Transition and Choice in Residential Long-Term Care for Older People in England

Min Young Tak

Department of Social Policy and Intervention
St. Hilda's College
University of Oxford

Trinity 2014

A thesis submitted in partial fulfilment of the requirements for the degree of Doctor of Philosophy in Social Policy in the Social Sciences Division at the University of Oxford

Min Young Tak, St. Hilda's College

Transition and Choice in Residential Long-Term Care for Older People in England

Abstract

Care transition, the process of moving from community care to residential care, is one of the biggest changes that older people can experience in their later life. Evidence from the literature suggests that older people's experiences of care transition tend to be negative and traumatic, with most of them being little involved in the process of care transition.

How older people exercise choice during the period of care transition is important for understanding their experiences of care transition for the following two reasons: first, choice has been referred to in the literature as the key to less stressful care transition experiences, which can subsequently lead to a better quality of life in residential homes; second, the introduction of choice in public services has been the key plank of British social policy in recent decades and there has been a movement towards extending choice in residential care.

This research aims to study older people's care transition experiences and their exercise of choice during the process of care transition, to explore the meaning and the perceived effects of choice and to identify the role of choice in promoting a positive care transition.

This thesis presents findings from 48 in-depth interviews with older people who became new residents in one of the ten participating residential homes in London and had their care paid for by the local authority. This research identified four groups of older people who showed marked differences in terms of their needs, their exercise of choice during the care transition process and their adaptation to residential care: Active Planners, Conformists, the Unsettled and Shelter-Seekers.

The findings from this research suggest that the older people's care transition experiences varied and that they stretch beyond the prevailing evidence emphasising the stressfulness of the care transition. The cases of Active Planners and Shelter-Seekers show the potential for positive roles for care homes in the case of users with genuine needs for residential care. An overwhelming majority of the older people who were interviewed were great proponents of choice and many of them actively exercised choice in the course of their care transition. This challenges the claim of the passivity of older people which has been argued in the literature. However, the cases of some Conformists who did not want to exercise choice also highlight that having no choice can be a choice for some older people. On the whole, older people's exercise of choice played an important role in facilitating a positive transition, despite it not being a precondition for such a transition. However, there were administrative issues limiting the level and the extent of choice that were available to the older people and the Unsettled experienced an undesired move into a care home, having their choices denied or rejected. This thesis also questions the working of choice and competition in residential care, as the older people did not seem to enjoy the expected benefits of choice relating to service improvements which have been argued for in the literature.

TABLE OF CONTENTS

Abbreviations

CAQDAS	Computer Assisted Qualitative Data Analysis Software
CQC	Care Quality Commission
CSCI	Commission for Social Care Inspection
FACS	Fare Access to Care Services
LAC	Local Authority Circular
MCI	Mild Cognitive Impairment
NHS	National Health Service
OFT	Office for Fair Trading
SCIE	Social Care Institute for Excellence
SSD	Social Services Department

List of Tables, Figures and Boxes

Tables

Figures

Boxes

1. Introduction and Overview

This thesis examines the degree and the extent of the choice that older people exercise regarding different aspects of publicly-funded residential care. It also explores the meaning and the role of choice in their care transition. Care transition, defined in this thesis as the process of moving from community to residential settings, is a life-changing experience for older people. Along with the emphasis on choice in public services in recent decades, care transition in later life will receive more attention in ageing Britain.

This chapter first presents an overview of the research context and introduces the research questions and aims. It then explores the analytical frameworks that the researcher developed for this research, followed by a brief discussion of the research methods employed. The chapter then presents a summary of the main findings of the research and, lastly, explains the structure of the thesis.

Research context: Care transition and choice

Research context at a glance

The introduction and the extension of choice in public services has been a key theme in British social policy for the last few decades. Choice in long-term care has received considerable attention in recent years and Direct Payments[1] are planned to be extended to users of residential care from April 2016, following the Law Commission's report *Adult*

[1] Direct Payments are payments for publicly-funded users of social care. Personal Budgets assigned to individuals can be paid to the users in the form of Direct Payments, so that they can arrange and purchase their own care.

Social Care (The Law Commission 2011) and the *Caring for our Future* White Paper (DH 2012). The move from community to residential care often involves a type of care transition that can be the most radical and traumatic that one can experience in old age. Older people are known to experience the transition negatively and as passive recipients of care. The concept of choice is particularly important in residential care, since older people's having 'choice' has been constantly referred to as the key to a positive transition (Nolan and Grant 1992; Nolan *et al* 1996; Lee *et al* 2002). Yet, older people's lived experiences of exercising choice during the care transition have rarely been the subject of study, despite considerable changes in the welfare mix and the emphasis on choice in the provision of residential care.

Background

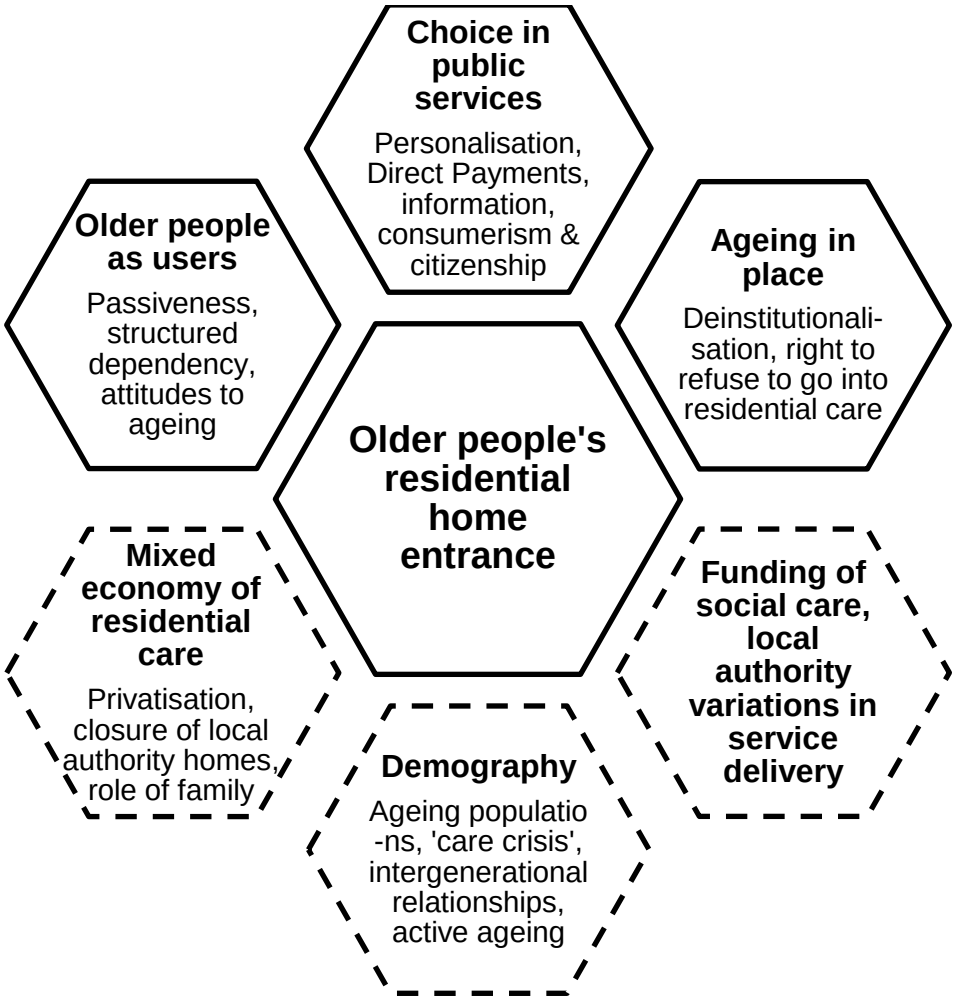
Before discussing the research context in more detail, it is helpful to understand how the research topic fits into the wider social policy context. Figure 1.1 summarises the policy context of the research by illustrating how it relates to different areas of social policy and current social policy debates and which areas this research particularly focuses on. The policy areas or issues illustrated in the figure are explored below in order to disentangle the research context.

In England[2], long-term care can be provided in three different settings according to the needs of service users: in the community, in a residential home (a care home with personal care), and in a nursing home (a care home with personal and medical care). The experience of the transition from community care to residential care is not uncommon amongst older people in England and Wales, with about 12% of men and 23% of women aged 85 or over living in

[2] This research concerns the provision of long-term care in England only as the system of funding and delivery of social care is different in Scotland, Wales and Northern Ireland.

residential or nursing homes in 2001 (Summerfield and Babb 2004). About two-thirds of all residential places in England (349,000 in 2011) are funded by local authorities (Lievesley *et al* 2011; DH 2013). People living today are enjoying the longest ever life expectancies, but it is debatable whether they are necessarily ageing in a healthy way. The increasing importance of long-term care policy comes from this context.

Figure 1.1 Care transition and social policy[3]



Source: Author's own illustration

[3] Topics written in the solid (full) line hexagons are the ones this research is particularly focusing on. Topics in the dotted line hexagons are related to the research questions and discussed in relation to the findings in the subsequent chapters, but not the focus of this research.

In British social policy on long-term care, the emphasis in the last few decades has been on deinstitutionalisation and ageing in place. Nevertheless, the number of older people experiencing residential care is expected to increase in the years to come as the population ages (Sandberg *et al* 2002; Herrara *et al* 2011). Knapp *et al* (2005) forecasted a 151% increase in residential places over the next 50 years. The concern about the increasing demand for care home places and for long-term care as a whole triggered the discussion of the introduction of the National Care Service (HMSO 2010), the publication of the Dilnot Report on a fairer funding system for long-term care (Commission on the Funding of Care and Support 2011) and the subsequent Care Act 2014 (HMSO 2014).

Moving from one care setting to another can be a life-changing experience for older people and, in particular, the move from community care to residential care involves major changes to virtually every aspect of their lives. The changes not only include the locus of care, the nature of care and the people involved in caring, but also changes in their home environment, their way of living and their social relations. The period of moving into a care home has been referred to as the time that is most likely to induce high tension and complex negotiation in the long-term care for older people (Strang *et al* 2006). It has also been found that the quality of the move determines the quality of life of these older people and even of their family, relatives and friends (Biggs 1993). Hence, studying 'how older people cope with the transitional period' has considerable importance in practice, even leaving aside the social, political and academic importance of such study in an ageing society.

In order to indicate the radical nature of the changes involved in the move and the degree of changes that older people experience during the move from the community to residential homes, this thesis refers to the move as 'the care transition'. The term 'transition' was used

first in relation to moving into a care home by Ray *et al* (2009) in their discussion of transitions in later life and the role of critical gerontological social work. In their study, older people's experiences of different transitions were interpreted through life-course and biographical perspectives. This thesis uses the term 'care transition', reflecting these perspectives of seeing a transition as a continuing life-course experience and George's (1982) neutral view of seeing change as a transition rather than a crisis. This thesis also recognises the move from community care to residential care as a process, rather than a one-off life event, as it has often been described in the relevant literature. The period of care transition is defined here as the period between the initiation of the move and the adaptation after the move.

The concept of 'choice' is considered important for, and closely related to, older people's care transition experiences for three reasons: *First*, there have been a number of policy initiatives in the last few decades relating to the promotion of choice in public services and choice in residential care is planned to be further institutionalised through the introduction of Direct Payments in April 2016; *Second*, older people's having choice, which has been lacking in most relevant studies, has been continuously referred to as the key to less stressful transition experience; And, *third*, older people have often been described as passive recipients of welfare who are not interested in exercising choice in public services.

First, the concept of 'choice' has considerable importance in the provision of publicly-funded residential care, with the Government's recent unveiling of the plan to extend Direct Payments to users of residential care in 2016. In a broader context, users' right to be in control of their care was formally established by a series of Acts relating to safeguarding adults. They include the 1998 Human Rights Act (which emphasises the protection of the

rights of citizens), the 2005 Mental Capacity Act (which is designed to empower those who lack capacity to be involved in decision making as much as possible) and the 2010 Equality Act (which aims to prevent discrimination in service provision) (HMSO 1998; HMSO 2005; HMSO 2010; DH 2011; SCIE 2012).

More explicit rights to choice regarding the use of residential care began with the 1948 National Assistance Act (HMSO 1948). There has been an element of choice in residential care since the 1948 Act, which recognises users' choice of accommodation (Le Grand 1991). Local authorities used to be the main provider of residential care until the late 1970s, but the introduction of the 1980 Supplementary Benefits Regulations encouraged private sector involvement in the service provision (Allen *et al* 1992; Glendinning 1998*a*). The principle of the 1948 Act was confirmed and strengthened in the 1992 Local Authority Circular (LAC) *National Assistance Act 1948 (Choice of Accommodation) Directions,* which outlines clearly that local authorities should make every effort to provide a choice of residential homes that are suitable to meet the needs of users within their financial limits (DH 1992).

These legislations were conceived in the context of the widening division between different sectors in the welfare mix in terms of funding, providing and regulating residential care. The mix of public (run by local authorities), private and voluntary residential homes has been changing significantly since the early 1980s (Glendinning 1998*a*), with a significant number of private homes emerging while the existing local authority homes were closing down. The divisions of welfare in the funding, provision and regulation of residential care have become wider since the 1990 NHS and Community Care Act, which introduced the local authority assessment of users' needs and stressed user empowerment and competition between suppliers (Baldock and Ungerson 1994). Consequently, the changing nature of the welfare

mix has assigned the role of funder to local authorities, the role of provider to various private and voluntary sector care homes and the role of regulator to an independent inspectorate set up by the government.

After the turn of the 21st century, older people's choice in residential care (choice of home) was further emphasised by the introduction of the National Minimum Standards for care homes for older people (DH 2003), following the Care Standards Act 2000 (HMSO 2000). The importance of offering choice to users in residential care was recognised in the wider context of personalisation in social care in the 2005 Green Paper *Independence, Wellbeing and Choice* (DH 2005), the 2008 LAC *Transforming Adult Social Care* (DH 2008) and *A Vision for Adult Social Care* (DH 2010*a*). Following the 2011 Law Commission's (2011) recommendations and the 2012 *Caring for Our Future* White Paper, there has been a discussion on the introduction of Direct Payments in residential care. Direct Payments have been piloted in some local authorities from 2013 (DH 2012; Ettelt *et al* 2014) and the Government has recently decided a national roll-out of Direct Payments in residential care in April 2016 (HMSO 2014; Ettelt *et al* 2014).

