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The Relationship between the Delivery of Day Care Services for Older People and the Design of Day Unit Premises

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ABSTRACT
In response to recent community care policies in Britain, co-ordinated, needs-led models of care have been introduced into day care services for older people. Whilst their introduction has prompted detailed consideration of the changes required in the organisation and management of these services, less attention has been paid to their implications for the design of day care premises. Yet design factors impinge on all aspects of service delivery and any shortcomings in design may undermine the effective delivery of new models of care. This article uses findings from recent research to explore how design factors may facilitate or constrain service delivery, focusing on two aspects of the new models of care – that services should meet the needs of individual users and be locally-based.

KEY WORDS – Day care services, day centres, day hospitals, day hospital/centre design.

Introduction

In Britain, day care services for older people have received increasing attention with the implementation of community care policies. In the White Paper, *Caring for People* (Department of Health 1989: 3), community care was defined as '…providing the services and support which people who are affected by problems of ageing, mental illness, mental handicap or physical or sensory disability need to be able to live as independently as possible in their own homes, or in "homely" settings in the community.' Providing such services required fundamental changes in the balance of provision within and between health and social services. In the health services it involved the

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'movement of services out of hospital settings into more local, domestic settings'; for local authorities it required changes in the balance between the provision of residential care and the provision of day and domiciliary services (Audit Commission 1986: para 10(b)). The framework for implementing change in Britain was provided by the NHS and Community Care Act 1990, which gave local authorities the lead responsibility in planning community care. This Act did not specify policy goals for day care services at national level but it set the context within which day services are expected to develop at local level.

In developing co-ordinated, needs-led models of care in response to these reforms, detailed consideration has been given to the planning, financing, organisation and management of these day care services (Department of Health, Social Services Inspectorate 1992; Brearley and Mandelstam 1992), but less attention has been paid to the built environments in which they are provided. This gives cause for concern not only because of the costs of day care premises, but also because their design impinges on all aspects of service delivery. Any shortcomings in design, therefore, may serve to undermine the best efforts of providers to introduce new models of care into day services.

This article addresses the question of how design-related factors may facilitate or constrain the delivery of day care services for older people, focusing on two central themes of the reforms as these relate to design: that services should be tailored to meet the needs of individual users; and that wherever possible they should be locally based. The discussion draws on research undertaken in England and Wales by the Buildings Research Team, Oxford Brookes University, and funded by NHS Estates and the Department of Health. As the overall aim of this research was to develop design guidance for this building type, its main concern was to identify examples of good and poor practice in design within a wide variety of building and unit types, in order to provide practical information for those involved in the planning, design and delivery of day care services to older people.

Research Methods and Day Unit Types

The term 'day care services', when used in connection with older people, covers a wide range of services. For the purposes of the research, it was used to refer to those day units which conformed, in the main, to Tester's definition (Tester 1989: 37). Included in this were those statutory and voluntary-run day hospitals and day centres, organised

by paid staff and/or volunteers, which provided care in a communal setting in premises outside users' homes for at least four hours a day for at least one day per week. Excluded from this definition were all other types of day services, such as day places in residential care homes.

The research had three stages:

1. A preliminary study of nineteen day hospitals and day centres in two areas of England in the mid-1980s, to assess the extent to which their premises met users' requirements, and to identify issues relevant to the design of this building type. Information was collected by observations, questionnaires and interviews (Bacon and Dubber 1987).
2. A national postal survey in 1990, to identify the types of day units provided in England and Wales, and to obtain information about each unit type in terms of their premises, organisation, and their users. A stratified random sample of 58 Social Services Departments (SSDs) and 102 District Health Authorities (DHAs) was selected. Questionnaires were sent to day units in these areas and information on policies for day care services came from questionnaires sent to senior managers in the providers' organisations (Bacon and Lambkin 1991).
3. In 1992, a detailed study was made of day care provision in six local authority areas included in the postal survey. This aimed to: identify the implications for day care building design of key policy issues in the delivery of health and social care to elderly people; elicit the views of a range of health and social care service providers, users, and carers on aspects of good and poor day care building design; and identify components of good (and poor) practice in day care building design. In each area senior managers in the providers' organisations were interviewed. Visits were made to a sample of 51 day units, including examples of the different types identified in the postal survey; data were collected through interviews and observations of the building in use. Visits were also made to a few day units, identified as having an innovative approach to day care but which were located outside the six sample areas (Bacon and Lambkin 1994; NHS Estates 1994).

In the postal survey of 1990, nine types of day unit were identified as providing care for older people, as shown in Table 1. As Table 1 shows, nearly three-quarters of the sample consisted of three types of unit – day care centres (30 per cent), geriatric day hospitals (26 per cent), and psychogeriatric day hospitals (17 per cent). However, the range of unit types identified was greater than that reported in earlier studies (Carter 1981). Information on when the units opened showed that a majority

TABLE 1. *The types of day unit identified in the postal survey*

	Number	%
Day Centres		
Voluntary sector	37	6
Social centres for the active	20	3
Day care centres	178	30
Resource centre units	16	3
Care for mixed user groups	41	7
Care for the elderly mentally ill	26	4
Day Hospitals		
Psychogeriatric	100	17
Geriatric	156	26
Mixed user groups	25	4
All units	599	100

NB Percentages have been rounded and so may not add up to exactly 100%.

of the psychogeriatric day hospitals, the mixed day hospitals, the resource centre units, and the day centres for the elderly mentally ill were opened from 1980–1990. In contrast, the majority of the geriatric day hospitals, the social day centres, and those for mixed user groups opened before 1980. The day care centres were in an intermediate position; just over half opened from 1980–1990, the remainder before 1980.

