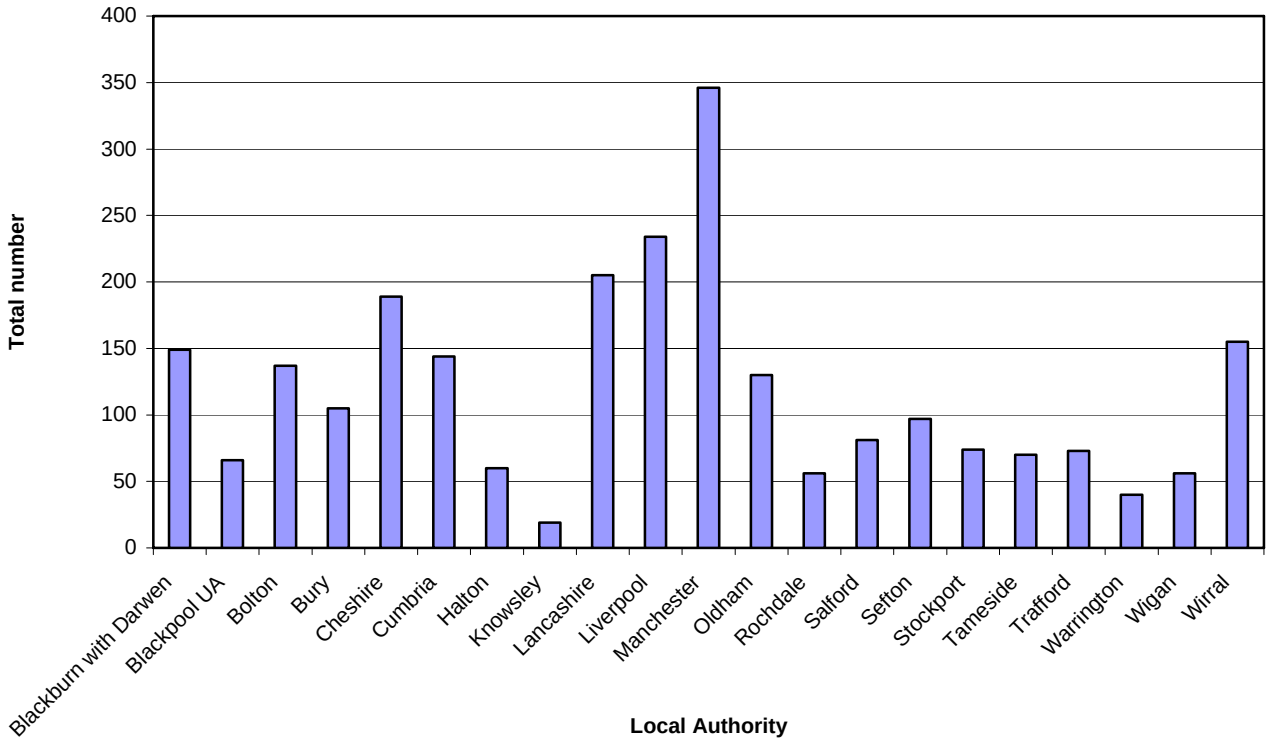
ii. Total designated dementia day care places