The introduction of choice in public services was intended to reflect the ever-diversifying needs of people living in contemporary Britain and to increase the quality and efficiency of public services. Among them, social care has been at the forefront of the agenda for the promotion of choice among service users. However, what distinguishes residential long-term care from other types of social care in the discussion of choice is the contrast between the values of choice in social care and the de-institutionalisation that has been simultaneously promoted in the literature and in British social policy. The UK government has promoted community care over residential care, putting forward the phrase 'ageing in place'. The focus

on community care has been fortified by the adoption of the 1991 United Nations Principles for Older Persons (UN General Assembly 46/91, 1991) and the narrow interpretation of the 'active ageing' agenda, which was promoted by major international and inter-governmental organisations, including the WHO.

The image of residential care and of care homes has remained somewhat horrendous to the public, following the media coverage of tragic events in care homes and the academic literature reporting on the hostile care home environment. In particular, structured dependency theorists have argued that residential homes are the places for creating and reinforcing the dependency of older people (Townsend 1981; Walker 1982). As a result, despite the continuous emphasis on choice, the de-institutionalisation agenda has resulted in limiting older people's ability to make genuine choices in long-term care. Developments in choice have been slow and limited regarding residential care and the concept of 'active ageing' has been interpreted narrowly only to include older people's being active in the community.

By contrast, there have been some important developments in the context of increasing user choice in community care. The consumerist approach represented by marketization and the application of choice has been clearly outlined in the social care reforms in Britain, from as early as the late 1980s. The 1989 White Paper *Caring for People* (DH 1989) and the subsequent National Health Service and Community Care Act 1990 (HMSO 1990) introduced user choice in the area of social care. There was also a strong movement for independent living by users of community care (those with disabilities) and it played an important role for the introduction of Direct Payments for users of community care in 1997 (HMSO 1996) and Individual Budgets in 2008 (DH 2006). The stress on choice is still

evident in the 2006 White Paper, *Our Health, Our Say: A New Directions for Community Services* (DH 2006), in the Government's vision for adult social care (DH 2010*a*) and in the new Care Act (DH 2014).

The imbalance between the developments of choice policy in community care and residential care makes one question whether active choice can be properly facilitated for older people needing residential care. What would be the user experience of residential care in a situation where there is a dual emphasis on choice and de-institutionalisation? Although the existing literature usefully shows the importance of the concept of 'choice' in older people's care transition, there has been a lack of study on the link between the introduction of choice in residential care and older people's exercise of choice.

The discussion on choice in public services is currently focused on the rationale and the benefits of introducing choice in public services, in particular, in education, health and community care. The emphasis on choice has been underpinned by the argument that the introduction of choice can provide those who are marginalised in society with the opportunity for more control and autonomy, which has only been available to those who are better off. Advocates of choice have listed a number of benefits choice can offer, the most prominent ones including enhancement of user autonomy, service quality, efficiency, equity and responsiveness (Le Grand 2007; Greve 2010). Yet, there have also been strong criticisms of the choice policy. For example, it has been claimed that the introduction of consumerist principles in public services would undermine public service ethos and democratic accountability originate from collective provision of welfare. It has also been argued in the literature that choice may cause unexpected and/or undesirable side effects, such as

increasing inequality in the use of some public services (Hunter 2009), post-decision regret (Schwartz 2004) and other psychological effects (Salecl 2010; Iyengar 2010).

The discussion on the benefits and the rationale of introducing choice in public services is also relevant to the user experience of choice in residential care. However, there are also some important service-specific aspects to be considered. In particular, it has been recognised in the literature that choice in residential care provided some specific benefit to those who exercised it, namely, the mitigation of negative effects of moving into a care home.

The majority of the relevant literature presents the nature of the care transition experience as one of loss and suffering (Nay 1995, Lee *et al* 2002). It is often argued that significant life changes, such as relocation, can have negative effects on individuals, both physically and psychologically (Schulz and Brenner 1977; OFT 2005). Few studies have looked at the whole process of care transition that older people experience, but there are several studies on older people's experiences of moving into a care home, which found that their experiences were painful and stressful (Lee *et al* 2002). Such negative research findings continued to be reported throughout the last 50 years since Townsend, in his two landmark studies on residential care, reported appalling conditions in care homes in the late 1950s and the early 1960s (Townsend 1957, 1962). In fact, the transition from community care to residential care can be particularly hazardous and stressful, as it can often be the first experience of change in care settings for older people. In other words, the nature of the transition from community care to residential care is more radical than other types of care transition, such as the move from hospital to a care home or the move between different types of care homes, and might thus have more impact on older people.

However, it is also notable that since the publication of Townsend's studies and of other studies rejecting the idea of 'institutionalisation', there has been a great deal of improvement in the standard of care provided in care homes and their physical environment (Johnson *et al* 2010). Some studies have also recognised that care homes can have some positive functions (OFT 2005; Johnson *et al* 2010). Nevertheless, older people's experiences of transition have been continuously described as traumatic and stressful (Tobin 1989; Victor 1992; Biedenharn and Normoyle 1991, Lee *et al* 2002) and the perspective of seeing community care as superior to residential care has remained unchanged during the last half century. Residential care has been seen as 'the last refuge' for older people, which creates and reinforces their dependency (Townsend 1981). This calls into question the actual care transition experiences of older people living in contemporary society and the possibility of a positive care transition.

A 'positive care transition' is defined in this research as a care transition that takes place in a way that reflects older people's choices, facilitates their adaptation to the new care and living environment and enables them to maintain their sense of self and of autonomy. Despite the largely unfavourable research evidence, it is not the case that the possibility of a positive care transition has been completely denied in the literature. A couple of studies found mixed evidence of negative and positive transition experiences (Allen *et al* 1992; Kellaher 2000). In these two studies, and in other studies which reported negative experiences of care home entrance, it is notable that there was a theme that is constantly recurring in the discussion of promoting positive experiences of care home entrance – namely, choice and active involvement (Chenitz 1983; Allen *et al* 1992; Nolan *et al* 1996; Kellaher 2000).

Nolan *et al* (1996) defined the most desirable type of residential home entrance as a 'positive choice', as it was named in the Wagner Report (HMSO 1988*a*), and they described it as a

move that takes place after sufficient anticipation, participation, exploration and access to information. Although it is not clear from the literature how choice works in the facilitation of positive care transition experiences, the importance of choice has been stressed in many studies and is considered the key to a positive transition. This poses some important questions: what types of choice are available to older people using residential care in England and how do they actually exercise such choice?

The questions mentioned above bring up the third point for discussion, which relates choice in residential care to older people's attitudes towards choice and their exercise of choice in public services. Old age is often seen as the period of decline and loss (the view based on the medical model of ageing) and older people have been referred to as passive recipients of welfare. Older people have been described as an 'inverse critical case', a group of people who are least likely to adapt to, or be affected by, policy changes (Roberts and Chapman 2001). Along with the negative experiences of care transition, what has also not changed throughout the last 50 years is the portrait of older people as passive recipients of welfare. Studies on Direct Payments and Personal Budgets reported findings that can consolidate this view. These findings include the ones on older people's low take-up of Direct Payments compared to other groups of service users (Glendinning *et al* 2008) or the uncertain benefits of Personal Budgets on older people's well-being (Netten *et al* 2012). Boyle (2013) concluded that older people using local authority funded social care did not appear to want 'the additional burden' involved in planning and arranging their own care.

Studies on care home entrance found that older people's exercise of choice and their participation in the decision making process were low. In most cases, the move to a residential home was initiated not by the older people themselves, but by others around them

(Townsend 1962, Chenitz 1983; Phillips and Davies 1990; Allen *et al* 1992; Glendinning 1998*a*; Williams 2005). Townsend (1962) reported that there was no active exploration of the available care options and there was little choice of a specific care home or any reflection of the older people's preferences in relation to other aspects of the move, including the timing of the move. He interpreted the lack of older people's involvement in their move as a reflection of their reluctance to go into residential care. In fact, Townsend (1962) found that there were a considerable number of relatively fit people who reluctantly moved into a residential home. Several studies on residential home entrance have suggested that older people still remained passive users of residential care (see Chenitz 1983; Phillips and Davies 1990; Allen *et al* 1992; Nolan *et al* 1996; Roberts and Chapman 2001). This has often been the focus of relevant studies as to whether and how older people 'accept' their move, not to speak of their exercise of choice or expressing any preferences during the move. With the exception of a couple of studies which found some cases of positive care transition experiences (Allen *et al* 1992; Kellaher 2000), the element of involvement and choice was hardly found in the literature on older people's care home entrance.

To sum up, there has been a lack of research which defines the care transition as a process (rather than a one-off event) and which explores the dynamics behind the actual experiences of moving in and exercising choice, despite the increasing importance and frequency of the care transition process. The contribution of the social policy literature to the research on older people's experiences of care transition, and their exercise of choice in residential long-term care, has been limited over the last few decades. To date, the research evidence on older people's experiences of care home entrance has stressed the following three points: a) older people were little involved in the process of the move and tended to be passive, b) their experiences of the move tended to be negative and painful, and c) their active involvement in

decision making regarding the move seemed to be the key to yielding more positive experiences. The research evidence, together with the government's plan for the extension of choice in residential care, draws special attention to the application and the role of choice in residential long-term care and relevant user experiences. Choice in residential care has been referred to as the representative type of choice in public services that most resembles patient choice in health care (Fotaki *et al* 2005). Yet, older people's lived experiences of care transition and choice are still not known in the context both of policy application and practice. Older people have been described as passive recipients of public services, who neither want nor exercise choice; but how older people experience the care transition as a process and how they exercise choice and attach meaning to their choice during the process have yet to be studied. Exploring these issues, therefore, can not only inform the literature, but also the future policy and practice in times of extending choice in residential care.

Research questions and aims

This research attempts to fill these gaps in the literature by recognising older people's experiences of changes in their care environment as a process and bringing the concept of 'choice' into the research. By studying older people's lived experiences of the care transition process and their exercise of choice, the thesis aims to enhance understanding of the needs of older people moving into residential care and to inform policy and practice by placing their care transition experiences in the context of social policy and administration. In order to uncover the dynamics behind older people's care transition experiences and how the concept of choice is interwoven with the dynamics, the thesis explores the following four research questions:

1. What are older people's lived experiences of the transition from community care to residential care in England?
2. How, if at all, do older people exercise choice in their transition to residential long-term care?
3. What are the meaning and the perceived effects of choice in residential care?
4. What is the role of choice in shaping a positive care transition?

Introducing the analytical frameworks

The researcher developed analytical frameworks in order answer the four research questions. The researcher employed semi-structured in-depth interviews as the main method of data collection. Seven pilot interviews were conducted in order to test and revise the topic guide. The methods of data collection and of analysis used in this research are introduced briefly, in the next section, and are explained in more detail in Chapter 3. The analytical frameworks were devised during the interpretation of the interview data and were based on the research findings, the literature and the researcher's theorisation of choice in public services, which was developed throughout the research (see Chapter 3 for more details).

Before we move on to discuss what these analytical frameworks consist of, there needs to be a discussion of the key concepts used in this research. The two key concepts in the research are, as is evidently shown in the research title, care transition and choice. The concept of 'care transition' is defined in this research as a process that encompasses four different stages of initiation, exploration of options, the exercise of choice and adaptation. The thesis is open to the possibility of older people's experiencing a positive care transition, which has largely been denied in the literature. In the same way, the researcher's definition of a positive care

transition (which is discussed in Chapter 3) does not mean that the researcher expected to find, or particularly looked for, any cases of positive care transition experiences during the analysis of the interview data.

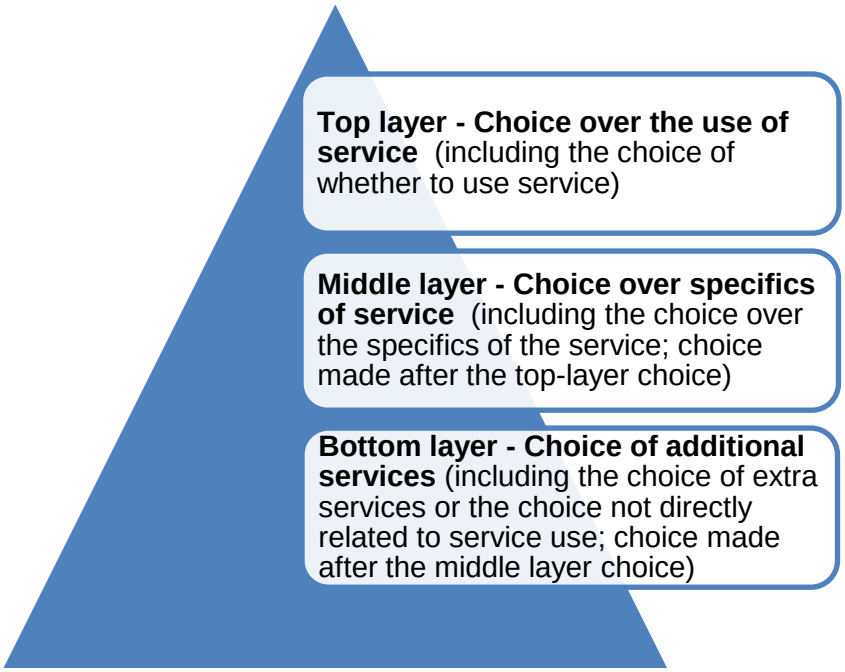
In the literature, choice often means an option or the act of choosing, but the concept of 'choice' is mostly interpreted here as the right to choose. The interpretation of choice in this thesis is two-fold: first, that choice is multi-faceted; second, that choice works at various levels. The first interpretation can be understood in the context of the Le Grand's (2007) idea of 'dimensions of choice'. Le Grand (2007) argues that there are different aspects of choice in public services and that there are choices of 'what, when, where, who and how' regarding the use of public services.

The second interpretation is based on the researcher's idea of 'layers of choice' (this idea is discussed in more detail in Chapter 3), which was informed by the findings from both the pilot interviews and the main stage fieldwork interviews. The idea of 'layers of choice' recognises that choice in public services works at three different levels (at the top, middle and bottom layers) in different order. Types of choice on the top layer are related to whether to use the service itself or to find alternatives (e.g. choice of whether to use residential care) and those in the middle layer are linked to choice over the actual use of the service (e.g. choice of a care home). The bottom layer concerns choice of additional services. Choice at this level is not directly related to the use of service itself and made after higher level choices are made (e.g. choice of personal belongings to take with them to a care home).

The level of choice that one can exercise indicates the degree and the extent of user choice in any one service area (see Figure 1.2). It can tell us more about the application of user choice

in public services than the idea of 'dimensions of choice', in terms of the degree of autonomy and control allowed to individual service users.