In keeping with the findings of other studies (*e.g.* Tester 1989), a basic distinction could be made between day hospitals and day centres. The day hospitals gave priority to assessment, rehabilitation and skill maintenance, medical treatment and nursing care, but also provided personal care, lunch and some social activities. Most opened from Monday to Friday. No charge was made, except in some cases for services such as hairdressing. Geriatric day hospitals cared for older people with physical disorders; attendance tended to be on a short-term basis. Psychogeriatric day hospitals catered for those with mental health problems; in some, long-term attendance tended to be the norm, particularly where respite care was provided, but in others short-term attendance was usual. In 'mixed' day hospitals, older people with physical disorders and those with mental health problems were cared for together, or provision was made for those in one or both of these groups along with younger people.

All day centres, irrespective of type, offered a basic programme of lunch and social activities. Some provided additional services such as baths/showers and chiropody; these were less likely to be available in the voluntary sector and in the SSD social day centres than in the other

types of day centre. In most day centres, care staff predominated, attendance tended to be on a long-term basis and invariably a charge was made towards the cost of the service. The client group in day centres for older people with mental health problems was clearly defined. This was not the case in the other types of day centre but in general the voluntary sector and the SSD social day centres tended to cater for a less dependent client group than the other types of day centre. In 'mixed' day care centres, the client mix might be between age groups, and/or between those with physical disabilities and those with mental health problems; in some cases different client groups attended on different days.

Changing day service provision in response to community care policies

The follow-up study in 1992 found that the pattern of day care provision was beginning to change, as senior NHS, SSD and voluntary sector managers co-operated to develop local health and social services in accordance with recent community care legislation. This involved reviewing overall service provision for older people in their areas. Three groups identified as being particularly in need of day care were those with mental health problems, carers of elderly people, and, in some areas, ethnic minority elders.

Inter-service co-operation aimed at more co-ordinated patterns of day care, without the gaps and overlaps identified in existing provision (Brearley and Mandelstrom 1992). This involved clarification of the different agencies' responsibilities for services, resulting in a sharpening of boundaries between providers. Emerging patterns included SSDs concentrating on meeting the needs of the more dependent elderly people, voluntary organisations assuming responsibility for those users of SSD-run units who required a socially-orientated service, and health-care providers concentrating on rehabilitation and treatment. There were examples of different providers working together using joint finance to provide new, and in some cases innovative, day units. However, some issues were still being debated, such as the extent to which it was appropriate for health care providers to continue to provide long-term maintenance and respite care.

In all six areas needs-led as opposed to service-led models of day care services were being developed. Some providers had identified guiding principles for these and other community care services. These principles

reflected the emphasis placed on quality by central government (Department of Health, Social Services Inspectorate 1992). Some of these focused on service users, stressing, for example that services should affirm users' abilities, affirm their dignity, respect their need for privacy and confidentiality, and be responsive to their individual needs, taking into account their social, cultural, and ethnic backgrounds. Others related to the staffing and organisation of the service and the premises used, emphasising that services should be accessible, integrated within the community, non-stigmatising, welcoming, friendly, informal, comprehensive, and managed so as to ensure the efficient use of resources.

In developing day services in line with these principles, new approaches were being explored, taking into account the need to co-ordinate day care with other services when providing individual packages of care. For example, greater flexibility in day unit organisation was seen not only as a way of meeting the changing needs of users, but also as a means of coordinating day unit attendance with other parts of an individual's package of care. However, developing a more flexible service had implications not only for the allocation of day unit places, but also for staffing, transport, and for the amount of space and types of rooms required.

In some instances a needs-led model of service delivery, incorporating specified policy principles, was being introduced in individual day units. In relation to design, the success of such a model depends on an understanding of the dependency levels of users, stemming from their physical disabilities and/or mental health problems, and a recognition that these may change over time.

The characteristics and capabilities of day service users

The postal survey sought data on those characteristics of day service users that were most likely to have implications for design – in particular on mobility problems, as indicated by the use of wheelchairs and walking aids, and by the level of assistance required from others when walking; incontinence; mental health problems; and sensory impairment. Heads of day units were asked to estimate the number of day service users with each characteristic with reference to a five-fold categorisation – 'none,' 'a few' (*i.e.* one or two), 'some', 'most', and 'all'. In addition, information was obtained on the gender and age of users. This showed that women comprised over half of the users in 90 per cent of the day units. In 61 per cent of the day units, all of the users

TABLE 2. *Day units caring for at least one user requiring a specific type of assistance with mobility*

Assistance required	Day units %
Assisted wheelchair	83
Self-propelled wheelchair	45
A large wheelchair (i.e. one with an inclined back-rest/extended leg-rest)	16
Walking frame	93
Walking stick	98
Walking with assistance from one person	97
Walking with assistance from two people	71