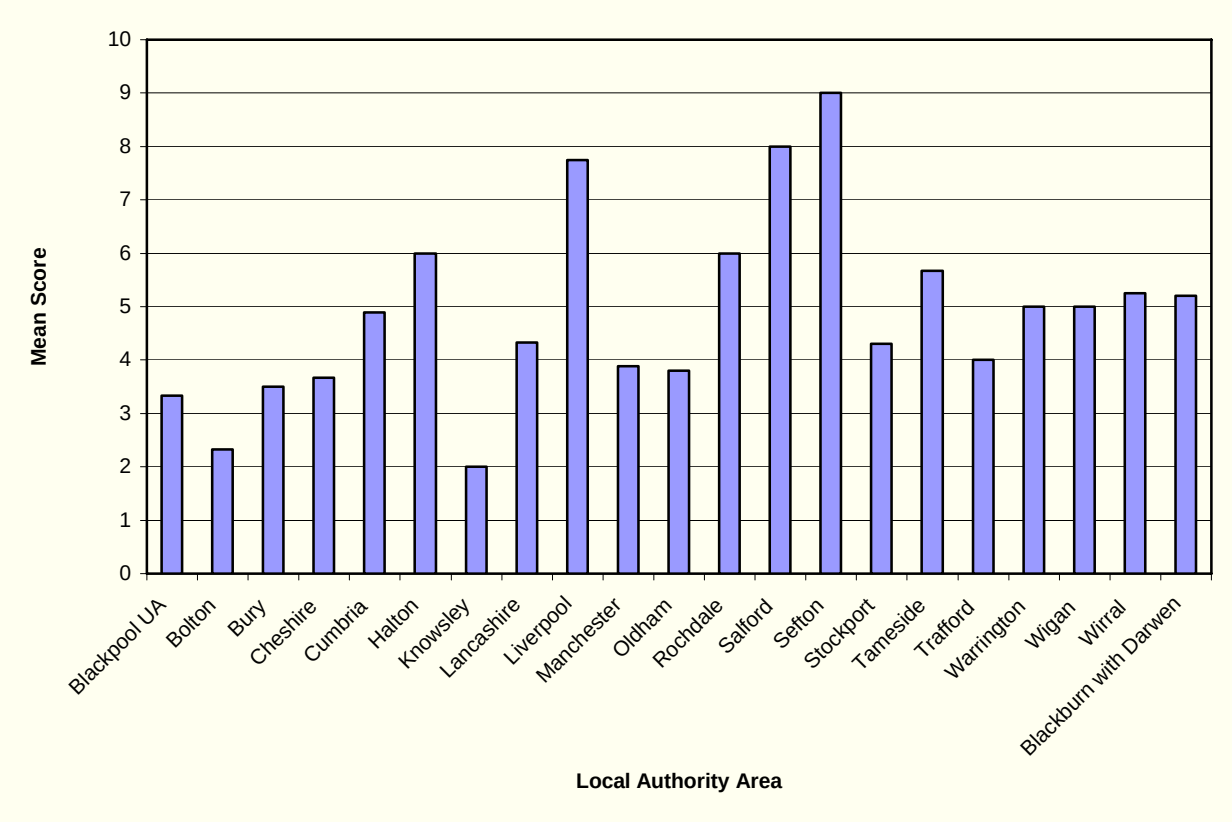
iii. Care worker good practice



iv. Total number of service users with dementia

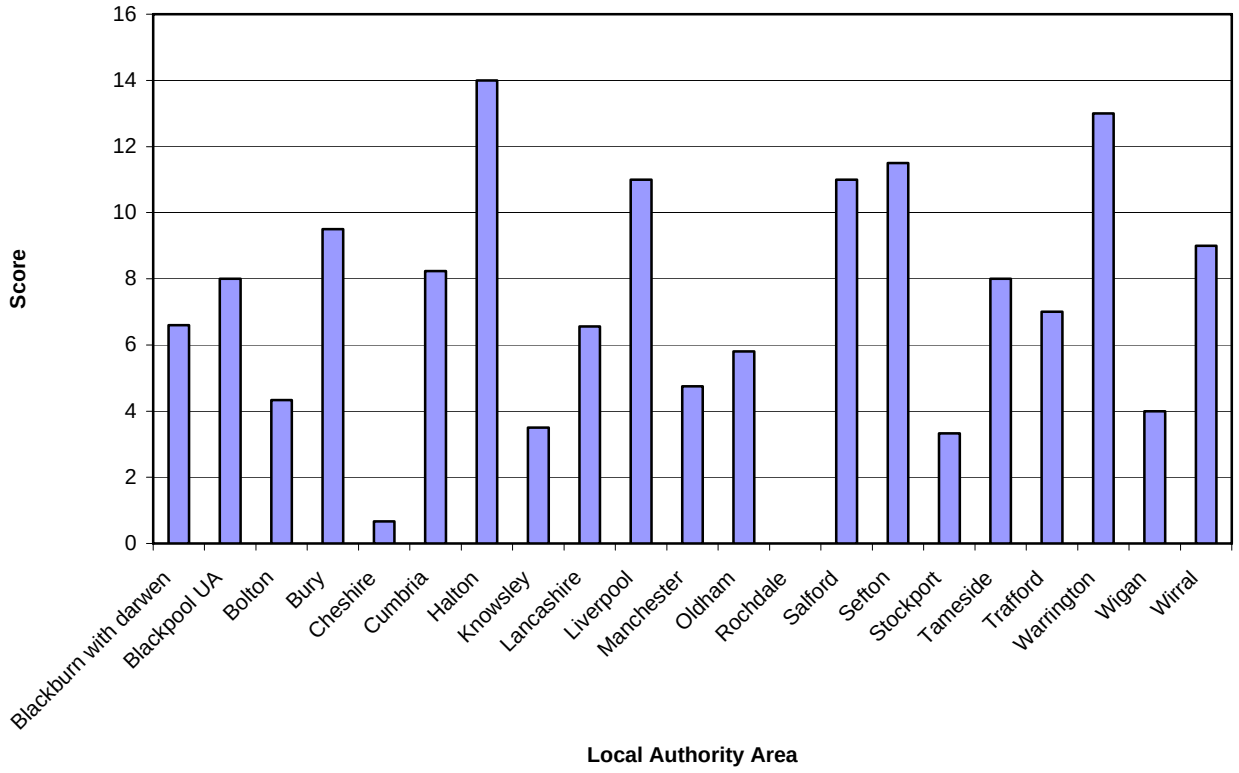


v. Service specialism mean score (composite variable)