Figure 1.2. *Layers of choice applied to residential care*



Source: Author's own illustration

With these key concepts in mind, we will now turn to exploring the actual analytical frameworks that the researcher developed for this research. Different analytical frameworks were developed, modified and refined throughout the main stage of the research in order to answer each research question.

Q1. What are older people's lived experiences of the transition from community care to residential care?

The first research question is an attempt to explore older people's experiences of care transition. Based on the findings on how the older people coped with the changes that they

encountered during the care transition, the researcher classified the changes that they experienced into four categories; environmental, emotional, physical and relational changes. The four categories were used to study the broad experiences of the care transition. Then, there was the second analytical framework that the researcher devised, which was also informed by the interview findings. This framework allowed the researcher to study older people's perceptions of care home life by asking them about the merits and demerits of living in a care home, compared to living in the community.

Q2. How, if at all, do older people exercise choice in their transition to residential long-term care?

The second research question concerns older people's exercise of choice during the care transition. The interpretation of choice in this thesis is most clearly shown in the following two analytical frameworks that are designed to answer the second research question. The researcher intended to examine both the type and the degree of choice that older people exercised during the transition process. First, in order to explore the type of choice that individuals exercised, the researcher compiled different dimensions of choice in public services using the research findings and the literature. Initially, the five different dimensions of choice put forward by Le Grand (2007) were interpreted as different types of choice that older people can exercise in the use of residential care and were adjusted for use in this research (see Chapter 3 for detail). Two types of choice suggested by Williams (2005) were also included in the framework. In addition, three other types of choice found during the fieldwork interviews were added to the framework.

The second analytical framework that was used to study the second research question was based on the idea of 'layers of choice', which was developed and refined by the researcher throughout the main stage of the research. Different types of choice in relation to public services were further divided into three categories and were placed in three different layers: the top layer involved choice over the use of a service; the middle layer encompassed choice over the specifics of the service; and the bottom layer included choice of additional services. The level and the extent of the choice allowed to individual service users decreased significantly as we went from the top layer to the bottom layer. Using this framework, the degree of choice that individual users exercised was examined.

Q3. What are the meaning and the perceived effects of choice in residential care?

The third research question is related to the meaning and the impact of choice. In order to answer the third research question, this research explored older people's perceptions of the experience of exercising choice. Possibilities of their having both positive and negative perceptions of the exercise of choice were considered. During the analysis of the interview data, the researcher found some positive perceptions of choice found in the literature, including the fundamental sense of well-being (Schwartz 2004; Giddens 1991). Also included in the analytical framework are various benefits of choice that are expected to occur through the introduction of choice in public services, including improvements in service equality, efficiency, equity and responsiveness (Le Grand 2007; OFT 2005). Negative perceptions of choice were also added to the framework, which are mainly found in the psychological literature on choice and post-decision regret (Schwartz 2004) and an increase in anxiety (Salecl 2010). The research also explored that the perspective of seeing choice and consumerist approaches as undermining the concept of citizenship.

Q4. What is the role of choice in positive care transition?

The last research question is about finding the role of choice in a positive care transition. While exploring elements of a positive care transition, the researcher linked the degree of choice that individuals exercised (active/moderate/slight) to the users' satisfaction with and their adaptation to care home life. The analytical framework also included the following 'processes' that helped older people to adapt to life in care homes which were found by Chenitz (1983) and Nolan *et al* (1996): centrality, continuity, desirability, legitimation and reversibility. How these five processes were related to the interviewees' experiences of care transition is dealt with in Chapter 8. A detailed exploration of the analytical frameworks and their application is discussed in Chapter 3.

Research methods

Data collection

The research employed qualitative in-depth retrospective interviews in order to best study the four research questions (details of the research methods employed are discussed in Chapter 3). Considering the nature of the research questions, which are intended to explore in-depth and to understand older people's lived experiences, a qualitative investigation seemed appropriate. Interviews were carried out in a semi-structured manner in order to cover the key interview topics and allow some flexibility (e.g. extra questions, depending on the interviewees' experiences) at the same time. Retrospective interviewing was necessary as older people are

known to be in a vulnerable state during the initial period of the care transition, namely, for the first few months after moving into a care home in most cases.

A topic guide was devised and seven pilot interviews were initially carried out in Birmingham and Oxford between September 2009 and November 2009 to test and revise the topic guide. For the main interviews, contacts were initially made to individual care homes by letter and the researcher phoned homes that agreed to participate in order to make an appointment. The researcher made a visit to the homes and explained the research topic to the care home managers and other members of the staff. The researcher also had a chance to look around the homes and to have a casual chat with the residents during the visit. Care home managers and staff helped the researcher to find potential interviewees and distributed information booklets with a reply slip. There were ten participating homes and all of them were located in one of three boroughs in London (two inner London boroughs and one central London borough). The three boroughs showed contrasting figures in their social exclusion and poverty index and the proportion of older people living in the borough. The three boroughs also had the most varied types of care homes among the thirty-two London boroughs, having all the three types of private, voluntary and local authority homes. Having this variety (both in terms of the local authority area and of the welfare mix) helped in recruiting a balanced sample from different backgrounds and preferences.

During the main fieldwork, 50 interviews were initially conducted between April 2010 and August 2011, but two interviews had to be excluded from the analysis due to the interviewees' fast-developing dementia. All the interviewees for this research were recruited based on the following criteria: those who a) were aged 65 or over, b) were living in residential homes in England, c) had sufficient cognitive ability to be interviewed, d) had experienced the care

transition for the first time from community-based home care to residential care, e) had their residential care paid mostly by the local authority, and f) spent between six to twelve months in the homes as an adjustment period. It was necessary to invite people who spent between 6-12 months after their move into the care home, as older people are known to be in a particularly vulnerable state during the care transition. Whether potential interviewees had cognitive ability which was sufficient to participate in the research was judged on the basis of the care home administration record and the opinion of care home staff and the medical staff. These sampling criteria were used to recruit the research sample which enabled the researcher to explore the lived experiences of public service users (i.e. those on low income who hence qualify for publicly-funded care, who made their first care transition) in a safe way (i.e. interviewing residents 6-12 months after the move to avoid the period of great vulnerability) and in a non-discriminatory manner (i.e. not excluding those with mild cognitive impairment). All the interviews were recorded using a digital voice recorder and were fully transcribed for the analysis.

Data analysis

Thematic analysis was used for the analysis of the interview data. Thematic analysis was suited to the purpose of the analysis for several reasons. First, thematic analysis is designed to deal with data that involves rich and often lengthy qualitative data derived from people's experiences. Second, thematic analysis also entails collecting stories and creating conceptual groupings from the data (Reissman 2005), which helps researchers understand and demonstrate 'the ways that people organise and forge connections between events and the sense they make of those connections' (Bryman 2004, p. 412). Last, thematic analysis is the method that is often used with retrospective interviews (e.g. life history research) and allows

a researcher to see the process of, or the stages of development involved in, certain events or experiences among specific groups of people. Data analysis is discussed in more detail in Chapter 3.

The main findings of the research

In answering the four research questions, the main findings of the thesis can be summed up as the following four points. Each of the four main findings can be interpreted in the context of responding to each of the four research questions.

First, it was found that older people's experiences of care transition varied, in terms of their needs, their exercise of choice and their adaptation to the care home environment. This implies that older people are not a homogeneous group of users and that their varying needs and preferences should be considered in policy and practice. The research identified four conceptual groups of older people who showed marked differences in their experiences of care transition. In the taxonomy developed by the researcher, they were named *Active Planners, Conformists, the Unsettled* and *Shelter Seekers*. Many interviewees experienced a positive care transition, unlike the prevalent evidence from the literature reporting on negative experiences of care home entrance (see Lee *et al* 2002). The cases of Active Planners and Shelter Seekers showed that there were many older people with intensive care needs who actively choose residential care. This presents a considerably different picture of residential care and of the care home population to that put forward by Townsend (1962), which highlighted a large number of older people with low care needs, who were placed in a care home without choice. However, a lack of information in a user-friendly format was a shared problem among the interviewees, despite a series of legislations aimed at providing

better information for users (DH 2003; DH 2006; DH 2010*a*; HMSO 2014). The experiences of the Shelter Seekers illuminated the under-researched role of residential care in meeting their special needs and the importance of safeguarding both inside the community and in care homes. This finding suggests that the role of residential care, including the role of care homes and their limitations, may have to be reconsidered.

The second main finding of the research challenges the claims about the passivity of older people in the process of care transition and in the use of public services, which have been put forward by many studies across different disciplines in the social sciences (see Chenitz 1983; Nolan *et al* 1996; Townsend 1962). This research found that older people were great proponents of choice, regardless of the level of choice that they exercised, contradicting Hunter's (2009) argument that choice is simply a middle class obsession. However, the analysis of the interview data using the idea of 'layers of choice' revealed that the degree and the extent of choice that the interviewees were able to exercise were limited. There was a minority of older people who exercised limited choice due to a sudden crisis, but in most cases, the lack of choice was related to systematic and administrative limitations. There were also considerable local authority differences in practice and some older people who had their choice of a home compromised. More importantly, the type of choice which operates at a high level - for example, the choice of whether or not to use residential care - was not provided to some service users and they could not avoid moving into a care home against their wishes. It appeared that the undesired moves into a home were conflicting with the Human Rights Law (HMSO 1998) and the principles of personalisation and plurality outlined in the Government's vision for social care (DH 2010*a*). The trauma of forced entry or having their choice rejected lasted for a long time and affected every aspect of the lives of the Unsettled. The introduction of Direct Payments in residential care (HMSO 2014) would help

older people to choose their preferred accommodation (often located near to their family and relatives), but there would still be a need to resolve the lack of social care funding and the 'post-code lottery' of residential care provision in order to pursue the principles of personalisation and prevention (DH 2010*a*) at the same time.

It was notable that there were several Conformists who outsourced their right to choose to others whom they trusted. This finding signifies that, for some older people, having no choice in the use of public services can be a result of the exercise of choice. In this context, choice in residential care should be ensured within the big picture of allowing more autonomy and control to service users.

The third key finding of the research challenges the arguments put forward by structured dependency theorists and questions the working of choice within public services, when it is not accompanied by comprehensive national guidelines and systems of information provision. The interviewees' experiences showed that the concept of 'dependency' created by their care needs can be a subject of positive acceptance and that it preceded their exercise of choice. Contrary to the arguments by structured dependency theorists, their experiences of residential care illustrated that a residential home was not necessarily a place of reinforced dependency, but can be a place for regaining a sense of independence. The research also found that older people's needs differed from those of the disabled people discussed in the literature, despite their perceived similarities. Their interpretation of choice and independence differed considerably. This implies that each of these groups of service users have their own unique needs regarding the use of public services.

Evidence from this research also shows that, despite most older people's longing for choice, their exercise of choice did not necessarily result in their ending up in a better quality care home or receiving more efficient or responsive service. Considering that the reasons for their not getting the expected benefits of choice were related to administrative issues and local variations, it becomes clear that the introduction of choice alone does not guarantee improvements in service quality, efficiency, equity or responsiveness. This finding challenges Le Grand's (2007) theory that the principle of choice and competition effectively replaces the mechanism of demand and control and works as another invisible hand, automatically controlling the running of the market. It also suggests that the elements of choice have to be part of a well-designed policy package, so that they accompany clear national guidelines and a strong system of quality control and information provision. It is possible that the emphasis on information and advice outlined in the Care Act 2014 might bring positive changes to the experiences of residential care users. In addition, the interviewees' exercise of choice did not lead to their recognising themselves as consumers or customers of care. Despite the heated discussion on 'citizens becoming consumers', their interpretation of having choice was related to the right to express their preferences as a user of public services. This suggests that there may be insufficient reflection of users' views and ideas in the current debate on choice.

Lastly, this research found that choice plays the key role in facilitating a positive care transition, despite its not being a precondition. In spite of the questionable working of choice and competition in some of the cases the researcher studied, the importance of choice that has been stressed in the literature was confirmed in this research. All of the interviewees who exercised choice reported that they experienced a positive transition. Among the five elements of a positive transition, namely, *voluntariness, informed choice, continuity, justification and informal support*, four of the five elements were related to the concept of

choice: voluntariness, informed choice, justification and continuity. The older people's exercise of choice facilitated their positive transition experiences by giving them the sense of continuity of life, greater potential for their justification of the move and greater satisfaction arising from the voluntariness of the transition. The exercise of choice made the greatest contribution to a positive transition if it was informed.

However, once the interviewees moved into a care home, the role of informal support became prominent in securing older people's well-being. The older people's relatives and friends acted as their advocates and raised their voice on any concerns regarding the provision of services in the home. It meant that choice in residential care was limited to the point prior to the move and the mechanism of choice as a means to expressing their preferences was replaced by voice (delegated voice) inside the care home. Older people's lack of choice inside the care home suggests that there is a need to ensure choice inside the care home and to promote relationship-based care, which can better reflect users' voice and choice. Overall, informal support from volunteers, peer residents and the family and friends of the older people played a major role in shaping their positive experiences. This finding highlighted the cases where older people contributed to other residents' positive transition as peers, relatives and friends and it showed that active ageing can take place in the context of residential care. It also implied that the role of family was important in the mixed economy of care and that it remained important even after the move.

Structure of the thesis

This chapter serves as an introduction to the whole thesis by setting out the subject under investigation and the need for this research by introducing the research agenda and

demonstrating how the research questions were answered in the thesis. Chapter 2 reviews the literature on care transition and on policies relating to the application of choice in public services and in residential long-term care. It looks at both older people's experiences of care transition and their exercise of choice during the care transition process. Evidence relating to the former can mostly be found in the literature, whereas evidence on the latter has to be preceded by an exploration of the mixed economy of residential care (which is the background to the introduction of choice in residential care) and the development of the relevant policies. Chapter 3 consists of two parts: the first part consists of the discussion of the key concepts and the application of the analytical framework; the second part explains the methods of data collection and data analysis, together with a consideration of ethics.