TABLE 3. *The approximate number of people attending who use pushed wheelchairs when inside the unit's premises*

	Percentages				
	None	A few	Some	Most	N (= 100%)
Day Centres					
Voluntary sector	16	73	11	0	37
Social centres for the active	30	60	10	0	20
Day care centres	7	62	30	1	178
Resource centre units	7	73	20	0	15
Care for mixed user groups	2	46	46	5	41
Care for the elderly mentally ill	62	39	0	0	26
Day Hospitals					
Psychogeriatric	44	55	1	0	100
Geriatric	6	62	29	4	144
Mixed user groups	13	79	8	0	24
All units	17	60	22	2	585

NB Percentages have been rounded and so may not add up to exactly 100%.

were at least 60 years old. In 15 per cent of the units, most were aged 60–75 years, in 61 per cent, most were aged 76–85 years, whilst in 3 per cent, most were at least 86 years old.

Mobility

Evidence from the postal survey showed that the percentage of the day units in the sample caring for at least one user requiring a specific type of assistance with mobility ranged from 16 per cent for users of large wheel chairs to 98 per cent for those needing a walking stick (Table 2). These percentages varied considerably according to the type of day unit, as shown in Tables 3 and 4.

TABLE 4. *The approximate number of users requiring help from one person to walk when inside the unit's premises*

	Percentages					N
	None	A few	Some	Most	All	(= 100%)
Day Centres						
Voluntary sector	11	49	16	24	0	37
Social centres for the active	20	65	10	5	0	20
Day care centres	1	64	29	6	0	175
Resource centre units	0	81	19	0	0	16
Care for mixed user groups	3	53	38	8	0	40
Care for the elderly mentally ill	12	62	19	4	4	26
Day Hospitals						
Psychogeriatric	4	76	18	2	0	100
Geriatric	0	26	47	28	0	144
Mixed user groups	0	50	38	13	0	24
All units	3	55	30	12	0*	582

* = less than 0.5%.
NB Percentages have been rounded and so may not add up to exactly 100%.

TABLE 5. *The approximate number of users reported to be incontinent*

	Percentages					N
	None	A few	Some	Most	All	(= 100%)
Day Centres						
Voluntary sector	27	68	5	0	0	37
Social centres for the active	40	45	15	0	0	20
Day care centres	7	54	39	0	0	178
Resource centre units	6	44	50	0	0	16
Care for mixed user groups	12	56	29	2	0	41
Care for the elderly mentally ill	15	46	31	4	4	26
Day Hospital						
Psychogeriatric	4	46	43	7	0	100
Geriatric	1	43	56	1	0	145
Mixed user groups	0	58	29	13	0	24
All units	8	50	40	2	0*	587

* = less than 0.5%.
NB Percentages have been rounded and so may not add up to exactly 100%.

Incontinence

In 92 per cent of the day units there was at least one user who was incontinent. In at least 40 per cent of each type of day hospital there were more than one or two such users; the comparable proportion for the different types of day centre ranged from 5 per cent–50 per cent (Table 5). In just over half the day units there was at least one user who

TABLE 6. *The approximate number of users reported to be suffering from dementia*

	Percentages					N
	None	A few	Some	Most	All	(= 100%)
Day Centres						
Voluntary sector	31	34	26	0	9	35
Social centres for the active	40	35	25	0	0	20
Day care centres	9	38	50	3	0	171
Resource centre units	7	20	67	7	0	15
Care for mixed user groups	25	50	25	0	0	40
Care for the elderly mentally ill	8	0	4	39	50	26
Day Hospitals						
Psychogeriatric	3	3	30	43	21	100
Geriatric	7	61	31	1	0	139
Mixed user groups	17	22	39	17	4	23
All units	11	35	36	11	7	569

NB Percentages have been rounded and so may not add up to exactly 100%.

was doubly incontinent but in most of these units there were only one or two such users.

Mental health problems

In 89 per cent of the day units there was at least one person suffering from dementia; the variation by unit type is shown in Table 6. In just over two-thirds of the day units at least one person suffered from a mental illness other than dementia.

Sensory impairment

Nearly all of the units (98 per cent) were caring for at least one user who had significant difficulty in hearing. In most (95 per cent), there was at least one user who had significant difficulty in seeing, and in 89 per cent there was at least one person with a significant difficulty in speaking. The majority of each type of day unit was caring for only a few suffering from each of these three types of impairment.

These findings confirm that many of the day units were catering for dependent older people with a mobility problem, a sensory impairment, incontinence, and/or a mental health problem, with a spread of different types of disability across all types of day unit. An important implication of this for the design of day unit premises is that the needs of those with different disabilities must be considered in every day unit. More detailed information about how the delivery of day services to

those with different needs was affected by the design of the premises, was gathered during the visits to the sample of day units in 1992.

Service delivery and the design of day unit premises

Implementing a needs-led model required changes in day service delivery. In making these changes, managers and day unit staff faced the difficult task of meeting the requirements of users' individual care programmes in a group situation. In most cases changes were being introduced not into new day units in specially designed premises but into existing day units. Proposed changes could be in the client group, in staffing patterns, in staff approaches to care, in the number of hours the unit was open, in the programme of activities, and, in some cases, in developing a more positive role for service users, their carers, and/or volunteers in the running of the unit. These changes varied in terms of their scale and scope. Some were fundamental, others incremental. Some were within a specific service organised by one type of provider, others involved inter-service co-operation. The pace of change varied. In some day units new initiatives had been introduced, in others change was proving more difficult.