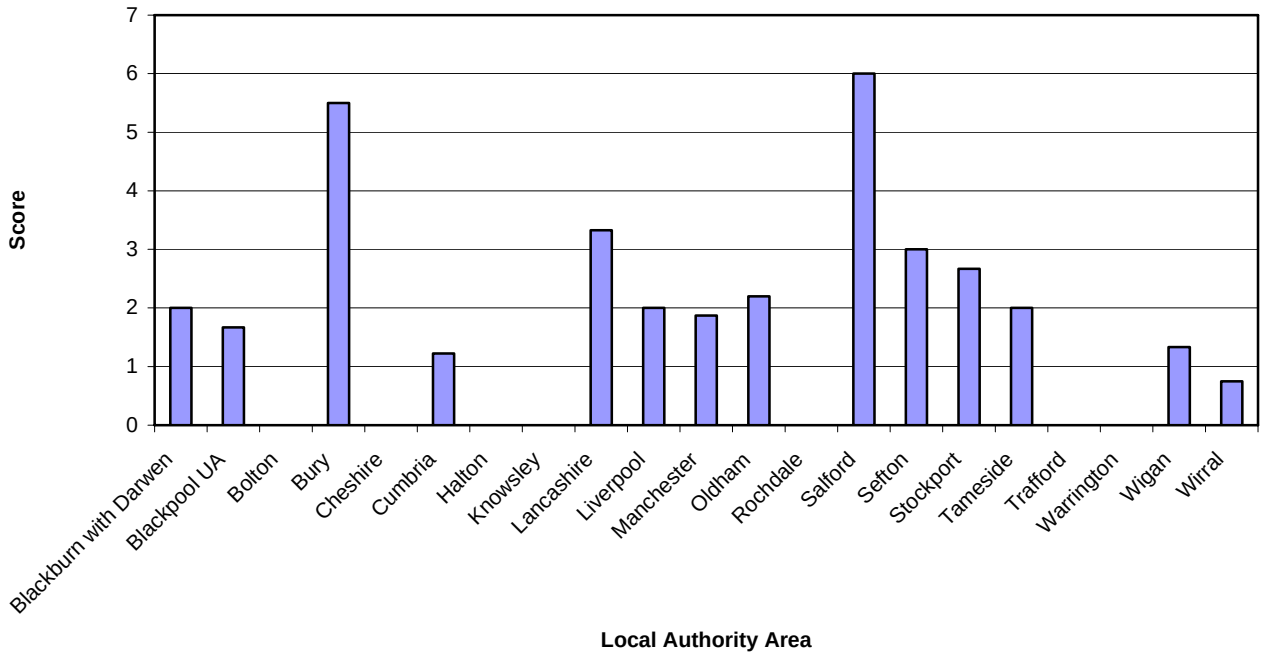


2. User centred practice

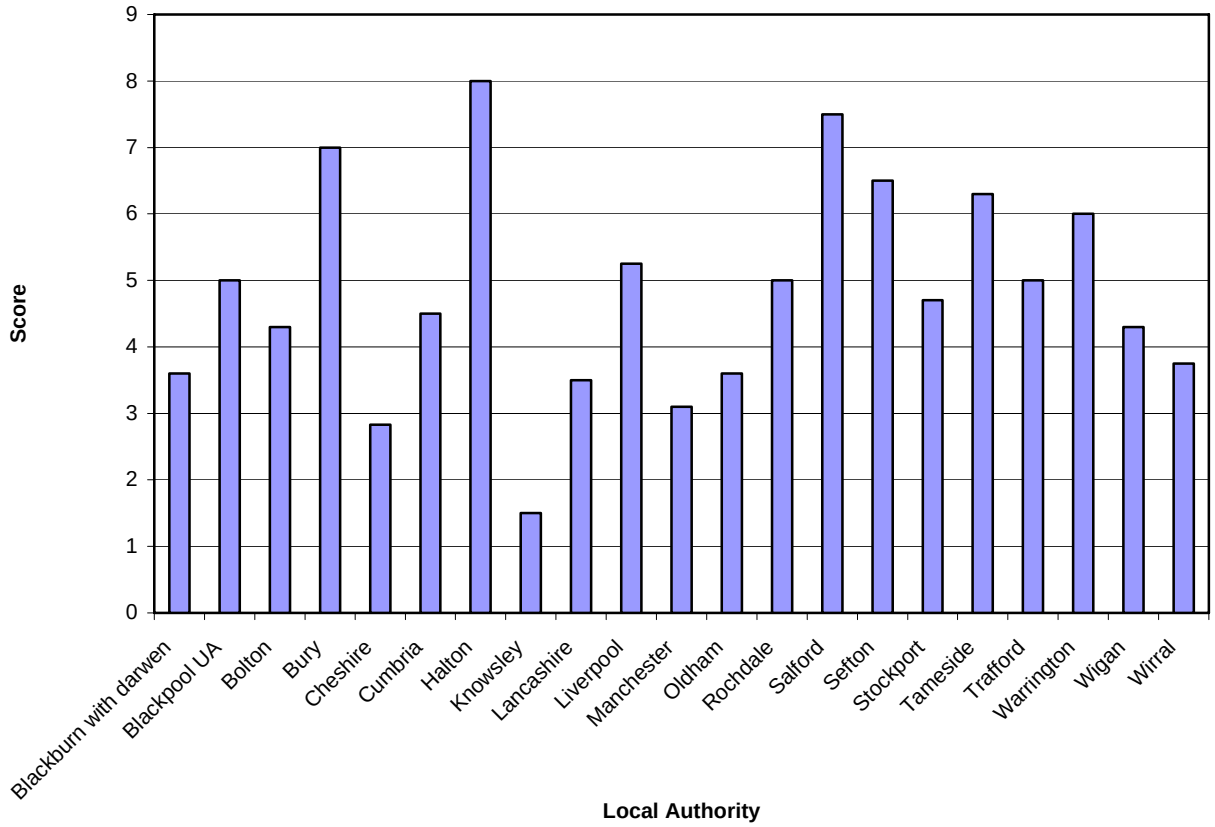
i. Total assessment score



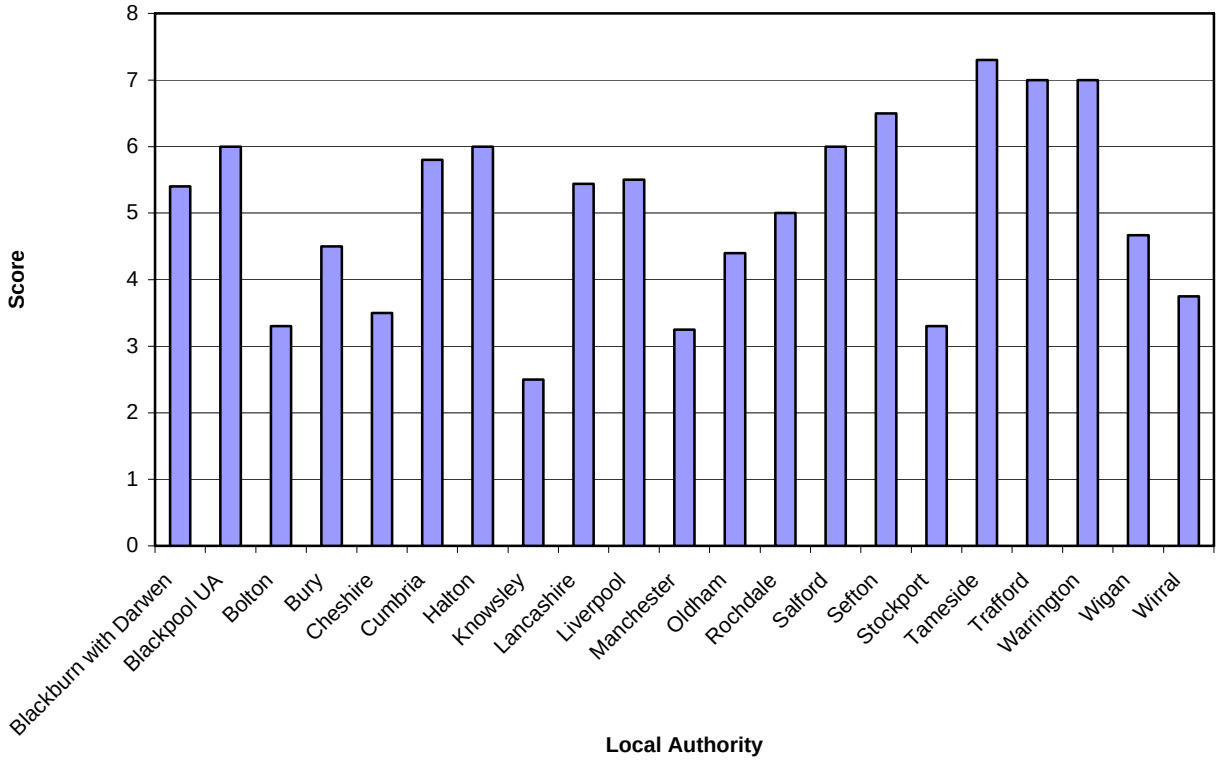