Chapters 4, 5, 6 and 7 attempt to answer the four research questions in turn. Chapter 4 introduces the procedures involved in older people's transition from community care to residential care, explores stages of the care transition and shows how the four conceptual groups (Active Planners, Conformists, the Unsettled and Shelter Seekers) were formed through the thematic analysis of the interview data. Chapter 5 looks at the experiences of the individual groups, with a focus on their exercise of choice. Older people's exercise of choice was examined using two analytical frameworks. First, the types of choice exercised by older people were explored using an analytical framework developed by the researcher using Le Grand's (2007) conception of choice in public services, Williams' (2005) discussion of choice in residential care and the pilot interview findings. Second, the degree and the extent of the choice that they exercised were studied using the researcher's own idea of 'layers of choice'. Chapter 6 seeks to disentangle the meanings attached to older people's exercise of choice and explore the effects of choice on their experiences. Then it discusses how the older people perceived their own experiences of choice. It is also discussed whether the older

people's exercise of choice brought any perceived changes to their identity as a service user. Chapter 7 discusses the five elements which constituted a positive care transition and identifies the role of choice in shaping positive care transition experiences. The five elements of a positive care transition - voluntariness, informed choice, continuity, justification and informal support - are explored in turn. Concluding remarks are presented in Chapter 8, including the revisiting of the research questions and the key findings, the contribution of the research to the literature, its implications for policy and practice and the scope for further research.

Chapter 2. Review of Literature and Policy

This research is driven both by gaps in the literature and by the need for more research that can inform policy and practice to improve older people's experiences of care transition and their exercise of choice in long-term care. The concept of 'choice' used in this research has a policy background, meaning older people's exercising their right to choose in the use of public services. Therefore, this chapter necessarily looks at both the literature and the relevant policy developments. This chapter consists of two parts: it first collates literary evidence on older people's experiences of care transition and their exercise of choice during the transition; then it discusses the context of offering user choice in residential care by reviewing relevant policy.

The first part of this chapter starts with an exploration of the nature of the transition and the prevalence of care home entrance in England. Then it moves on to discuss previous research on older people's experiences of moving into residential homes and possibilities for a positive transition. The second part of the chapter introduces the welfare mix in the provision of residential care and provides an overview of the application of choice in public services, with a special focus on the area of residential care. By reviewing the relevant policy and literature, this chapter identifies gaps in the literature and shows how this research can contribute to the literature.

Older people's experiences of care transition

The nature and the prevalence of care transition

Employing the approach taken by Ray *et al* (2009), this research saw the move to residential care as a change people can experience over their life course and used the term 'care transition' to describe the process of moving from community-based care settings to care homes. The move to residential care itself has been referred to as 'transition' in studies by Lee *et al* (2002) and Ray *et al* (2009). The use of the term 'care transition' reflects the fundamental differences between the two types of care the move connects. The process of moving not only involves different environmental settings, but also different forms of services provided to older people at different level by different people. The period of care transition[4] is important, not only because it can determine the quality of life of older people living in a care home (Biggs 1993), but also because it can affect the lives of their carers and other family members (Dellasega and Nolan 1997). The period of transition is also the time that is most likely to induce high tension and complex negotiation in long-term care for older people (Strang *et al* 2006).

The nature of the transition can be revealed more vividly if one thinks about the starkly contrasting images of community care and residential care. Care provided in homes (formally called 'institutions') has been perceived as care provided in enclosed and protective settings (Biggs 1993) and has been associated with the creation and the reinforcement of the structured dependency (Townsend 1981). In contrast, community care has been seen as care provided in the environments that enables older people to maintain their dignity and has often been valued as a 'labour of love' (Graham 1983). The negative image of residential and nursing care has been reinforced by the government's constant emphasis on community care from the late-1940s (Walker 1982). From then, with the publication of research findings and media reports on hostile care home environments (Townsend 1957, 1962), the concept of

[4] The term 'care transition' itself was not used in other studies. They often used the expressions such as 'the time before/after/around the move' and captured part of the transition process. The term 'care transition' has been used here for convenience instead of the expressions mentioned above.

community care has always been at the centre of social policy making. It has also been known that older people prefer community care over residential or nursing care. Some argue that residential care does have some positive attributes, including its contribution to residents' anxiety reduction and an increased sense of control and closeness (Nussbaum 1991; Biggs 1993; Johnson *et al* 2010). Nevertheless, the studies also recognise that these attributes have not received much attention.

However, care provided in communal establishments has remained an important area of social and long-term care, providing a considerable volume of care for older people every year. In 2004, there were 410,000 older people living in 15,700 private, voluntary and local authority care homes in the UK (OFT 2005). The estimated value of care provided in communal establishments is more than £8 billion per annum (OFT 2005). The prevalence of care home entrance makes residential care and the concept of care transition more important for older people. The experience of transition from community care to residential care is not uncommon among older people in England, despite the fact that care home places are increasingly occupied by people with more frailty than ever before. Although there is only a minority of the population aged 65 or over living in communal medical and care establishments, the minority is large among the old-old who are aged 85 or over, reaching 24% in 1993 (Redfern and Ross 1999; Grundy and Jitlal 2007; Victor 1992) and 12.2% for men and 22.9% for women respectively in 2001 (Summerfield and Babb 2004). Phillips (1992) found that, among those who moved into a residential home, 82% lived in the community before their move. This signifies that the transition from community care to residential care is, and will continue to be, a process that many families undergo and struggle with, despite the long-standing emphasis on community care in the UK and the global attention on ageing in place since the 1991 United Nations Principles for Older Persons (United Nations 1991).

The number of older people living in communal establishments is expected to increase continuously in the next 50 years (Comas-Herrera *et al* 2012). It is forecast that by 2020, people aged 65 or over will form a fifth of the population of OECD countries (OHE 1997, cited in Glendinning 1998*b*). With a 255% rise in the projected number of the 'old-old', Knapp *et al* (2005) expected a 151% increase in residential places over the next 50 years. The residential care home population has remained more or less unchanged between 2001 and 2011 (ONS 2014)[5]. However, the rising life expectancy and the consequent ageing population is likely to create an increasing demand for residential care. The absolute increase in the number of older people using residential care alone can create extra demand for staff, regulation and infrastructure. There has been an increase in the provision of alternative types of housing with care in recent years, but the occupancy rate in residential homes in the UK has been high, fluctuating around 90% between 2003 and 2012 (Colliers International 2013). The changing demography adds more importance to the study of care transition. Davies and Nolan (2003) argue that placing a relative or a family member will be a more common experience in the near future and should be regarded as a 'usual stage in a caring career' (p. 447).

Previous research on older people's experiences of care transition

It is defined in this research that the period of transition starts from one's anticipation of the move into a care home and lasts until her/his adaptation to the care home environment. However, the majority of the literature describes the care transition as a one-off event that takes place at one point in time. Thus, it is still not known how the recognition of the need for

[5] The older (aged 65 or over) residential care home population remained stable between 2001 and 2011, with an increase of 0.3% in terms of the *number* of older people using residential care during this period. This represented a decrease of 0.3% in the *proportion* of older people using residential in 2011 compared to 2011.

residential care leads to exploration of options, to choice making, to the actual move and to the subsequent adaptation, and how each step can affect the next steps ahead and, consequently, the quality of life in a home after the move. Therefore, the review of the literature on older people's experiences of transition does not tell much about the process of the move, but only about the move itself.

It is estimated that around two-thirds of the care home population in the UK is supported by local authorities to pay for their care, with the number of self-funders fluctuating between 30% and 33% of all residents (Lievesley *et al* 2011). A more recent estimate of the proportion of self-funders provided by Laing and Buisson (2013) was 39%. The population experiencing the transition in old age largely consists of female service users (Lee *et al* 2002). This is reflected in the differences between the proportions of males and females living in communal establishments and between the number of male and female participants in studies of care home residents (Phillips and Davies 1990; Kellaher 2000). Older women are also found to be the most likely group to live alone (Bennett and Dixon 2006), and living alone has been identified as an important factor influencing care home entrance (Martikainen *et al* 2009).

Older people moved into a residential home for various reasons. Among the primary reasons were: deteriorating health, caregiver exhaustion, fall/fracture, acute illness, poverty, inadequate housing, loneliness and lack of appropriate community services (Allen *et al* 1992; Sinclair 1998, cited in Biggs 1993; Gold *et al* 1995, cited in Strang *et al* 2006). Factors influencing the entry to a home have also been examined by a number of quantitative studies. It was reported that living alone, being female and old, having activities of daily living restrictions or cognitive impairment, being in contact with social services and having a low

socio-economic status were positively associated with the entry into a care home (Martikainen *et al* 2009; Hancock *et al* 2002; Prior and Hayes 2003).

Older people's move from community care to residential care has seldom been the subject of study in the field of social policy (Szczepura *et al* 2008). Relevant studies were mostly conducted in the field of nursing, between 1960s and 1990s. Most studies on older people's transition conducted in 2000s were based on the review of the literature and interviews with professionals (Lee *et al* 2002; Roberts and Chapman 2001; Fotaki *et al* 2005; Williams 2005). There is also a little recognition that the transition to residential care is a process that involves initiation, exploration, choice making and adaptation. However, the existing research evidence shows that the following two themes are closely related to older people's care transition: namely, *distress* and *passivity*. The two themes are explored in order below. By discussing the two themes, it is demonstrated that choice can be an important element in facilitating a positive transition.

The move into a care home as loss, discontinuity and suffering

Previous research on older people's move into care homes largely presented negative experiences of the care transition, focusing on their being distressed during the period of transition. This leaves little room for positive care transition (Nay 1995; Lee et al 2002).

Nay (1995) argues that there are different types of losses associated with the move to residential care: abstract, material and social losses. Some even observed the fear of losing oneself (Peace *et al* 1997, cited in Kellaher 2000). This psychological effect of the care transition is well-illustrated in the following accounts:

> Psychological effects of this anticipatory period are a result of feeling of abandonment and, also, of a redefinition of self as a person who can only survive if provided with institutional care (Tobin 1989, cited in Biggs 1993, p. 149).

Nolan *et al* (1996) found that most of the five elements of positive transition they identified were missing in the cases they studied. Some research findings also showed older people's difficulties in adjusting to the new care environment (Allen *et al* 1992). In the study by Kellaher (2000), it was also revealed that the process of adjusting was complex and lengthy for some older people and some care homes were left short-staffed, not being helpful to the older people.

Older people as passive users

Besides the distress the care transition might involve, studies on older people's move into a care home often paid attention to their passivity during the move. In his late 1950s' study on residential homes in England, Townsend (1962) found passivity of older people in the process of moving into a home. Townsend (1962) interviewed 530 older people living in 173 homes in England and, in over 80% of the cases studied, the move into a home was not initiated by older people themselves, but by other people around them, including relatives, GPs, almoners and local ministers of religion. It was also admitted by most welfare officers that older people virtually had no choice of a residential home. These findings were echoed in the studies by Phillips (1992) and Roberts and Chapman (2001). Townsend (1962) also collected research evidence on different aspects of choice over the use of residential care and found that besides the choice of a home, older people also did not have choice over the timing of the move and other aspects of the move.

The conventional description of older people as passive recipients of welfare services has not changed much between the late 1950s and the 2000s in the use of residential care (Willcocks *et al* 1987; Phillips 1992). Allen *et al* (1992) found that two-thirds of older people who took part in their study did not have any choice. Chenitz (1983) also used a passive term 'submission' to express older people's acceptance of the move. Nolan and Grant (1992) employed two new concepts, anticipation and embracing, to describe more active roles played by older people during the move into residential homes, but found that anticipation and embracing did not take place much in the reality. The most desirable type of residential home entrance has been referred to as 'a positive choice' (HMSO 1988*a*; Nolan *et al* 1996). Nolan *et al* (1996) identified key components that shaped 'a positive choice' – anticipation, participation, exploration, and information – but, found that most of the components were missing in the cases they studied. Studies on older people's choice in community care also reported on older people's low take-up of Personal Budgets (Netten *et al* 2012) and Direct Payments (Glendinning *et al* 2008). Older people have also been referred to as an inverse critical case, a group of people who are least likely to adapt to, or be affected by, policy changes (Roberts and Chapman 2001).

The influence of the third party in the move to residential care was also evident in the studies conducted between the 1970s and the 2000s. It was remarked that real consumers in residential care were not the older people themselves (Phillips and Davies 1990). Older people were not involved much in the decision making process and the decision to move into a residential home was often expert-driven (Williams 2005).

Stigma, information and a forced entry

There are some possible explanations for older people's passivity and their negative experiences. These experiences were related to the fear of 'being institutionalised', a forced entry to a care home, the administration of residential care or the lack of information.

It has been recognised in many studies that older people's passivity and their negative experiences of transition partly originated from older people's feelings of reluctance coming from their perception of residential care and the negative connotation attached to the use of service. It is known that experiences of moving house and home at any stage is a serious upset, and the move into a residential home has been found to be especially stressful (Kellaher 2000; Biedernharn and Normoyle 1991). The anxiety about the move is sometimes amplified by the abhorrent image of residential care highlighted by the media, academics and politicians, and the negative connotation it carries, which originated from the Victorian workhouse tradition (Ungerson 2002). Townsend (1962, 1981) strongly criticises the residential care environment and argued that it is the 'last refuge' that creates and reinforces unnecessary dependency of older people. UK governments' policy on social care has promoted care in the community on the grounds that community care (which largely relies on informal care) is cost-efficient and also matches older people's commonly known preferences to remain in their own home as long as possible rather than moving into a residential home (Johnson *et al* 2010). Kellaher (2000) also found that there was an unspoken dread of the stigma of becoming a care home resident. Some older people who participated in the study by Allen *et al* (1992) were too upset even to talk about their experiences. The reluctance of older people to apply for care home entrance was also explained by Townsend (1962) in terms of the application being seen as a humiliation of their pride.

Older people's passive attitudes and negative experiences of care transition were also related to their finding the move into a home unacceptable. Allen *et al* (1992) found that some older found the move unacceptable or illegitimate. Many older people accepted the move although it was a reluctant one, but some older people insisted that they could have managed at home given the chance. They did not see themselves as having the need for residential care, but had to move into a residential home against their wish. There were also some older people who thought that their move was temporary, but had their move made permanent afterwards (Allen *et al* 1992; Nolan *et al* 1996). In some other cases, the move into a care home was made in a short time and arranged by a third party and did not leave the room for older people's involvement (Allen *et al* 1992; Nolan *et al* 1996).

Other explanations for older people's low level of involvement could be related to the residential care market and the administration of residential care. There was a possibility that potential choices regarding the use of residential care were pre-selected by purchasers (local authority) through their making block contracts with certain care homes (Roberts and Chapman 2001). There were also traces of variations between local authority areas in the delivery of services (Allen *et al* 1992) and it was suspected that choice might not be evenly available, as in the case of GP choice (Roberts and Chapman 2001). Townsend (1962) and Allen *et al* (1992) also found that older people were not able to choose when to move in, since there was a lack of vacancies and the decision to move in was often a snap decision involving professionals and others around them. Roberts and Chapman (2001) found that only 38% of the local authority professionals they interviewed believed that there was scope for older people's choice.