The findings show that the delivery of day care services could be facilitated or constrained by the type of premises used and by their design. There were three aspects of service delivery where this effect was identified: the range of activities that could be provided, users' participation in activities, and resource use.

The activities provided

Each unit offered, in varying degrees, a combination of nursing/medical care, rehabilitation therapy, personal and/or social care. This comprised sets of activities organised by staff with different skills, requiring specific equipment, furnishings, fittings, and technical services, all of which have spatial and other implications for the design of day unit premises. For the purposes of the research, activities were divided into five groups: the provision of food, social/leisure activities, personal care, rehabilitation and training, and nursing/medical care.

The size of the premises and the combination of rooms available could affect the comprehensiveness of the service in terms of the number and types of activity which could be provided. Information from the postal survey showed that the size of the units' premises, as indicated by the number and types of rooms available, varied

considerably. The most basic premises consisted of one core activity/ dining-room in which most activities took place, plus a kitchen, storage area, and toilet facilities. In other units this was supplemented by a separate dining-room and an additional lounge(s). Further possible additions were an office, rooms for personal care (such as a bathroom, hairdressing room and/or chiropody room), special craft rooms, therapy rooms, and rooms for medical examination or treatment. The three types of day hospital were likely to have more rooms than the six types of day centre. Amongst the day centres, mixed day centres tended to have the highest level of provision, whilst social day centres and voluntary sector units were likely to have the lowest.

The differences in the number of rooms were not consistent with differences in the maximum number of places available per day (which ranged from under ten to over a hundred, with 72 per cent of the units having up to thirty places per day). Day hospitals of each type tended to have a comparatively large number of rooms, but a relatively low number of places; the reverse tended to be the case for some types of day centre. However, day centres for mixed user groups tended to have a comparatively high number of rooms, and to offer a relatively large number of places per day.

Availability of specific spaces could determine whether or not certain activities were provided. For example, 60 per cent or more of seven types of day unit, 35 per cent of social day centres, and 11 per cent of voluntary day centres had access to a bathroom, but the other units did not. In the latter, providing baths or showers was impossible; in such units, it was difficult to care for those who were incontinent and needed to wash themselves and/or their clothes. Certain types of craft activities such as pottery, requiring specific equipment, space and/or storage, could not be offered where suitable spaces were unavailable. Different types of therapy and medical treatment could only be provided where suitable spaces and equipment were available; such spaces were more likely to be provided in day hospitals than in day centres. For example, whilst 54 per cent of the day units overall had no specific room for assessment/ rehabilitation/training, more than two-thirds of each type of day hospital had at least one such room, as did 41 per cent of the mixed day centres; the comparable percentages for the other types of day centre ranged from 0 to 25 per cent.

In addition, the number and combination of rooms was found to affect whether or not services were delivered effectively. This can be demonstrated by looking at two sets of activities provided by almost all of the day units – food provision and social/leisure activities – in relation to the type of spaces used. Of the more than seventy

social/leisure activities mentioned by postal survey respondents, eleven were common to all types of day unit and provided in a majority of the units overall; these were board games/cards, bingo, singing/making music, listening to the radio/music, quizzes, knitting/crochet, hand-sewing, painting, talks/slide-shows, watching television, and day trips/meals out.

Although each of the latter activities (with the exception of the last) and eating lunch/snacks could take place in a multi-purpose activity/dining space, the types of spaces available for them in different day unit premises varied considerably. Of the units responding to the postal survey, a majority of all unit types had a combined lounge/dining space (51 per cent–84 per cent); other units had a separate dining-space (15 per cent–49 per cent). A substantial proportion of eight types of day unit had at least one separate lounge (32 per cent–55 per cent), but only 19 per cent of geriatric day hospitals did so. At least half of the day centres for mixed user groups and the psychogeriatric day hospitals had a quiet room, but only a minority of each of the other seven unit types did so. Less than a third of each unit type had a separate television room.

The availability of such spaces could have a significant impact on the delivery of care. For instance, in basic premises with only one dining/activity room, it was more difficult to tailor activities to need. Preparation for lunch could mean that the dining area was unavailable for other activities until after lunch. In some units staff had to move tables and chairs to provide sufficient space for large group activities. In basic premises, it was often easier for staff, particularly where they were few in number, to organise large group activities such as bingo or singing for all users, rather than small group or individual activities appropriate to particular needs. Ideally, the latter activities required spaces free from noise or visual distractions, particularly where there were dementia sufferers who can be easily disturbed by noises or movements ignored by others. In some units, screens or furniture had been used to divide large rooms into smaller, more intimate spaces, but in most cases group activities taking place in them were disturbed by noise and/or visual distraction from other groups.