ii. Overall quality of care plan



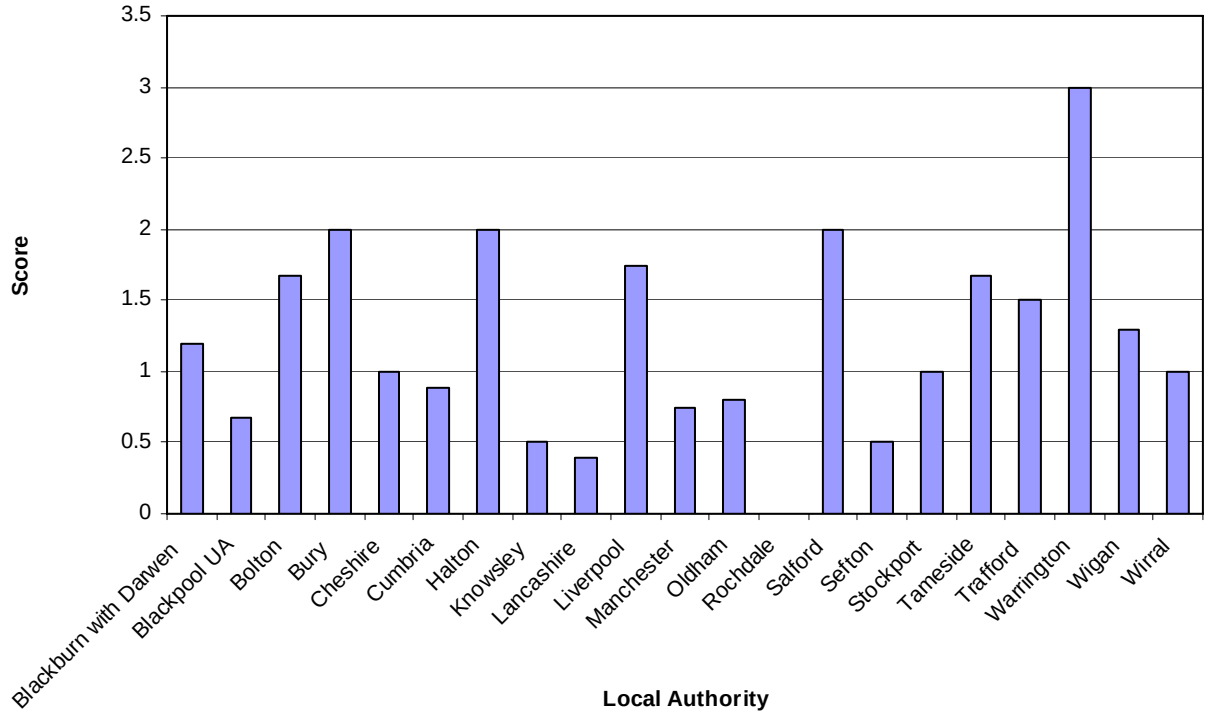
iii. Rehabilitation potential



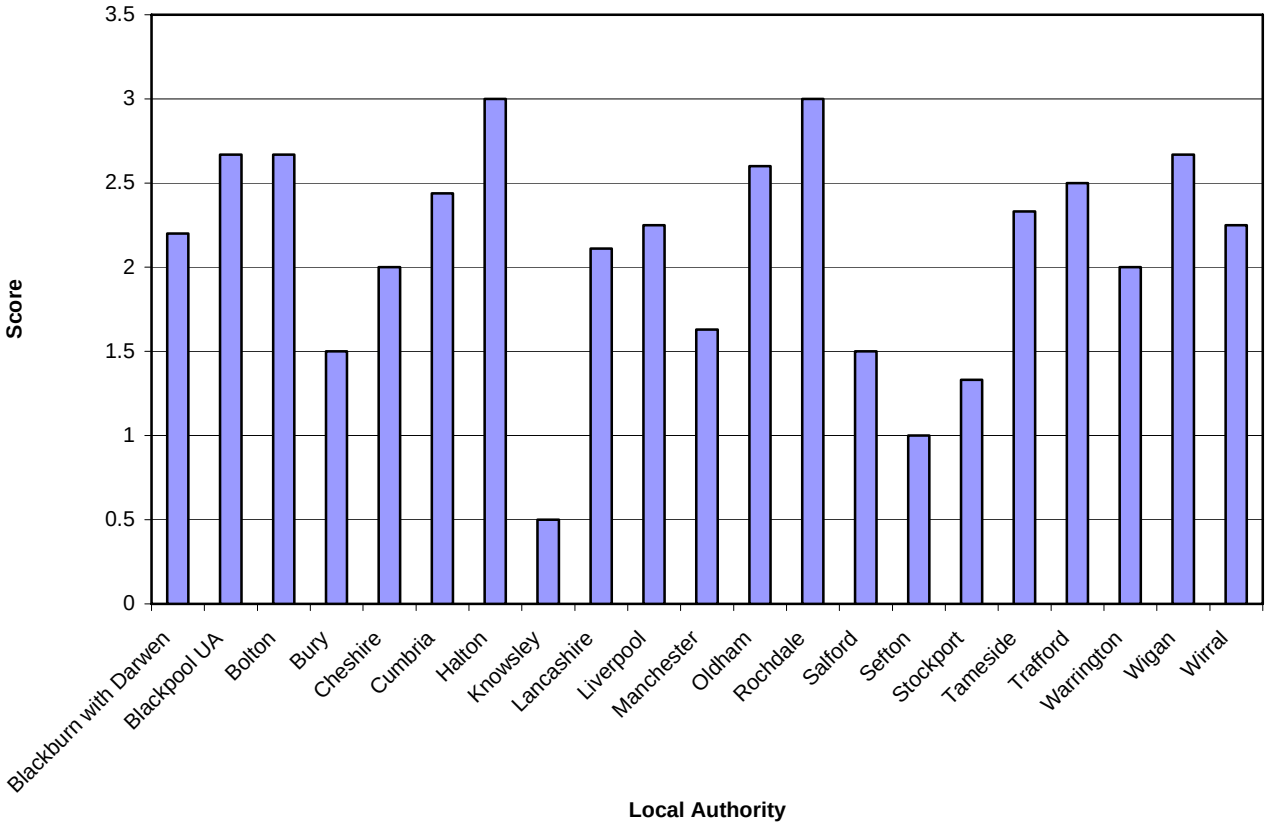
iv. Individual care