It seems that the scope for choice for older people can be limited further in the future, with the recent introduction of the requirements which made local authorities to spend no more than 40% of their adult social care budget on residential care (CSCI 2009, cited in Land and Himmelweit 2010). This means that the already tightening eligibility criteria, which are largely open to the interpretation by each local authority (Baldwin 2008), may be tightened further in the future.

Some also found that older people's passivity and traumatic experiences were rooted in their lack of awareness of, and information on, the system of residential care provision. It has been reported that there has been a lack of information for both publicly-funded residents and self-funders (Allen *et al* 1992; Barnes and Prior 1995; Henwood 2011, Boyle 2013; LGiU 2013; NAO 2013). Also, it was often the case that older people did not know what to look at when they explored care homes (Allen *et al* 1992), despite their having certain preferences to small homes and homes that were close to their relatives (Phillips and Davies 1990). Older people often paid attention to the exterior of the care home they visited and were not aware of the existence of the Care Quality Commission inspection reports (Fotaki *et al* 2005). Good information was a precondition for ensuring safe decisions in residential care (HMSO 1988*a*), but older people often lacked good quality information.

The cases of negative experiences mentioned above have something in common – that the move lacked older people's choice and participation and left them unprepared for the move practically and emotionally.

Possibilities for a positive transition

Most studies found the lack of choice as the primary cause of a traumatic move into a residential home and this highlights the role of choice during the process of care transition. Although few studies focused on how choice affects older people's experiences (Fotaki *et al* 2005), the existing evidence does suggest that older people's exercise of choice would be the key to a positive transition (Tobin 1989; Nolan and Grant 1992; Nolan *et al* 1996; Lee *et al* 2002) and to their well-being in residence (Tobin 1989; Weaver *et al* 1985; Roberts *et al* 1991). According to Allen *et al* (1992), those who had choice over the move to a residential home, even if the choice was notional, settled in well to their new home environment. Tobin (1989) also found that older people's active participation in decision making helped to mitigate the negative psychological effects. The concept of 'desirability', defined by Chenitz (1983) as the extent to which the move was perceived as being desirable and undertaken out of choice, was also found to be an important element affecting older people's perception of their move. The same concept, desirability, was emphasised again by Nolan *et al* (1996).

Despite the evidence against positive care transition, not all experiences of older people have been found to be negative. For example, Allen *et al* (1992) found that some older people were only too happy to enter residential care, and stressed that the move into residential care can be a positive choice. The 1988 Wagner report on residential care also stated that there were people who were respected, felt secure and well cared for in residential homes (HMSO 1988*a*). Similarly, Phillips (1992) reported that some interviewees were relieved as a result of coming into a care home, arguing that the public perception of residential care needs to be changed and older people who enter residential care should do so by the exercise of 'positive choice' (HMSO 1988*a*). Kellaher (2000) found that, although 51% of her sample were self-funders, as much as two-thirds of the residents experienced more or less positive change in their disposition and sense of well-being after the move.

With the publication of some positive research findings, some academics, despite their being a minority, started to recognise the role of residential care. It has been argued that a well-run care home provides a vital service for older people and their relatives (OFT 2005) and that residential care has a role to play in responding to the challenges of a rapidly ageing society (Johnson *et al* 2010; Victor 2005). Several studies found that the satisfaction rate was high among care home residents they interviewed, with those who would like to recommend their home to a friend ranging between 79% and 95% (Phillips and Davies 1990; OFT 2005; Jenkins and Gibson 2005, cited in Fotaki *et al* 2005).

It was often the case that the positive traits of residential care were more frequently mentioned by self-funders, rather than by those whose care was funded by the local authority (OFT 2005). Nevertheless, in most studies, whether they were self-funders or publicly-funded residents, older people who adapted well to the new care environment were more likely to have initiated the move, consulted about the move with their family and actively participated in exploration of care homes and in the decision making process (Allen *et al* 1992; Nolan *et al* 1996). The concept of 'choice' emerges in this context of promoting positive care transition for older people and it draws more attention when considering the introduction of choice in public services and the extension of choice in residential care, which has taken place in the last few decades.

Choice in residential care

The application of choice in residential long-term care

There has long been an element of choice in residential care. As Le Grand (1991) acknowledged, in a way, choice has been built into the system of residential care from the implementation of the 1948 National Assistance Act. The Act clearly outlines local authority residents' right to choose a care home (HMSO 1948). There has been a formal recognition and the stress on 'choice' in residential care in the 1992 Local Authority Circular *Choice of Accommodation Directions* (DH 1992). Then, the principle of choice was further emphasised in many policy documents, including the 2000 Care Standards Act, the Government's Vision for Social Care (DH 2010*a*) and the Care Act 2014. Choice in residential care will receive more attention in the near future, as it has been recently decided that Direct Payments will be introduced in residential care from April 2016 (HMSO 2014; Ettelt *et al* 2014).

Background – the mixed economy of residential care

In order to understand older people's exercise of choice during the transition, it is necessary to explore the environment which facilitated the introduction of choice in public services. When the (mostly critical) studies on residential care started to be conducted, the majority of care homes were owned by local authorities. In 1960, about two-thirds of residential home beds were under the control of local authorities (Townsend 1962). The size of the homes was large, with 17% of residential homes (all owned by local authorities) having 250 beds or more (Townsend 1962). Most studies on residential care were thus conducted in local authority homes, primarily because of accessibility to researchers and feasibility of large-scale studies (Johnson *et al* 2010).

Since the mid-1980s, there has been a rapid growth of the new private sector market of residential homes in the UK. In the area of social care, privatisation was most evident in the

provision of residential care (Johnson 1999; Glendinning 1998*a*), dramatically changing the percentages of residential places in local authority homes and private homes. Residential places provided by local authorities dropped from 62.7% in 1980 to 26.8% in 1995, while places provided by private care homes shot up from 17.4% to 55.7% during the same period (Johnson 1999). By 1997, the majority of the 307,000 users of residential care were living in private homes already (Johnson 1999).

The involvement of the private sector increased substantially by the introduction of 1980 Supplementary Benefits Regulations (Allen *et al* 1992; Glendinning 1998*a*). The changes in social assistance regulations on funding residential and nursing care triggered the growth of private sector involvement by allowing older people to claim the full amount of their care fee and hotel cost in a private home (Glendinning 1998*a*). The funding was provided on the basis of older people's means, but not on their needs, and this resulted in the unintended rapid increase in social assistance expenditure on long-term residential and nursing care, from £39 million in 1982 to £2530 million in 1992 (Laing 1993, cited in Glendinning 1998*a*). The increase in the involvement of the private sector was accelerated by changes in the provision of hospital-based long-term care, with a 33% increase in the number of long-term care beds in hospitals for older non-psychiatric patients between 1980 and 1994 (HC 1995, cited in Glendinning 1998*a*) and a 42% decrease in the length of stay in hospital wards for older people between 1979 and 1986 (Walker 1995, cited in Glendining 1998*a*). The expansion of the private sector in residential care was further promoted by the requirement imposed on local authorities that 85% of the transferred funding must be spent on non-local authority services (Glendinning 1998*a*).

The government made an effort to limit access to social assistance funding for residential and nursing care, and transferred the funding and management responsibilities to local authorities, with the introduction of the current system of the assessment of needs and means (Glendinning 1998*a*). The 1990 NHS and Community Care Act, which was implemented in 1993, introduced local authority assessment of users' needs. This change has brought a fundamental change in the role of social workers and what Phillips (1992, p. 26) called an element of 'social worker autonomy' in the decision-making process has been increasingly replaced by user choice. Following the local authorities' withdrawal from the direct provision of services, the role of social workers has become facilitators and enablers.

The rise of the private sector in the provision of residential care also has its roots in the strong criticisms of large institutions and local authority financial considerations. Local authority homes started to close during the 1980s and many care homes became part of a big chain of hundreds of homes run by a multi-national company (Johnson 1999). In 2006, organisations running 11 or more care homes, such as BUPA, Southern Cross (which ceased to be an operator in 2011) and Four Seasons, provided 30% of total home places (OFT 2005). Despite the fact that there has been a slight tendency towards expansion of the size of care homes in recent years from 23.13 places per home in 2004 to 25.17 in 2010 (Lievesley *et al* 2011), the size of the then newly built homes in 1980s and 1990s was small and still remains small, reflecting the strong criticisms of large institutions.

The changing welfare mix in the provision of residential care discussed above offers a ground for the introduction of choice in residential care and for the new research. The divide between funding and service provision has often been seen as a condition that can facilitate the dynamics of choice and competition.

The introduction of choice in public services and in residential long-term care

It is commonly understood that choice policies in the UK have their roots in neo-liberal ideas, represented by Hayek's (1976) arguments for efficiency of market mechanisms in maintaining the 'spontaneous order'. Le Grand's (2007) argument for the introduction of choice and competition in public services is also based on the neo-liberal idea. Choice and competition were referred to as 'an invisible hand', which can bring a multitude of benefits regarding the delivery of public services. Public choice theory assumes that people are motivated by self-interest (Fotaki *et al* 2005) and also recognises that consumer choice can be a remedy for the inefficient allocation of goods and services by bureaucratic means (Niskanen 1971, cited in Fotaki *et al* 2005).

The introduction of choice in public services is also associated with the empowerment of the vulnerable and the Third Way politics (Greve 2010). Le Grand (2007) puts forward that the choice in public services is desired by those who are in a disadvantaged position in the society. In fact, some policies introducing choice are put forward by vulnerable user groups themselves, as was in the case of the introduction of Direct Payments for disabled people (Morris 2006). Choice in the context of Third Way politics is about public-private partnerships, flexible and efficient public services and changing responsibilities between the state and individuals, as can be found in the theories of reflexive modernity (Beck 1992, Giddens 1991).

The goals of choice policies have been found to differ between public services, reflecting service specific aspects of the service considered (Greener and Powell 2008). However, despite the diverse perspectives on, and goals of, choice, the presentation of choice in policy

papers and legislations has been markedly similar – with neo-liberalism at their root, committed to higher quality services and the empowerment of service users, using choice and competition as the means to achieve the aim. The table below (Table 2.1) summarises important policy developments relating to choice in public services.

Table 2.1. Major initiatives on choice in public services[6]

Legislation	New developments	Policy background	Commitment	Means
Education **1988 Education Reform Act (HMSO 1988*b*)**	Greater parental choice, league tables, national curriculum, market principles	Neo-liberalism	Driving up standards	Choice and competition ('every extra pupil means extra money for the school', HMSO 1994)
Health and social care **1990 NHS and Community Care Act (HMSO 1990)**	Introduction of an internal market/ GP choice, local authority assessment of need	Neo-liberalism	Empowering users	GP choice and competition, devolution of budgets
Social care **1996 Community Care (Direct Payments) Act (HMSO 1996)**	Introduction of Direct Payments for users of community care aged 18-65	The New Right and neo-liberalism (Glasby and Littlechild 2002)	Giving more independence and control to users	Stronger user choice and provider competition - further devolution of budgets
Housing **Quality and Choice: A Decent Home for All (DETR 2000)**	Introduction of Choice-Based Letting (CBL)	(Neo-conservatism and) neo-liberalism (Marsh *et al* 2004)	Improving quality of social housing and empowering service users	Tenant choice and competition
Health and social care **Our Health, Our Care, Our Say (DH 2006)**	More personalised services – Direct Payments and Individual Budgets	Neo-liberal individualism (Roulston and Morgan 2009)	More responsive service, more choice and control for users	Practice Based Commissioning, competition between providers (removing barriers to entry for third sector)

[6] The summary table is created by the author based on the information gathered from the original Act, Green Paper, or White Paper. Otherwise, reference stated.

Public services in general **Open Public Services (HMSO 2011, White Paper)**	Reforming public services (no specific scheme introduced)	Neo-liberalism (Hayek's theory of knowledge)	Provision of high quality, accessible public services	Increased choice and competition, decentralisation,
Residential care **2014 Care Act**	Introduction of Direct Payments for users of residential care	Personalisation based on neo-liberalism	Offering more autonomy, control and responsiveness to users' needs	Devolution of budgets (further details are to be announced)

The concept of choice in public services started to be introduced in the field of education by the Education Act 1988 and it still remains as one of the two most prominent areas in terms of the application of choice in service delivery. Health and social care is the other area where the concept of choice has been emphasised. The National Health Service and Community Care Act 1990 set milestones for ensuring choice in social and health care, by introducing market principles, user choice and the local authority assessment of needs. This resulted in the purchaser-provider split in the provision of social care. The Community Care Act 1996 offered younger users of community care (those aged between 18 and 65) the entitlement for the receipt of Direct Payments, in order to allow them an enhanced sense of autonomy and control. The 2006 White Paper *Our Health, Our Care, Our Say* extends the principle of choice in social care, with a focus on the provision of Individual Budgets and Direct Payments. Choice has been introduced relatively recently in the field of housing, with the introduction of Choice-Based Letting (CBL). The government's reform agenda outlined in *Open Public Services* (HMSO 2011) reaffirmed the personalisation approaches introduced in the last few decades. The Care Act 2014 has also promoted user choice and made the receipt of Direct Payments a legal right of all users of social care.

Choice in residential care: the dual focus on choice and de-institutionalisation

'Social care' is an umbrella term that encompasses different types of interventions and services to meet the needs of older people, younger adults and children in their daily lives (SCIE, cited in Waine *et al* 2005). Long-term care is part of social care and some regulations introduced policy directions that can be applied to the social care area as a whole. A survey of public service users and professionals found that both users and professionals of social care favoured the prospect of choice, believing that the introduction of choice would lead to improvements in the service (Clarke *et al* 2007).

In principle, users of local authority-funded residential care were able to have their choice of home since the introduction of the 1948 National Assistance Act. The choice of a home was explicitly stated in the 1992 Local Authority Circular (LAC) *Choice of Accommodation Directions*. According to the directions, local authorities should make every effort to provide a choice of homes which are suitable to meet the needs of users within their financial limits. Choice in residential care was further strengthened by the introduction of the National Minimum Standards for Care Homes for Older People (DH 2003), which sets out the requirements for individual homes to help users with making informed choices.

The need for choice and control for users of residential care was also recognised in the 2005 Green Paper *Independence, Wellbeing and Choice* and the subsequent 2008 LAC *Transforming Social Care* (DH 2008). It was recognised that 'the ability to make choices about how people live their lives should not be restricted to those who live in their own homes', and people should be given 'better support, more tailored to individual needs and preferences in all care settings' (DH 2005, p. 5).