Making changes in the programme of activities in accordance with the new policies had proved a positive experience in some units, particularly where users had been asked about their preferences. In some cases staff had tried to build a care programme around these by incorporating such activities as helping with food preparation at lunch-time, cooking or baking, and growing and looking after plants. In a day centre specifically for Asian elders, great care had been taken to ensure

that activities could be undertaken according to users' cultural traditions. For example, an easily accessible wash-basin had been provided in the dining-room so that users could wash their hands as appropriate during the meal, according to their custom. In such units the changes made were dependent on the availability of suitable spaces and equipment.

A few examples of an innovative day care service were identified, specifically planned to meet the individual needs of older people living in the area, and accommodated in new, specially designed premises. One is a collaborative venture between local health service providers, the SSD, and a voluntary organisation in an inner London borough. This project cuts across traditional service boundaries in order to reflect new community care policies in all aspects of service delivery, and in the design of the purpose-built premises. These are located on a busy, high-street site, with entry into the building directly off the pavement. The centre offers a multi-faceted service for people aged 65 years and over, except those with mental health problems, who can receive day care in a nearby hospital. The new unit includes a day care centre, a lunch club, health and personal care facilities, and an open access coffee bar, restaurant, hair-dressing salon and laundry; it also acts as a resource for community groups. It has multi-disciplinary teams of staff, supported by generic care workers, working together to provide a 'seamless service' for users (Bacon *et al.* 1994).

Users' participation in activities

The design of day unit premises could affect users' participation in activities. Three aspects of design had an important impact on this: the image and atmosphere prevailing in day units, the availability of sufficient suitable spaces, and the access to and within the premises. Before considering these, it is important to note that the relationship between design and users' participation could be modified by other factors such as the expectations of staff and users regarding participation, the reactions of users to being in a group setting and the general attitudes of staff and users when in the day unit. For example, there was a clear contrast between the day hospitals and the day centres in the expectations staff had regarding users' participation in activities. In the former, users were expected to take part in activities, most of which were directed towards a specific goal such as rehabilitation, skill maintenance, or treatment. In comparison, activities in day centres tended to be less goal-orientated; some managers pointed out that the centres were for the people attending and should be used as they

wished. However, day centre users tended to be more involved in the running of the unit than those in day hospitals; for example doing domestic tasks, suggesting activities, and fund-raising. The postal survey showed that users helped in some way in the running of the unit in only 42 per cent of the day units. This percentage, however, was much higher for five types of day centre (59 per cent–78 per cent) than for the three types of day hospital (7 per cent–22 per cent) and for the day centres caring for those with mental health problems (31 per cent).

Being part of a group and having to take part in activities with others can be difficult for some older people. They may feel sensitive about their disabilities, embarrassed about their own or others' appearance or behaviour, have language or other communication difficulties, have had little recent experience of being in a group, and they may not know anybody else attending. In such settings, patterns of behaviour can arise which have implications for service delivery and the use of space. Amongst those identified in the research were: users being unwilling to accept changes in the daily routine either in relation to activities or in the surroundings – the re-arrangement, for example, of furniture; laying claim to a particular chair in the sitting area; refusing to move to an activity elsewhere; and segregation of seating according to gender or into smokers and non-smokers, either in the same room or in separate rooms. Where such behaviour was established, staff could experience difficulties when introducing changes in activities. Finally, negative attitudes on the part of users and staff could result in limited user participation in activities, even in a well-designed building. Given these qualifications, participation in activities could be facilitated or constrained, directly or indirectly, by several design-related factors.

The image presented and the atmosphere prevailing in day units were dependent to a considerable extent on the interior design of the premises, which could contribute to the creation of an environment where users felt comfortable and perhaps more willing to take part in activities. A 'homelike' setting is recommended in community care policies. There was general agreement in day centres and psycho-geriatric day hospitals that this was appropriate. What some users described as a 'home-from-home' had been achieved in some units, usually day centres. Design elements contributing to this were relatively small rooms, a good level of natural lighting, carpets on the floors, a variety of armchairs, bookcases, plants and pictures, a comfortable temperature, warm colours and different textures used for walls, floor-coverings, and furnishings, and pleasant views from the windows.

Achieving a homelike image depended in part on the age and condition of the building and its former use. Some older premises

conveyed an institutional feel created by large rooms, which could be difficult to heat and draughty. Other features contributing to this were artificial lighting that had to be used all day to supplement natural light, standard furniture, and vinyl floors throughout. In some cases the prevailing image was that of the building's former use. Although there was general agreement that an institutional setting or one resembling a hospital ward were not appropriate, some geriatric day hospital staff wanted an environment which emphasised the therapeutic aims of their unit and distinguished it from day centres providing respite care. Whatever the image required, some premises had bright, cheerful spaces, contributing to a welcoming atmosphere as recommended in policy documents. This was achieved by several means, notably the use of warm colours and different textures for interior decoration, an effective combination of natural and artificial lighting, and an efficient heating/ventilation system which could respond quickly to temperature changes.

The number of rooms and their size and layout could affect users' choices about taking part in activities. In basic premises with only one activity/dining room it was difficult to provide more than one activity at the same time. Users not wishing to participate in a large group activity had to remain in the same room because there was nowhere else for them to go. Such users included not only those with sensory impairments or confusion, for whom participation in an activity such as bingo was difficult, but also those who felt tired, unwell or had a quiet disposition.