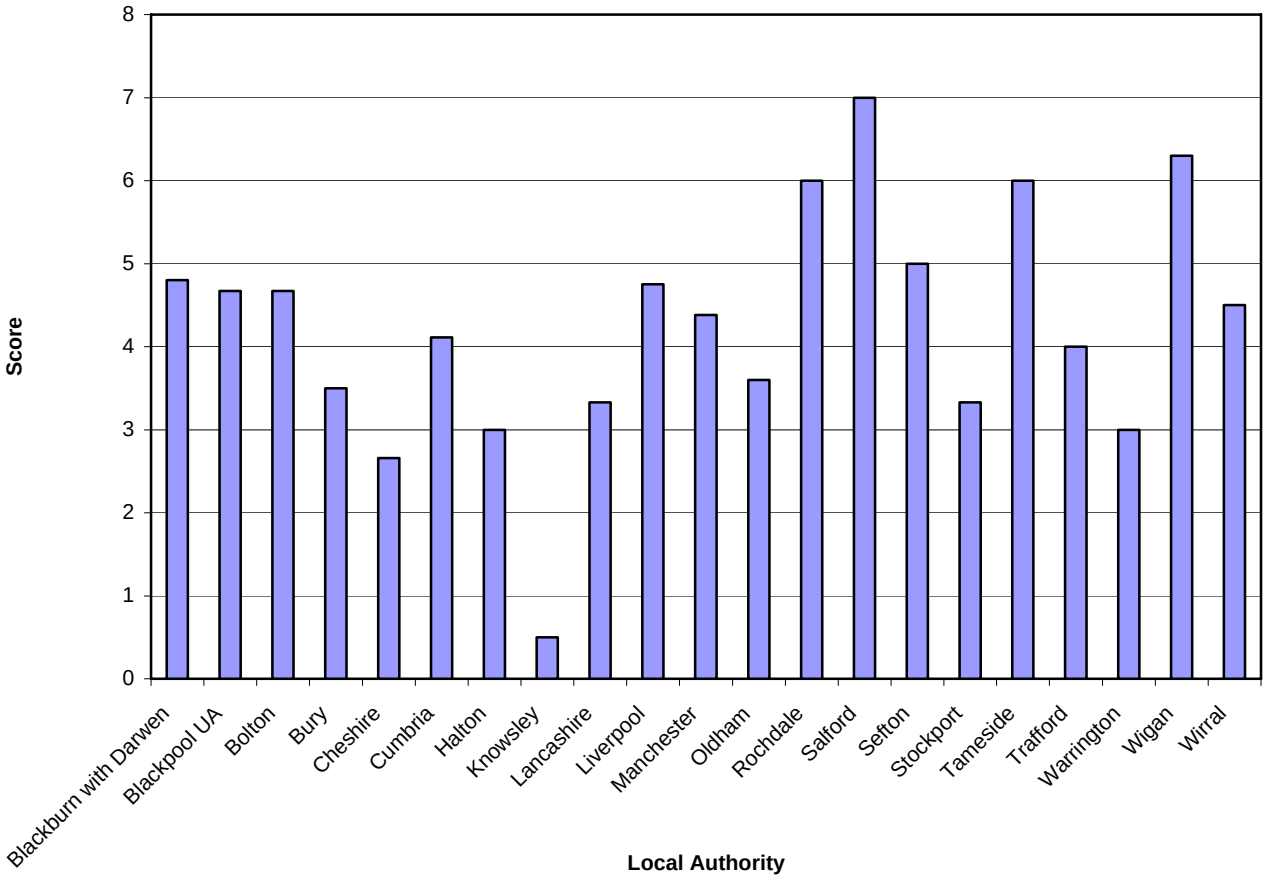
v. Building design features



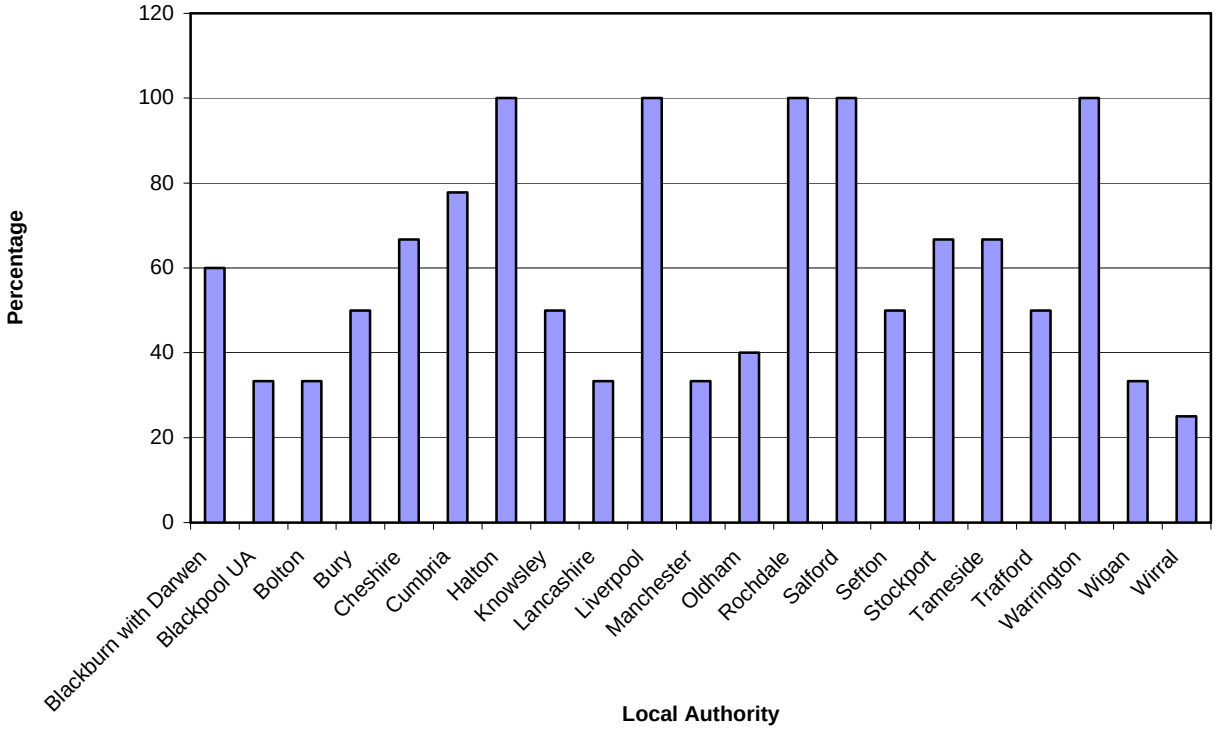
vi. Care worker good practice



vii. Carer involvement

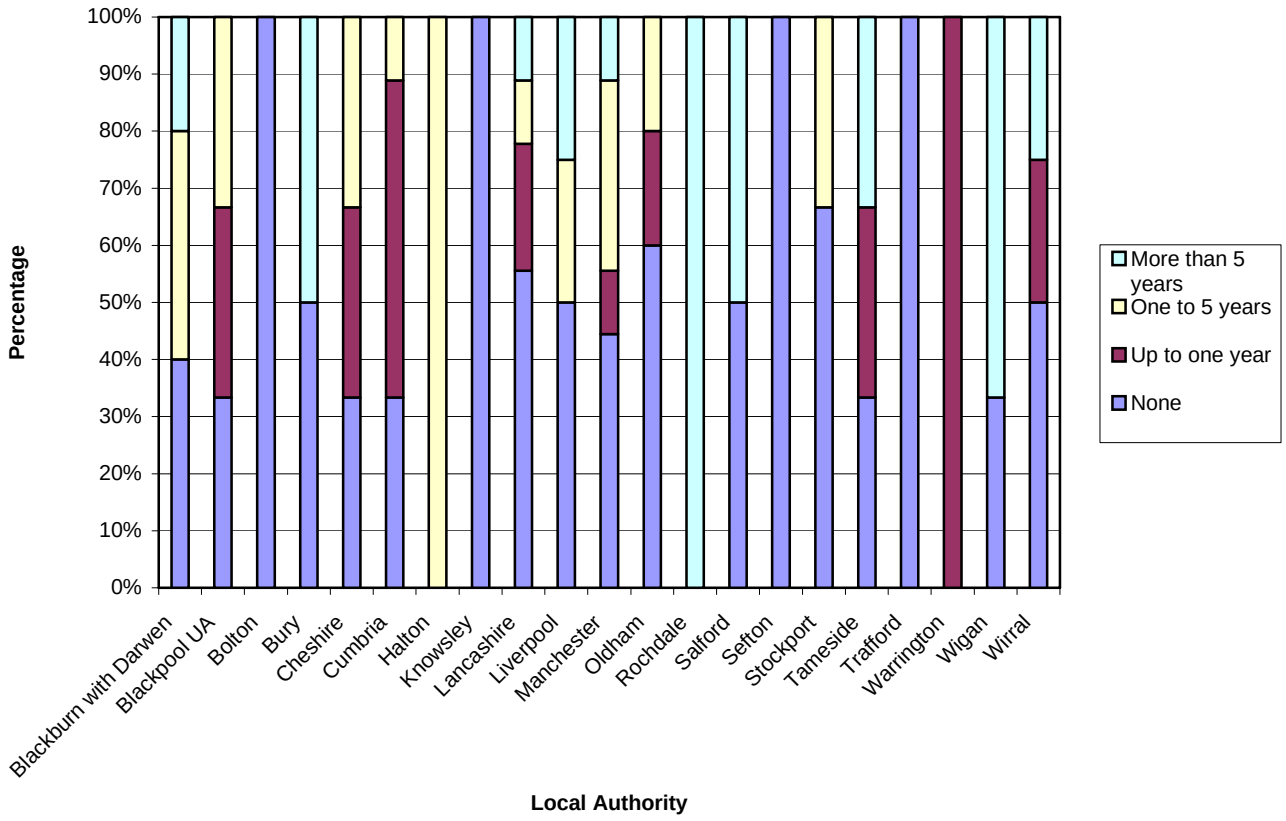