Choice in residential care has been receiving more attention recently with the publication of the Reports by the Law Commission (2011) and the Commission on the Funding of Care and Support (2011) on future directions of social care reforms. The former recommended the extension of Direct Payments for users of residential care, while the latter suggested a fairer funding system for adult social care. Most of the recommendations made by the Law Commission were reflected in the Care Act 2014, which established the legal right to the Personal Budgets (especially in the form of Direct Payments) for all social care users. It also placed a duty on the local authority to provide information (knowledge) and advice (help and guidance) to facilitate users' exercise of choice (HMSO 2014).

The Dilnot Report (The Commission on the Funding of Care and Support 2011) recommended placing a cap on individuals' contributions towards paying for residential care in order to make forward planning possible. The first report of the Royal Commission was published in 1999 suggested that long-term personal care, which is intimate enough to involve 'touching the body' of service users, should be made free (Royal Commission on Long-Term Care 1999, 2003), as is the case for health care. This recommendation was partly accepted by the government and the provision of nursing care was made free of charge, but personal care provided in residential homes is still heavily reliant on a strict means test and needs assessment. If a maximum amount individuals have to pay towards their residential care can be set, the prospect of older people's exercise of choice would be substantially improved, as it makes it possible for them to predict the future cost of care and plan for their care.

Despite the recent developments of choice policy in the area of residential care, choice in residential care was not at the centre of the debate. The detail of user choice in residential

care has not been dealt with in government Papers or Acts. The development of choice in residential long-term care was also slow and limited, with the type of choice formally recognised and supported only being a choice of a care home. For instance, regarding the choice of a home, a formal guide to the directions laid out in the 1992 LAC was published in 2004 (DH 2004).

The lack of attention paid to choice in residential care could be interpreted in the context of 'de-institutionalisation'. The government's emphasis on ageing in place, the research evidence and the public perception of care homes, have led to strong resistance towards the 'institutionalisation' of older people. The grounds for older people to be in control of their care and to refuse unwanted institutionalisation was established through the introduction of a number of pieces of legislation, including the Human Rights Act 1998, the Equality Act 2000 and the Mental Capacity Act 2005. There has been a consistent emphasis on the importance of helping older people remain at home as long as possible, particularly since the publication of the Griffiths Report (Griffiths 1988), the Caring for People White Paper (HMSO 1989) and the introduction of the 1990 NHS and Community Care Act.

Developments in choice policies in community care and residential care have also reflected the two themes of choice and de-institutionalisation. Choice for users of community care was introduced many times by different regimes from the 1990s and this was extended quickly to various groups of users. Choice in community care has evolved fast through the introduction of a series of related pieces of legislation. For example, legislation regarding the provision of Direct Payments was first introduced in 1996 and updated in the 2001 and 2009 Health and Social Care Acts. The enhancement of choice in social care has led to plans for more personalised services and Individual Budgets (DH 2006, DH 2010*a*). However, developments

in choice in residential care have been slow and limited. Direct Payments will only become available to users of residential care in 2016, after 20 years since it was first introduced to users of community care (HMSO 2014). Choice for older people living in care homes has started to receive attention only recently through the My Home Life movement which aims to secure choice, voice and control for older people living in care homes (Owen *et al* 2012). The 'active ageing' strategy, which is often coupled with the 'de-institutionalisation' agenda (and which can be discriminatory in itself as it assumes that older people are not normally 'active'), also assumes that active ageing only takes place in the community. The lack of attention paid to choice in residential care and the autonomy and the preferences of the residential care users led to the lack of research on the working and the user experience of choice in residential care.

The effects of choice on older people's care transition experiences

The effects of choice for older people regarding their transition have been little explored in the literature. However, what choice means to older people and how it affects them may be closely related to the values they attach to their exercise of choice and their perception of choice during the transition. Therefore, the researcher reviewed the literature on both positive and negative perceptions of choice, including the social policy literature on choice in public services, psychology literature on choice, and sociology literature on choice and self-identity.

In the literature, the most frequently mentioned value attached to the exercise of choice is autonomy (Lent and Arend 2004; Schwartz 2004; Perry 6 2002). This interpretation of choice is related to the theory of reflexive modernity (the sense of self and identity in reflexive modernity), which has been argued by Giddens (1991) and Beck (1992). There was also an

assumption that older people would link the concept of choice with the sense of 'independence', as has been the case for those with disabilities (Morris 2006).

Social policy literature asserts that there are more practical benefits of exercising choice. Le Grand (2007) and OFT (2005) put forward that several other benefits of choice can be delivered through the market mechanism, including the improvement in quality, efficiency, responsiveness and equity.

Besides the positive perceptions of choice, there are some negative perceptions of choice, which have been mostly suggested by the psychology literature. Schwartz (2004) termed post-decision regret as 'buyer's remorse' and regarded it as a side-effect of having choice. In a similar context, Iyengar (2010) and Salecl (2010) suggest that having too many options can have negative consequences.

However, despite the debate on the benefits and adverse effects of choice, there is little evidence to suggest that having choice in public services can lead to users' recognition of themselves as consumers or customers. Clarke *et al* (2007) found that users of public services did not identify themselves as consumers or customers, but as citizens and service users. As Baldock (2003) argues, the introduction of choice in public services might not be accompanied by changes in service users' expectations.

The research on choice in public services has been focused on choice in education, health care and community care. There is little first-hand information which is up-to-date and which takes into account the recent policy developments regarding promoting choice in residential care. Older people's use of residential care involves one of the biggest decisions in their later

life. This research recognises the importance of studying their exercise of choice and the meaning and the value they attach to it.

Conclusions

This chapter reviewed the research evidence and policy developments relating to older people's experiences of transition and choice in residential care and found that there is a need for more up-to-date social policy research which can enhance the understanding of older people's needs and their experiences of care transition and choice making. The dynamics behind older people's experiences of transition has received little attention as the care transition has been hardly regarded as a process, which involves different stages and takes places over a period of time.

The contribution of social policy to the literature on the user experiences of choice in residential long-term care has been considerably limited, despite the burgeoning literature on choice in public services. There are few studies which have looked at the policy relevance of older people's care transition experiences, despite the relevant policy developments.

Older people's care transition has largely remained as an under-researched area. The relevant research evidence is based on the findings from the second half of the 20th century and only a few studies which involved the service users have been conducted in the last couple of decades. Older people have been described in the literature as passive recipients of welfare and the possibilities of a positive transition have largely been denied in the literature. There is little up-to-date evidence which can suggest any changes or continuities with the existing

evidence. As a result, there is a widespread prejudice against older people's care home entrance and against residential care.

This thesis seeks to contribute to the literature by studying older people's lived experiences of care transition in the 21st century and the meaning and the role of choice in their transition, while recognising the transition as a process. This research is open to older people's experiencing both positive and negative transition and explores the possibility of a positive care transition and of older people's active participation during the period of transition. The findings from this research could prompt a discussion on choice in residential care and in long-term care in general and would provide a chance to gain a better understanding of older people's needs and preferences in their use of residential care.

Chapter 3. Analytical Frameworks and Research Methods

If previous chapters were concerned with ‘what’ has been studied and ‘why’ it is important to conduct such research, this chapter looks at ‘how’ the research subject has been studied. Moving on from the review of the relevant literature and policy, this chapter explains how the researcher addressed the gaps in the literature by discussing the key concepts and the analytical frameworks used in this research and presenting the research methods employed to study the four research questions.

This chapter starts with a discussion on the two key concepts used in this research, care transition and choice and explains in detail how the analytical frameworks, which were briefly introduced in Chapter 1, were designed and applied to the research. Then, the chapter looks at both the methods of data collection and the methods of data analysis. The use of qualitative retrospective interviews as a way of data collection is explained, followed by a description of the sampling criteria and the sample. Next, information about the participating residential homes and extra interviews is presented. The chapter then deals with the methods of data analysis, introducing the thematic analysis and ATLAS.ti, a computer assisted qualitative data analysis software package. Finally, the chapter considers research ethics and explain how the researcher took appropriate steps to ensure that the interviews with vulnerable older people were conducted in a manner that minimises any discomfort or risks to the research participants.

Analytical Frameworks

Analytical frameworks were developed by the researcher in order to study the four questions,

as briefly explained in Chapter 1. The researcher's rudimentary understanding of the key concepts started to develop from the analysis of the pilot interviews. Then, the analytical frameworks started to emerge during the interpretation of the interview data. They were mainly informed by the research findings and the literature. Qualitative analysis is an iterative process and the analytical frameworks were developed and evolved throughout the research. In forming the frameworks, contrasting research evidence was taken into account in order to allow the researcher to explore the research topic in an unbiased manner. Before exploring what constitutes the analytical frameworks, there is a discussion of the two key concepts used in the research, care transition and choice.

Discussing the two key concepts: care transition and choice

The term 'transition' was used to denote the move into a care home in two studies conducted by Lee *et al* (2002) and Ray *et al* (2009). The researcher interpreted the term using the life course approach employed by Ray *et al* (2009), in order to reflect the radical and dynamic nature of the changes involved in older people's experiences. The concept of 'choice' has been interpreted differently in the literature and there are various approaches to the concept. Therefore, it is discussed below how the researcher interpreted the concept, and, at the same time, delimited the boundary of 'choice'.

Care transition and positive care transition

Terms such as 'admission', 'move' or 'placement', which are often used in the literature and practice to refer to older people's move into a care home, did not seem to capture their actual experiences and the 'process' of their experiences. In this research, the term 'care transition'

refers to older people's (defined here as those aged 65 or over, regardless of gender) move from community-based care (largely informal and mainly provided by the family) into formal residential care settings. While local authorities' Social Services Departments (SSDs) and the nursing literature often refer to older people's move into a care home as an 'admission' or 'placement', this research used the term 'care transition' for three reasons. First, the term 'care transition' can capture the radical nature of the changes involved in the move. Second, the term can also embrace the whole process of the move, from anticipation to adaptation. The researcher conceptualises 'care transition' as a process, not as a one-off event. Therefore, the period of care transition is defined in this research as the period starting from the point where one's move into residential care is first anticipated and finishing at the point when the person has actually moved into a residential home and adapted him/herself to the new environment. Third, the term 'care transition' leaves room for older people's involvement during the period of care transition, whereas terms such as 'admission' or 'placement' have connoted older people's passivity during the process of the move. There is no study which used the term 'care transition', but the term 'transition' has been interpreted by Ray *et al* (2009) in the broad context of experiencing important changes in old age as a continuum of their life-course.

A 'positive care transition' is defined in this thesis as a care transition that takes place in a way that reflects older people's desired choices, facilitates their self-defined adaptation to the new environment and enables them to maintain their sense of self and of autonomy. Defining the 'positive care transition' implies two things: first, it symbolises a desirable and ideal type of care transition that older people can experience in their later life; second, it implies that this research is open to possibilities of older people's having positive experiences of care transition, which have largely been denied in the literature.

Choice

'Choice' is a key concept in this thesis. There has been an abundance of literature on choice in public services in recent years (see Clarke *et al* 2007; Simmons *et al* 2009; Greve 2010), most of which uses interchangeably the concept of choice as a right to choose, as an available option or as an option that has been chosen as a result of the exercise of choice (often accompanied by a definite article), without making a distinction between the three. Despite the fact that choice as a right to choose is related to a more fundamental sense of expressing one's thoughts and preferences, the policy agenda of 'increasing choice' in public services is often interpreted as a simple increase in available options for service users. The frequently made claim that 'too many choices can lead to little satisfaction', originally suggested by Schwartz (2004) and still one of the major criticisms of increasing choice in public services in the media and the literature, reflects this limited and confused use of the concept.

To avoid confusion, this thesis makes a clear distinction between the three: 'choice' refers to 'the right to choose' and 'options' denotes available options to choose from. In the empirical chapters of the thesis (Chapters 6-9, in particular), the term 'choice' is often used in its plural form, 'choices', in order to refer to 'specific options that have been chosen by older people as a result of exercising choice'. The concept of 'choice' is primarily used and interpreted as the right to choose, and the increase in 'choice' in terms of the increase in available options is understood as one of the ways of promoting or increasing service users' right to choose.

Older people's behaviour of 'exercising choice' does not only refer to their expression of their preferences, but the notion also embraces the reflection of their preferences in the actual decisions made.

As explained in Chapter 1, the concept of choice has a two-fold interpretation in this thesis: (1) that it has multiple dimensions and (2) that it operates at various levels. The first interpretation of choice is based on Le Grand's (2007) conception of choice. Le Grand (2007) argues that choice is multi-faceted and that there are choices of what (choice of service), when (choice of time), where (choice of provider), who (choice of professional) and how (choice of access channel) regarding the use of public services. This conception of choice has been used in the literature to assess the application of choice in different areas of public services (see Simmons *et al* 2009). A modified version of Le Grand's (2007) idea of 'dimensions of choice' was used in this thesis in order to make the conception fit the nature of residential care that was found from the analysis of the interview data. This research, however, did not take Le Grand's (2007) view as a proponent of choice in public services, as examining the role of choice in the care transition was one of the aims of research.

The second assumption about choice is based on the researcher's conception of choice, which was developed throughout the main stage of the research. The researcher recognises that there are different dimensions of choice, as Le Grand (2007) argues, but further identifies that different levels or layers of choice exist in the provision of public services. Le Grand's (2007)'s idea of 'dimensions of choice' can be interpreted as different types of choice and the researcher's idea of 'layers of choice' demonstrates that different types of choice operate at different levels and that each type of choice represents a different level and extent of choice in any one service area. The idea of 'layers of choice' recognises that choice operates at three different levels and that there is (1) choice over the use of service, (2) choice over the specifics of services and (3) choice over the use of additional services. The application of the idea of 'layers of choice' is discussed in the next sub-section on the application of the analytical frameworks.

The concept of 'choice' has been dealt with extensively in the literature and has been theorised in the fields of neo-liberal economics (Fotaki *et al* 2005; Hayek 1976), social policy (Le Grand 2007; Greve 2010; Clarke *et al* 2007; Perry 6 2002; Lent and Arend 2004; Simmons *et al* 2009) and behavioural psychology (Schwartz 2004; Iyengar 2010; Salecl 2010). Sociological theories of reflexive modernity (Giddens 1991; Beck 1992) also add more perspectives to the meaning of user choice. The analytical frameworks used in this thesis draw on various theories on choice in order to show their relevance to the lived experiences of the interviewees. The use of theories in the analytical frameworks is explained in detail in the following sub-section.