In some instances the design of a specific space was unsatisfactory, mainly because of its size and/or the arrangement of furnishings and fittings within it. This could affect not only users' capacity to undertake activities independently but also their dignity and privacy. Examples of such spaces included toilet compartments and bathrooms, not least because of the special requirements many users had when using them. In 94 per cent of the day units there was at least one user who required assistance from one person when using the toilet (Table 7); in 71 per cent of the units there was at least one person who needed help from two people when doing so. As described previously 83 per cent of the units had at least one person attending who used a pushed wheelchair. Although 87 per cent of the day units had at least one toilet compartment specially adapted for people with disabilities, those remaining did not. Among the design-related problems reported with toilet compartments were: insufficient space to allow two members of staff, one on each side of the toilet pedestal, to assist a user; difficult access and/or insufficient space for wheelchair users; too many or too

TABLE 7. *The approximate number of users requiring help from one person to use the toilet*

	Percentages					N
	None	A few	Some	Most	All	(= 100%)
Day Centres						
Voluntary sector	27	54	14	3	3	37
Social centres for the active	45	30	20	5	0	20
Day care centres	3	46	49	3	0	178
Resource centre units	6	25	69	0	0	16
Care for mixed user groups	3	28	70	0	0	40
Care for the elderly mentally ill	15	35	31	19	0	26
Day Hospitals						
Psychogeriatric	2	35	53	10	0	100
Geriatric	0	16	52	32	0	145
Mixed user groups	4	13	71	13	0	24
All units	6	33	49	12	0*	586

* = less than 0.5%.
NB Percentages have been rounded and so may not add up to exactly 100%.

TABLE 8. *The approximate number of people requiring help from one person when having a bath*

	Percentages					N
	None	A few	Some	Most	All	(= 100%)
Day Centres						
Voluntary sector	0	67	33	0	0	3
Social centres for the active	0	50	50	0	0	8
Day care centres	0	26	48	25	1	122
Resource centre units	0	8	62	23	8	13
Care for mixed user groups	0	40	52	8	0	25
Care for the elderly mentally ill	0	13	27	53	7	15
Day Hospitals						
Psychogeriatric	0	45	34	21	0	80
Geriatric	1	19	32	45	3	131
Mixed user groups	5	24	48	24	0	21
All units	1	28	40	30	2	418

NB Percentages have been rounded and so may not add up to exactly 100%.

few support rails adjacent to the toilet; and/or doors which were difficult to close and/or lock, in some cases resulting in doors being left open when the toilet was being used. Similarly, nearly all the units providing baths were caring for one or more users who required help from one person when bathing (Table 8). In over three-quarters of these there were one or more users who required help from two people.

In many, the provision of assisted bathing was effectively constrained by design-related factors, such as insufficient space for manoeuvring a wheelchair, having access to only one side of the bath, and inappropriate hoists.

An accessible environment was a prerequisite to users being able to move to, and participate in, activities in a way which affirmed abilities, ensured dignity, and minimised dependence on staff. Critical to this was a building layout which was easy to understand, with all spaces designed to meet the needs of those with mobility problems, including wheelchair users and those needing help from others to walk, those with sensory impairments, particularly impaired sight, and/or those with mental health problems. Positive features included short, direct routes between rooms, particularly between the main activity room(s) and toilets; visual and tactile cues to help with way-finding; corridors and entrances wide enough for wheelchair access and manoeuvre; handrails along both sides of the corridors; and doors which were easy to open. Design features which could discourage users from moving within or between rooms or make them dependent on others when they wished to do so included long distances between rooms; a lack of, or unsuitable support rails; steps; steep ramps; floor coverings which were, or looked, slippery, or had striped or lined patterns which could be mistaken for steps, changes in floor coverings and difficult-to-open doors.

Inappropriately designed entrance areas could also result in users being dependent on staff unnecessarily; in order to enter the building some had to rely on staff to assist them with walking or to push them in a wheelchair. A quarter of the respondents in the postal survey reported design-related problems in this area. Particularly unsuitable were the long distance between the point where users alighted from their transport vehicles and the main entrance door, a poor surface on the route between these two points, a lack of or inadequate support rails, steps or the type of ramp to the entrance door. Sometimes, there was no canopy over the entrance area, or one of unsuitable design, and/or doors which were difficult or too heavy to open, or not wide enough to pass through in a wheelchair or when assisted by one or two people. In some units entrance doors were tied open to facilitate access, resulting in heat-loss and draughts within the building. Once inside some buildings, it was difficult to identify the location of the reception desk or office, or the appropriate route to take, because there were a number of doors or corridors and no indication of where to go. Some units had insufficient storage space for wheelchairs and walking-frames and their entrance areas were used for this purpose, causing blockages and impeding access.

The efficient use of resources

The research identified not only a lack of awareness of the links between policy, service delivery and the design of day unit premises, but also a limited appreciation of the building as a resource. Both factors could result in the inefficient use of the building, and also of other resources. In some cases it appeared that the implications of the needs-led model were not always being fully thought through in terms of space and equipment. For example, some managers wanted to introduce rehabilitation therapy, particularly physiotherapy, into day centres where this was consistent with users' needs. However, it seemed unlikely that this would be achieved given the limited space in many existing centres, the constraints on resources and a perceived shortage of appropriately trained staff. A few day centres with definite plans to provide rehabilitation therapy had not implemented these because of financial constraints, resulting in the under-use of spaces designated for this purpose.