viii. Percentage of services with effective transport arrangements

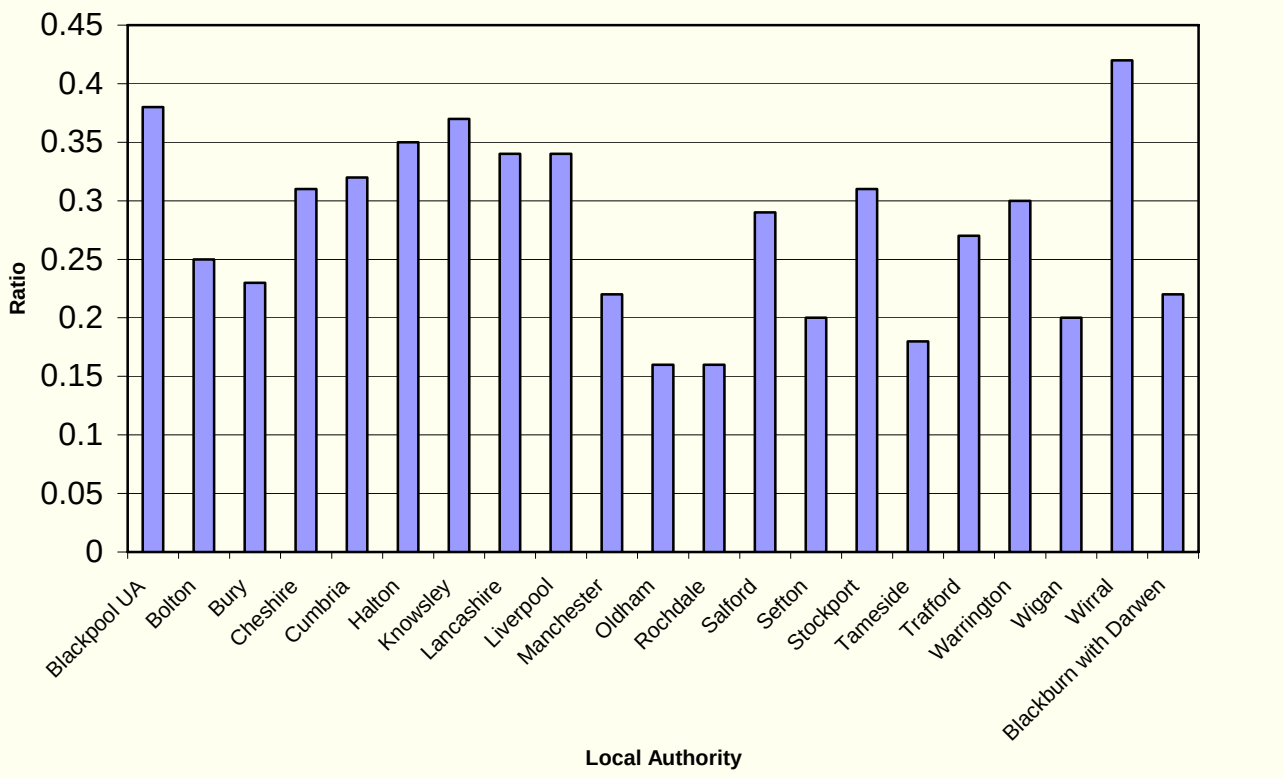


3. Organisation of care

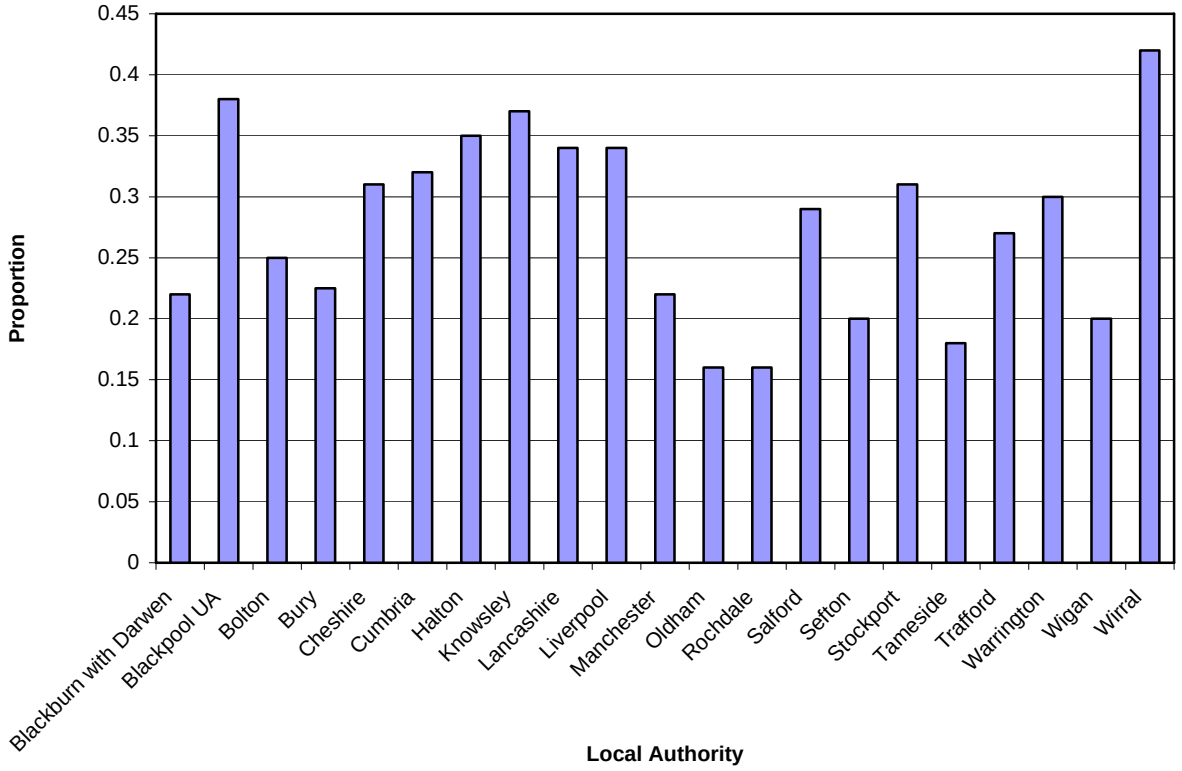