The application of the analytical frameworks

Analytical frameworks were developed for this thesis in order to answer the four research questions listed on page 2. They were mainly informed by the literature and by the research findings. The analytical frameworks were used as a set of lenses to examine the data collected during the fieldwork interviews. They were developed, reviewed and refined throughout the main stage of the research in order to optimise their use in addressing the four research questions.

Older people's experiences of transition to residential care

> **Question 1.** What are older people's lived experiences of the transition from community care to residential care in England?

The first research question seeks to explore older people's experiences of moving from community care into residential care. In order to answer the research question, the researcher developed a new framework, which was inspired by findings from both the main stage fieldwork interviews and the seven pilot interviews conducted with older people living in residential homes in Bournemouth and Oxford between September and November 2009.

The new framework was created to look at different types of 'changes' and the intensity of the changes older people experienced during the care transition (please see Box 3.1 for summary). The types of changes explored were divided into four categories by the researcher, namely, environmental, emotional, relational and physical changes:

Box 3.1. Types of changes explored in the research

- Types of changes that the care transition entails:
  - Environmental (changes in care and living environments)
  - Emotional (changes in emotional status during the transition)
  - Relational (changes in their relationship with people close to them)
  - Physical (changes in their health status during the care transition)

The focus of the new analytical framework is on 'change', not on 'loss', as found in the literature. Feelings associated with 'loss' have often been linked to the move to a residential home itself (OFT 2005; Nay 1995) or the adjustment period after the move (Kahn 1990, cited in Lee *et al* 2002). However, the new framework was intended to explore comprehensively both positive and negative experiences, and to be open to possibilities of older people's experiencing a positive transition.

Also included in the framework (summarised in Box 3.2) was an in-depth exploration of older people's perception of care home life, reflecting what older people think as merits and demerits of living in the community and of living in a care home.

Box 3.2. Merits and demerits of residential care

- Older people's perception of care home life:
  - Merits and demerits of living in a care home
  - Merits and demerits of living in their own home, in the community

Older people's exercise of choice in residential long-term care

> **Question 2.** How, if at all, do older people exercise choice in their transition to residential long-term care?

The second research question looks at older people's exercise of choice in residential care. First, the researcher explored the level of resources individuals had based on the accounts of older people. The level of six key resources that were available to individuals at the stage of choice making was explored. The six resources were time, money, information, personal network, mobility and willingness to exercise choice.

In order to study the types and the degree of choice older people experienced, the researcher developed two other frameworks; one based on the Le Grand's conception that choice has multiple dimensions and the other one based on the researcher's idea of layers of choice.

First, the types of choice older people exercised were examined using Le Grand's conception of choice in public services, Williams' (2005) idea of choice for consumers in the care home market and the data collected from the pilot and the main fieldwork interviews.

Le Grand (2007) argues that choice is multi-faceted and that there are choices of what, where, who, when and how regarding the use of public services. Choice can be interpreted in many ways and Le Grand's (2007) work illustrates the different dimensions of choice in detail. In this research, necessary adjustments were made to Le Grand's framework in order to fit his conception to the service specific aspects of residential care that older people experienced.

Le Grand is a well-known advocate of public sector choice and argues that command and control has reached its limit (Shaw 2009) and that choice and competition can be an effective new model for public service delivery (Le Grand 2007). This framework borrowed his conception of choice only, though, without reflecting his view as the proponent of choice in the framework. The nature of this research requires in-depth exploration of older people's lived experiences of choice and, thus, this research is open to the possibilities of older people's experiencing the negative side of having choice in public services (as discussed below). The researcher refrained from making any prior assumptions about older people's experiences of choice in residential care throughout the research process.

So far, research on choice in social care for older people has been confined to dealing with service users' choice on the funding of community care (e.g. Direct Payments, Individual Budgets), and rarely mentioned the basic dimensions of choice, such as how and when users make choices, how often and why such choices are made [exceptions to this include the works of Baldock and Ungerson (1994) and Glendinning (2009)]. There is a lack of research

on choice in residential care, despite it being referred to as the type of choice which is the closest to major choice initiatives, such as patient choice in health services (Fotaki *et al* 2005). Direct Payments in residential care are planned to be introduced from 2016 and there is a need for a more comprehensive analysis of user choice. In this sense, Le Grand's conception of choice is a useful tool to apply to the interviewees' experiences of choice in residential care.

Apart from Le Grand's conception of choice, the researcher added five extra dimensions of choice, two of them using Williams' (2005) potential choices open to users preparing to enter a care home: the choice of whether to move in or not (defined as a choice of whether to move into a care home) and the choice of other service options (defined as a choice of alternatives to residential care). The researcher further included other three dimensions of choice, which were informed by the findings from the fieldwork interviews: the choice of trial options (prior visits or temporary stays), the choice of personal belongings to take in and the choice of care arrangements during the care transition.

Table 3.1 brings together in summary form the different dimensions of choice put forward by Le Grand (2007), Williams (2005), and the researcher's application of it to the transition from community care to residential care. The three other dimensions of choice that were considered important by the research participants regarding their care transition are also included.

It can be seen from the table that some of the dimensions of choice suggested by Le Grand (2007) have been adjusted, excluded or merged with other dimensions. In residential care, the choice of provider (where) can explain two other types of choice, the choice of professional

(who) and the choice of service (what). Therefore, the three types of choice were tied to a single type of choice, choice of a residential home. Choice of time (when) was more specifically defined as the choice of when to move in (the timing of the move). Choice of access channel (how) is limited in residential long-term care because local authority professionals act as 'gatekeepers' who are in control of users' access to the service. The actual access to service cannot be 'chosen' by the users. For this reason, choice of access channel is excluded from the framework[7]. However, the researcher explored the matter of 'who' initiated the transition on what grounds and 'whose' choice was valued regarding each decision.

Dimensions of choice applied from the study by Williams (2005) and from the interview findings were used without having to make adjustments, as Williams' study and the fieldwork interviews were already about choice in residential care.

Analysis of the data collected from both the pilot interviews and the fieldwork interviews found that information was the key to older people's exercise of choice. Therefore, an additional aspect of 'information' was added to explore whether access to sufficient information about each dimension of choice was ensured for older people.

Table 3.1. Dimensions of user choice in residential care

Dimensions of choice		**Choice applied to the move into a residential home**
Choice of provider (where)	L	Choice of a residential home
Choice of professional (who)	L	
Choice of service (what)	L	
Choice of time (when)	L	Choice of when to move in
Choice of whether to move in	W	Choice of whether to move into a care home or not
Choice of other service options	W	Choice of alternatives to residential care

[7] Although excluded in this research, choice of access channel would be important for self-funding users of long-term care.

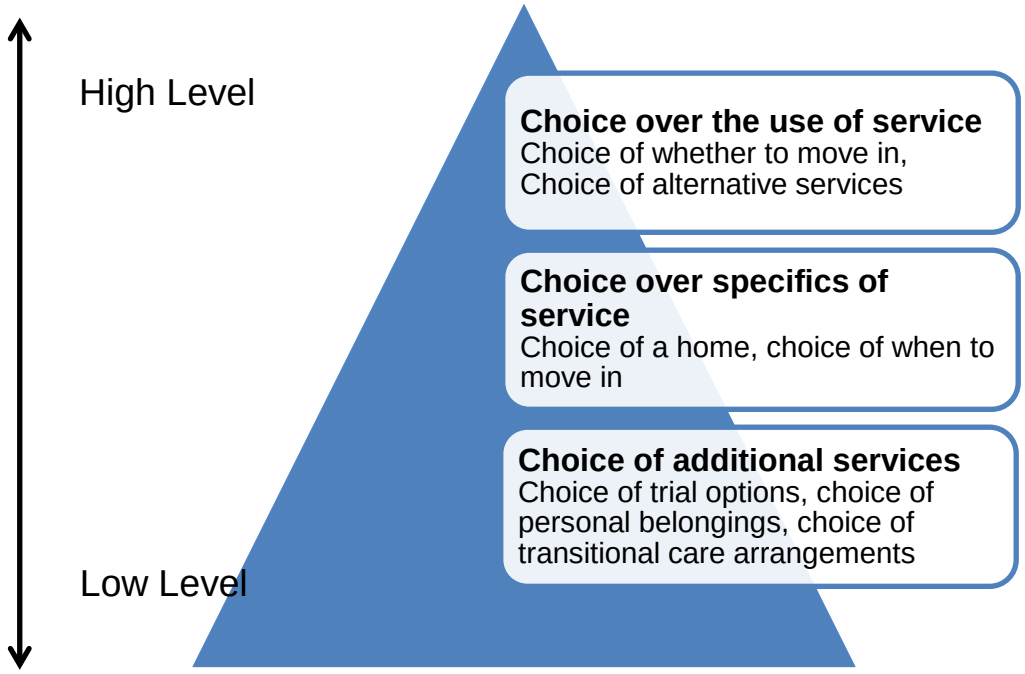
Choice of additional services	I	Choice of personal belongings to take in
	I	Choice of care arrangements during the care transition
	I	Choice of trial options (visits/short-term stays)

L = adapted from Le Grand's (2007) conception of choice
W = adapted from Williams' (2005) idea of choice
I = adapted from the interview findings
Source: Author's own elaboration based on the relevant literature and interview findings

The second analytical framework which was developed to examine older people's exercise of choice was based on the researcher's conception that different types of choice work at different levels (see Figure 3.1). The idea of 'layers of choice' was a reflection of the interview findings and the researcher's theorisation of choice and was refined throughout the main stage of the research. It recognises that there are three different layers of choice in public services, with the *top layer* encompassing the biggest choice a user can exercise, choice over the use of service itself, the *middle layer* concerning the most common types of choice mentioned in the literature on choice, choice over specifics of service, and the *bottom layer* involving choice of additional services, which is often made after the two other types of choice. Le Grand's different dimensions of choice fall into the middle layer (and also to the bottom layer, to some extent). The idea of 'layers of choice' encompasses the most fundamental choice over the use of service, which has largely been ignored in the literature, as well as considering the level and the extent of choice ensured for service users and the order of each choice in the use of public services.

How the concept was applied to the interviewees' experiences of residential care is presented in Chapter 6 (see Figure 6.1).

Figure 3.1. The three layers of choice in public services



Source: Author's own illustration

The meaning and the impact of choice

Question 3. What are the meaning and the effects of choice in residential care?

In order to explore the meaning of choice for older people, the researcher looked at older people's perception of their exercise of choice and the motivation for their choice making. Younger disabled people have been known to exercise choice in the pursuit of independence, but little has been known about older people's exercise of choice. Moreover, contrary to the concept of independence, old age has often been associated with structured dependency created by the organisation of social policy (e.g. pensions policy) that places older people in a less favourable position both financially and socially (Townsend 1981). The researcher explored the nature and the meaning of older people's exercise of choice and considered how they were related to the two concepts of independence and structured dependency.

Both positive and negative aspects of having choice were explored in order to examine the impact of choice on older people. Positive aspects of having choice have been put forward by Le Grand (2007) and OFT (2005). It is argued that the introduction of choice and competition in public services fulfils the principle of autonomy (Le Grand 2007), promotes higher quality service (Le Grand 2007) and greater efficiency (OFT 2005, Le Grand 2007), enhances responsiveness to users' needs and wants (OFT 2005, Le Grand 2007), and is more equitable than the alternatives mechanisms of service delivery such as command and control (Le Grand 2007). It is difficult to 'measure' the benefits of choice mentioned above using qualitative research methods, and, for this reason, this research looks at the perceived benefits of having choice for older people by comparing individual cases. It was examined whether older people who were actively involved in choice making enjoyed a greater sense of autonomy and/or found a care home that provides better quality service at lower price and/or more innovative and responsive service, than those who did not. It was difficult to examine in this research whether choice worked equally for those with less financial resources, as those who were funded by local authority had similar financial situations before they moved in. However, it was explored whether choice worked favourably for those in the interview sample who were better educated or who had a wider personal network.

Possible negative experiences relating to the exercise of choice found in the literature were also considered, including buyer's remorse (Schwartz 2004), choice as anxiety-making on the ground that it always involves a mixture of opportunity costs, a desire for ideal choice and social norms (Salecl 2010), and distress from having too many options (Iyengar 2010). The research evidence is reflected in the analytical framework developed to explore older people's perceptions of choice (see Box 3.3).

Box 3.3. The analytical framework for exploring older people's perceptions of choice

- Older people's perceptions of the experience of exercising choice
  - Positive perceptions of choice making
    - Sense of autonomy (Le Grand 2007)
    - Quality of service (Le Grand 2007)
    - Low weekly charge (efficiency) (OFT 2005)
    - Innovative or responsive service (OFT 2005)
    - Other positive perceptions
  - Negative perceptions of choice making
    - Buyer's remorse (post-decision regret) (Schwartz 2004)
    - Choice as anxiety-making (Salecl 2010; Schwartz 2004)
    - Negative consequences of having too many options (Iyengar 2010)
    - Other negative perceptions

The influence of choice on older people's care transition experiences

Question 4. What is the role of choice in shaping a positive care transition?

The last research question is associated with the role of choice in promoting a positive care transition. The researcher designed a new framework (summarised in Box 3.4) in order to canvass how choice affected older people's care transition experience and what constituted a positive transition.

Box 3.4. The exploration of perceived effects of choice

- Choice and positive transition
  - The degree of choice exercised in each dimension of choice:
    - Actively exercised
    - Moderately exercised

- Little exercised (voluntary/involuntary)

- Choice and satisfaction with care home life
- Choice and adaptation to care home life
- What constitutes a positive care transition? (in-depth exploration using a topic guide – explained in more detail in the next section)
- Choice and elements of a positive transition

In order to study the role of choice in the care transition, the researcher categorised older people's exercise of choice depending on the degree and desirability of the choice exercised. First, individual cases were examined based on the interview transcripts and categorised as choice that was actively exercised, moderately exercised or little exercised. Then, it was examined whether the choice exercised was voluntary or involuntary. The researcher created the distinction between the voluntary and involuntary nature of choice exercised based on the cases of some interviewees who happily accepted other people's suggestion of the move to a care home without future evaluation of the details. How choice affected older people's satisfaction to care home life and their adaptation after the move was also explored considering the degree and the voluntariness of the choice exercised. Finally, by studying what helped older people to be satisfied and adapt to care home life, there was an in-depth exploration of what constituted a (self-reported) positive care transition, a care transition that reflects older people's desired choices, facilitates their adaptation to the new environment and enables them to maintain their sense of self and autonomy.