The extent to which the day units' premises were actually used for day care varied considerably. Of the units responding to the postal survey, only 10 per cent were open more than five days per week; 71 per cent opened for five days per week, the others for less than this. About two-thirds of the day units were open for eight or more hours per day, but this did not mean that all users were present for all that time. In just over three-quarters of the units all users were present together from four to six hours per day. Information on the level of take-up of places also pointed to a less than optimum use of space. In 86 per cent of the units, the number of users who attended on the 'survey day' was less than the established maximum number of places per day. Three-quarters of respondents considered that attendance on that day was 'about the number that usually attends per day', indicating that for some units the short-fall was a regular occurrence.

The premises of just over half of the day units responding to the postal survey were used by (an)other group(s) when the day unit was closed; only a fifth of respondents found that this affected the running of the unit. As described previously, some providers were considering extending day services to evenings and weekends, but this could be difficult in shared premises, especially where these were rented.

Individual spaces in some premises were under-used or used inappropriately, with a consequent under-use of equipment and furniture. A change in policy or insufficient resources could result in the under-use of space. For example, in one case a decision that occupational therapists should carry out assessments and rehabilitation

in clients' homes rather than in the day hospital had resulted in under-use of the latter's activities of daily living (ADL) suite. In some units a bathroom had been provided but because of staff shortages or inappropriate design, baths were not given so the bathroom was not used or used for storage.

Staff could be diverted from working with users because they had to compensate for aspects of buildings where design was inadequate. For example, where the entrance door was some distance from the transport parking space, staff had to spend time at the beginning and end of the day escorting users, or taking them in wheelchairs, to and from the entrance. Wheelchairs also had to be used to take some users between rooms which were a long distance apart.

As older people tend to feel cold easily and are sensitive to changes in temperature and draughts, maintaining an appropriate temperature in day units is important not only for their well-being and comfort but also in helping to create a welcoming atmosphere. If costs are to be minimised, efficient use of energy is critical. However, this was difficult in some premises, and appeared not to be a priority in others. Maintaining an appropriate heat level was particularly difficult in older buildings with large rooms, large windows and/or high ceilings. Heat loss and draughts were a problem in some premises; one example of this was where the external entrance door opened directly onto the main activity room, or where it was tied open to allow easy access for users with mobility problems; another was in frequently used bathrooms where windows had to be opened briefly for ventilation. In some units the staff did not have access to the heating controls, making it difficult to maintain a comfortable temperature.

A community setting?

Community care policies advocate that day services should be based within the community, integrated within it, and easily accessible to service users and their carers. This implies that their premises should be located alongside or within buildings which are familiar to, and used by, the general public on a day-to-day basis, in order to ensure ease of access and to maximise opportunities for interaction with those living and working in the surrounding area. Achieving this requires careful siting of day unit premises, taking into account the physical relationship between the units' premises and the surrounding built environment, the need to provide opportunities for members of the wider community to come into the premises, and/or have links with the day unit to

facilitate integration, and the need for easy access for service users. The extent to which community-based day services can be achieved depends to a considerable extent on the existing pattern of health and social service provision, on the availability of resources, and on how providers, separately or together, plan to resolve the wider issues raised by community care reforms.

The extent to which existing premises of day units meet these requirements varies. Two design-related factors identified as being important to this debate were whether or not the unit's premises were on a shared site, and the image presented by the premises. Evidence from the postal survey showed that most day hospitals and many day centres used premises located on shared sites. Relatively few had premises standing alone on their own site; these were more likely to be day centres for mixed user groups than other unit types.

There was a clear contrast between day hospitals and day centres on shared sites in terms of the other buildings on the site. Most day hospitals used premises located on hospital sites; this was the case for more than two-thirds of each of the three types of day hospital, including 98 per cent of the geriatric day hospitals. In many instances the day hospital's premises were attached to or within the main hospital building. However, hospital sites vary considerably. Some can be described as community-based more readily than others. Such a description may be appropriate for a community hospital site in the centre of a small town, but it is less likely to be so for isolated hospital sites away from settlements, or for large, complex sites located in towns or cities but set apart from other buildings used on an everyday basis by the general public.

In contrast, the premises used by most day centres were on non-hospital sites. Some day centres used premises which were clearly community-based; for example rented accommodation in a community centre. Other day centres shared sites/premises with other facilities for elderly people, in particular residential homes and resource centres. Whilst many of these could be described as community-based, in some cases where premises were on sites apart from other buildings, there was potential for grouping a large number of older people together and a possible problem in establishing and maintaining links with the wider community.

Sharing a site and possibly a building with (a) related organisation(s) was found to offer a number of advantages and disadvantages to day units. The main advantage was the opportunity to share resources in the form of staff, spaces, equipment, facilities, and in some cases transport with the other organisation(s). This offered not only the

potential for optimising resource use, but also opportunities to provide service-users with a more comprehensive service and in some cases continuity in care. For example, users of day hospitals on shared hospital sites could see consultants or receive treatment in the main hospital during their visit to the day hospital. Users of day centres sharing a site with a residential care home were able to receive respite care, or move to full-time residential care, in a familiar building staffed by people they knew. Advantages for staff working in a day unit on a shared site included ease of contact with senior staff based in the same building, and more extensive staff facilities.