i. Security of funding arrangements



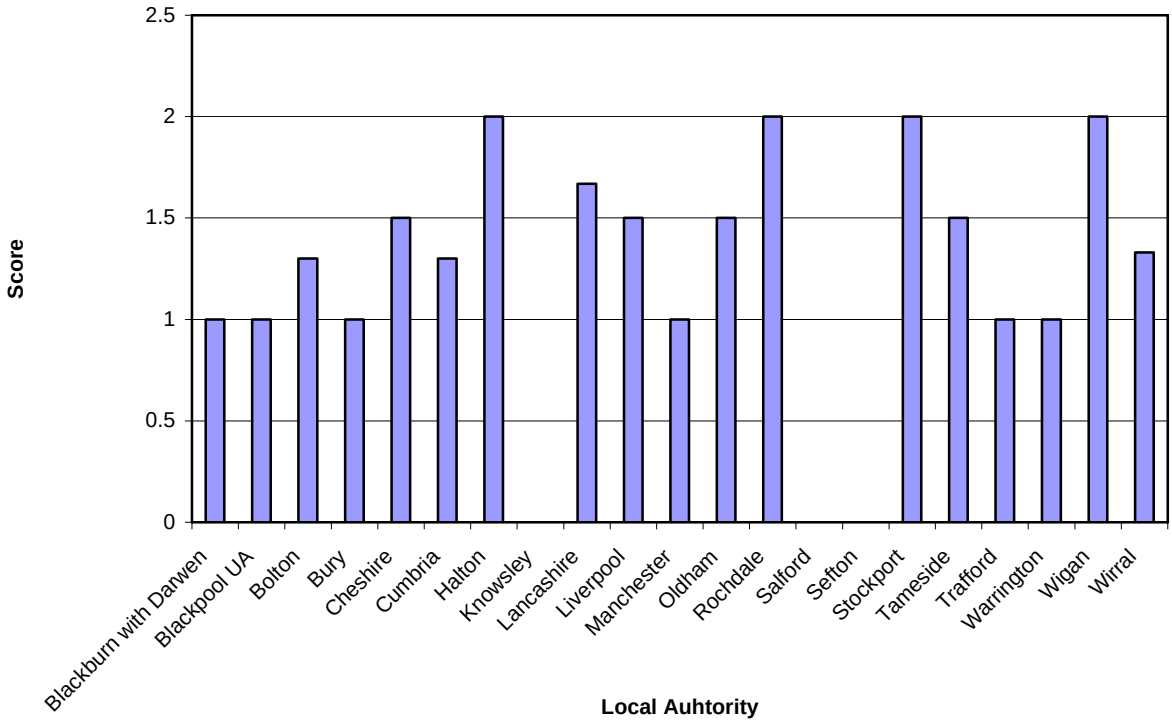
ii. Ratio of staff to day care places per day



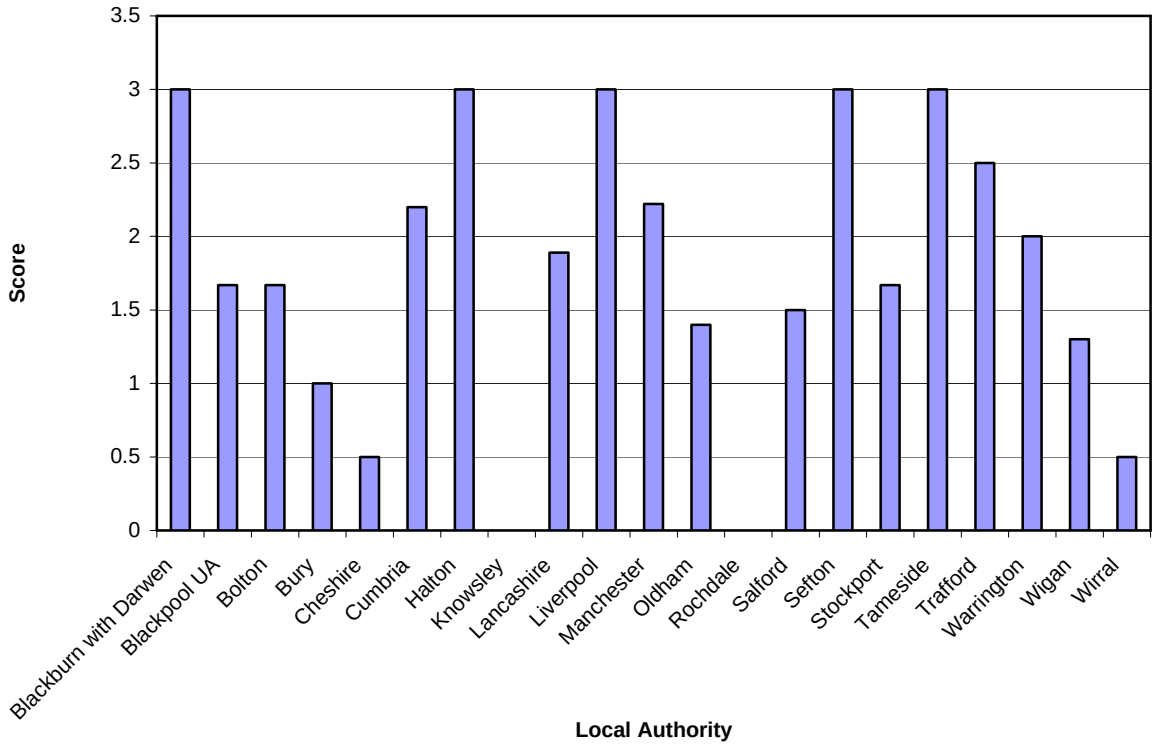
iii. Proportion of care staff to day care places



iv. Number of staff with specific training in caring for people with dementia



v. Provision for ethnic minority groups



vi. Integration