Another advantage for day units based on shared sites was that their premises were likely to be secure when the day unit closed, particularly where the neighbouring facilities had staff working there all the time. Susceptibility to vandalism tended to be associated with premises standing alone on their own site, an urban location, a site next to open ground, a one-storey building with a flat roof, and the day unit being closed in the evening and at weekends.

Some shared sites had disadvantages. In particular, day units based on hospital sites were likely to have larger catchment areas than those on non-hospital sites. Large catchment areas could result in some users having long journeys to and from the day unit. The longest distance any user had to travel between home and the day unit varied; it was up to five miles in 30 per cent of the day units, over five to ten miles in 40 per cent, and over ten miles in 31 per cent. The three types of day hospital were more likely to be caring for one or more users who had to travel more than ten miles (42 per cent–54 per cent) compared with the six types of day unit (less than a third of the units in each case).

Other factors which had implications, not only for ease of access, but also for integration were the image presented by the day unit premises, the identity of the day unit, and the ease of finding the day unit entrance. In some cases, boundaries between the day unit premises and those of another organisation sharing the same site/building were not always clearly delineated. This was more likely to occur where day hospitals were located within large hospital buildings, but there were examples of day centre premises within large residential homes or resource centres where this was also the case. Such units and their main entrance could be difficult to identify, and there could be a relatively long walk inside the building to reach the day unit. In organisational terms the day unit staff could find it hard to establish their unit as a separate entity with its own image distinct from that of the larger organisation. In the case of geriatric day hospitals, for example, nearly all of which were located on hospital sites, any attempts to present an

image emphasising rehabilitation could be challenged by the more pervasive image projected by the site as a whole. In some cases, staff had sought to establish a clearer identity conveying the preferred image by changing the name of the unit, for instance from day hospital to rehabilitation unit.

The question of whether or not day hospitals should move off hospital sites was being considered in the survey areas. In three of these, there were definite plans for psychogeriatric day hospitals to move off hospital sites to community settings, either as part of community hospitals or as part of community units for the mentally ill. There was uncertainty about how geriatric day hospitals would develop. In two areas, the possibility of moving geriatric day hospitals to non-hospital sites was an option, but implementation was dependent on finding suitable sites. In another area, geriatric day hospitals were to be included in two neighbourhood hospitals.

However, several examples were identified of day units funded either by the NHS or by joint-funding, which were providing health care in premises on non-hospital sites. These units were in premises which were integrated within the neighbouring built environment, and located on sites offering opportunities for links with local people, and ease of access for users. One example is the unit in London described previously. Another is a community unit in York catering for older people with mental health problems and their carers. This provides three separate but related services: a 14-bed continuing care unit, a 20-place day hospital, and a resource centre for use by voluntary groups and local residents. The two-storey premises were purpose built on a former school site, located on a side road amongst housing, with shops and a church nearby. The main entrance is clearly visible and easily accessible from the pavement; there are no signs to indicate the building's use, and it blends in with the surrounding housing.

Summary and conclusion

The research demonstrated that day service delivery can be facilitated or constrained by the location and design of day unit premises, and that any organisational changes affecting the former are likely to have implications for the latter. These implications have to be thought through in detail by service providers, if the requirements of the new models of service delivery advocated by recent community care policies are to be met by the location and design of the premises, taking into account policy principles, the initial characteristics and capabilities of

service users and how these may change over time, any identified longer-term organisational requirements or changes, and the resources available. A number of issues involving the location and design of premises were identified as being central to matching the organisational model of day service delivery to the setting.

Locational issues were concerned with providing day services in community-based settings. Given that most SSD and voluntary sector day centre premises were on non-hospital sites, these issues tended to be of greater concern to health service providers. For some, a critical issue was whether or not day hospital services for older people should continue to be provided in day hospitals on hospital sites or be moved to non-hospital sites. In broad terms the former is likely to have advantages in terms of resource sharing and the provision of a comprehensive day service, but disadvantages in terms of ease of access for users, and in establishing the required identity and image for the unit. Moving to a non-hospital site could contribute to overcoming such disadvantages, but raises questions about the form of the service to be provided, given that sharing hospital-based resources may be more difficult.

Design-related issues were concerned with the match between the requirements for service delivery and the setting for day care. For the purposes of this paper, service requirements were discussed in terms of the programme of activities provided, user participation in this, and efficient resource use. Elements of design identified as affecting these requirements were: the size of the building in terms of the number of spaces available; the building layout; the accessibility of the environment for all users, including those using mobility aids or wheelchairs, those with sensory impairments, those with mental health problems, and those requiring help and staff; the images projected by the building both externally and internally; and the quality of the heating, lighting, and ventilation systems, which could determine not only the comfort of users but also the efficient use of energy.

Such issues had been resolved by some providers who demonstrated that it is possible to introduce organisational change in the form of new models of day service delivery in community-based premises, either within one service or through inter-service co-operation. These included offering a range of health and social services in one centre; combining different services such as residential and day care, and possibly other community resources in the same premises; and changing the model of service delivery in existing day hospitals and centres.

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