It was also explored how older people expressed dissatisfaction or preferences once they have been moved into a care home (see Box 3.5 for summary). The interplay between the two key mechanisms of choice and voice during the stage of adaptation was explored.

Box 3.5. Older people's use of choice and voice in residential care

- Choice and voice in residential care
  - Choice after the move into a residential home
  - Voice (direct/surrogate)

Research methods

Methods of data collection

Qualitative retrospective interviews

This research aims to gather an in-depth understanding of older people's experiences of care transition and the nature of this enquiry conforms to the inherent characteristics of qualitative research based on constructionism, induction and interpretivism. Qualitative research puts an emphasis on 'understanding' and of studying people's 'lived experiences' (Snape and Spencer 2003), which has a fundamental importance in this research. Hence, the adoption of a qualitative design was crucial to conducting this research.

Another important characteristic of qualitative research is in its generation of rich data. It was conceived that the volume and richness of the data collected through fieldwork would make it possible to interpret and understand the social reality that older people face. Maas *et al* (2002) also stress the importance of colleting in-depth information about the individuals, groups, and institutions involved, and argue that qualitative designs are especially needed in nursing home research 'because so little is understood about these settings and the interventions needed to improve the quality of care and lives of the elderly residents' (p. 12). Although this

research involves people living in residential homes, not in nursing homes, it shares a similar background as residential care and is similarly an under-researched area and that there is a need to enhance understanding of it.

The use of qualitative in-depth interviews makes it possible to collect rich raw data on older people's experiences of the transition to residential care. Analysis of primary sources of data collected through in-depth interviews yield themes, patterns, insights, and the time perspective that are omitted in secondary analysis of data (Thompson 1981). This research employed in-depth interviews in a semi-structured form, as it was thought that semi-structured interviews can guarantee both flexibility and certain degree of formality at the same time during the data collection. As it is often the case in studies involving semi-structured interviews, the length of the interviews varied, and questions that were used in each interview changed slightly or new questions were added depending on the circumstances of the participants.

A topic guide was developed, tested during the pilot interviews (seven interviews in total) and appropriately modified for the main fieldwork (please see *Appendix B* for topic guides used in this research). The topic guide acted as an interview guide and there was an active use of open-ended statements to collect rich details of older people's experiences (Allen and Pickett 1987). Autobiographic vignettes were included in the topic guide. For example, the researcher asked the interviewees what would be the advice they would like to be given to the researcher's grandmother, who is preparing to move into a care home (what is the thing she has to consider when making her choice of a care home, whether there is anything to prepare before the move and whether there is anything they think she has to bring into the care home and so on). Among the purposes suggested by Barter and Renold (1999), the vignettes were

used in this research to build rapport with the interviewees and to study their attitudes and beliefs.

As this research explores older people's recent, but past, experiences of care transition, it was necessary to conduct interviews in a retrospective manner. Making direct observation of the transition experience, instead of conducting retrospective interviews, was considered, but was thought to be an infeasible option for three reasons. First, there is an ethical reason for not conducting interviews during the period of transition, as older people are known to be in a particularly vulnerable state during that period. Second, it is impossible to capture the process of transition from the start to the end, as the period of transition starts from the 'anticipating' stage, where older people themselves or others have raised the issue of entering a residential home. It would be impossible to predict who will need formal residential care in the near future and, even if it is possible, no one knows when the anticipation will take place. Third, not all older people whose admission to residential care is anticipated end up living in residential homes. There is a possibility of losing a significant proportion of the initial sample if there had been cases of the actual care transition not taking place, even if a researcher started to follow the sample from the anticipation stage. The research following the sample from the anticipation stage would have also been a complete different study, with different sets of research questions.

Retrospective interviews are often used in research that assigns interviewees the role of oral historian (Allen and Pickett 1987). Typical examples of research that employs retrospective interviewing are: family life course study, research on employment history and studies of the history of migration.

In the literature, retrospective interviewing as a research method has been considered inappropriate for some research projects. The use of retrospective data can be problematic in circumstances where the memory recalled by interviewees involves other people, not the interviewees themselves (George 2002). In other words, if the memory is not formed from direct experience, there can be a gap between the data collected and what really happened. There can also be a problem with interviewees' retrieving old memories and this problem can lead to inaccurate accounts of what actually happened. In this respect, the use of retrospective interviews in this research can be considered appropriate as it involves asking older people their recent, lived experiences of care transition. In this research, retrospective interviewing was used as a tool that enabled interviewees to speak on a recent and specific event and there was relatively little risk of interviewees' losing memory or providing wrong information, as long as the cognitive ability of the interviewees was ascertained in advance (the interviewees' cognitive ability to take part in the research is discussed in the section on ethics). The use of retrospective interviews in studies involving older people is common. Boocock advocates it and asserts that 'interviewing elderly people about the relatively recent past provides first-hand descriptions of events without researchers having to observe them directly' (cited in Allen and Pickett 1987, p. 3).

Retrospective interviews can also have other pitfalls and shortcomings. Bryman (2004) describes retrospective interviews as entailing 'reconstruction of events by asking interviewees to think back over how a certain series of events unfolded in relation to a current situation' (p. 339). This 'reconstruction' of events can cause a problem relating to the validity of the data as it may bring out distorted memories, whether it be intentional or unintentional. The researcher was aware of this problem. However, the use of retrospective interviews was necessary in this research for the reasons discussed above and the researcher tried to tackle it

in the following three ways: first, the researcher obtained the interviewees' consent to access administrative details about their move and about their health status (i.e. usually recorded on hourly basis) and cross-checked their care-related details with the administrative data which belonged to participating care homes. Some older people actively encouraged the researcher to ask the care home manager about their care when they were not sure about certain details (e.g. the date they moved in), even before the researcher asked for their consent to access their details; second, the researcher conducted extra interviews with care home managers and staff, social workers and relatives of the interviewees in order to better understand older people's experiences of the care transition and any difficulties that they might have had during the transition. From the extra interviews with other actors and with the CQC staff, the researcher was able to understand the role of other actors and to get a fuller picture of the care transition experience; third, during the interviews with older people, the researcher asked some extra questions or questions that were similar to the one asked earlier to confirm the information the researcher obtained and to increase the credibility of the data.

Sampling criteria

This research involved seven older people living in residential homes as initial interviewees for pilot interviews, and another forty-eight older people as key informants who engaged in the main part of the research – the semi-structured retrospective interviews. The pilot interviews were carried out with a tentative topic guide at an early stage of the field work. This opportunity of interviewing seven older people in residential homes in Bournemouth and Oxford enabled the researcher to understand salient issues that are not covered in the existing literature, and to revise the topic guide.

The researcher interviewed older people until she felt that additional interviews would not generate new data that provide fresh perspectives to the understanding of older people's care transition experiences (until the saturation was achieved) (O'Reilly and Parker 2013). There is no consensus on what number of research participants can be described as 'sufficient', but there are some academics who believe that there is a certain 'minimum number of interviewees' that can act as a parameter for conducting research that can be published, or research with convincing conclusions (Bryman 2004). For instance, Warren (2002) perceives the minimum number as between twenty and thirty, while (at the other extreme) Gerson and Horowitz (2002) see the minimum number as sixty and the maximum as one hundred and fifty. In spite of differing views on appropriate sample sizes, the size of sample is meaningful only if it is able to support convincing conclusions and, thus, can vary from situation to situation (Bryman 2004). In this sense, interviewing forty-eight informants was thought to be sufficient to produce rich data and convincing results.

All interviewees for this research (including those who participated in the pilot interviews) were recruited based on the following criteria: those who a) were aged 65 or over, b) were living in residential homes in England, c) had sufficient cognitive ability to participate in the research, d) experienced transition for the first time from community-based home care to residential care, e) received subsidies and support provided by local authorities, and f) had spent between six to twelve months in the homes as an adjustment period.

Each sampling criterion was necessary for the collection of meaningful data on older people's lived experiences of transition to residential care. The first criterion was essential, because 'older people' is conventionally defined in policy and academic literature as those who are aged 65 or over. The geographical boundary of the research was set to include residential

homes in England only. It was sensible to set this geographical boundary, as the law relating to social care has always been different in England from Wales, Scotland and Northern Ireland, and devolution has intensified the difference (Baldwin 2008). The third criterion on cognitive ability of the interviewees was important, as their having sufficient cognitive ability was essential in carrying out retrospective interviews and obtaining meaningful results. A more detailed discussion on the cognitive ability of older people is found below.

The fourth condition had considerable importance, since it was expected that there would be a distinct difference in older people's experiences between those who moved from community to residential homes, and those who have made transition from other places such as hospitals or other residential homes. Moving to residential homes from care settings other than community-based ones means that the older people involved in the move have already experienced 'transition' or radical changes in the environments in the past, when they moved to hospital or to other residential homes in the first place. It was assumed that their experience would inevitably be different from those who are leaving the community they belong to and entering residential care for the first time.

Next, from the start, this research limited its participants to those whose needs were assessed and whose paying for care was subsidised by local authorities. It therefore excluded those who voluntarily entered private residential homes without receiving any subsidies or support from local authorities' social services departments. The majority of the older people living in residential homes (about 60%) receive local authority funding. By limiting its research sample, this research focused on transitions of older people who had low income and who had relatively fewer choices (in some sense) on making the transition than those who could afford to pay for residential care themselves and could enter the homes they chose whenever

they wanted to. This enables the researcher to explore the exercise of choice of public service users. It also makes it possible to study the extent of choice ensured for those on low income, which has been questioned by some opponents of choice. Excluding those who privately and voluntarily entered residential homes can also be justified when considering that their admission to residential care was not necessarily based on (professionally assessed) 'need', whereas those who experienced the transition with help from local authorities typically go through the 'assessment' on the basis of their 'need'. In addition, those whose transition was supported by local authorities were clearly more related to policy, as their transition takes place within the policy framework (policy considerations play an important role from funding to service delivery). According to one information leaflet, local authorities in England help to pay for residential care for those who have assets below £23,250, although some individuals are required to contribute to paying for residential care (individual contribution: any assets that older people have over the lower threshold of £14,250) (Hampshire City Council 2012).

Last, it was important that interviewees spent sufficient time to adjust to the new environment. Conducting interviews during the move or shortly after the move can create risk, tension and confusion to the residents who are particularly vulnerable during the transition period. Jokinen *et al* (2002)'s study on Finnish people's experience of care stresses older people's vulnerability and suggests that they may need more protection while they are participating in research projects. Moreover, only after spending a minimum adjustment period can older people properly reflect back on the past in a more relaxed manner. The parameters used in this research – six and twelve months – have been frequently used in studies on care homes, and implicitly and explicitly referred to as the time that was needed for older people to ease the impact of transition. Having spent six months or twelve months was also used as a proof

that older people 'survived' in the new environment after transition [e.g. proportion of new residents remaining six months after transition (see Tobin 1989, Townsend 1962)].

This research involved those who live in residential homes only, and did not include those who lived in nursing homes, as residential homes are the places where older people normally experience life in communal living environments (institutional settings) for the first time. It is widely known that older people living in residential homes move to nursing homes at times when their physical and/or mental ability is seriously lost, or their ability is deteriorating at a fast rate, although there is a blurring boundaries between residential care and nursing care (see Chapter 6). For this reason, many older people in nursing homes are not able to make any decisions by themselves due to loss of cognitive ability, and the move to nursing homes is often not the first experience of transition. Therefore, this research limited its scope to include those who experienced the transition to residential care for the first time.

Recruiting the sample

The first step involved in recruiting the research participants was sending a letter to care homes and making an appointment for a visit to meet the manager and staff and to have a casual chat with the residents (the letter sent to care homes attached as *Appendix C*). It was essential to receive help from care home managers and staff helped the researcher in identifying potential interviewees through an initial screening of their residents based on the residents' cognitive ability and distributing information leaflets which invited them to participate in the research (please see *Appendix D* for information leaflets). They used both the administrative data and the hourly record on individual residents kept by the care home staff to identify who met the sampling criteria. Those who fulfilled the conditions listed above were regarded as potential interviewees (how the researcher selected the care homes

and the boroughs is discussed in the next sub-section). The residents who received the leaflet replied either by filling in the slip attached to the leaflet, or by telling the care home manager or staff directly.

The researcher used the following two strategies to reduce possible biases in recruiting the sample, in addition to the use of formal administrative data and the hourly records on residents. First, the researcher had a chance to have a casual chat with older people living in the care home once the care home agreed to support the research. This casual chat allowed the researcher to introduce herself and the research to the residents. Some residents volunteered to take part in the research (informal agreement) or informed the researcher of the names of the residents who moved in relatively recently. This helped the researcher to identify potential research participants, albeit informally. Second, the researcher asked different members of staff in any single care home to recommend any resident who might be able to participate in the research. Some members of staff came up with names of residents and they included those who they thought adapted well to the care home environment as well as those who were struggling to adapt or dissatisfied about living in the care home. Having used the two strategies, the researcher was able to have a more complete list of interviewees who met the sampling criteria in the participating care homes and was allowed to carry out a few more extra interviews.

Getting to know the home before starting interviews with residents was essential in this research, as it needed close cooperation with the selected homes for the integrity of the research (Maas *et al* 2002), and for ensuring that the research conformed to the UK Data Protection Act, especially on the matter of making first contacts with the residents. Formal contacts with the residents volunteering to participate in the research were made after the

researcher received their names and the date they found convenient to meet the researcher (which was part of the details filled in by the residents in the reply slip). The researcher explained the research and confirmed the date for an individual interview. On the day of the interview, individual participants were given time to read and sign the consent form (please see *Appendix E*). A large format version of the consent form was available, and the researcher read it for the participants if they had difficulties in reading. Each time, an actual interview began after obtaining the consent from a participant to record the interviews. Detailed ethical considerations are discussed in the last section of this chapter.

Description of the sample

In order to understand older people's experiences of moving into a care home and exercising choice in long-term care, fifty interviews were conducted with care home residents in ten residential homes located in three different boroughs in London (please see *Appendix F* for the interview schedule). With the interviewees' consent, all interviews were recorded using a digital voice recorder and were fully transcribed for analysis. The forty-eight interviews do not include the two interviews which were excluded from the analysis for validity reasons, as explained below. Hence, the total number of interviews used in the analysis is forty-eight. The forty-eight interviews lasted between 26 and 58 minutes. Care home staff and managers, and a small number of relatives, were also interviewed to obtain supplementary information about the residents and the information on extra interviews is presented in the next sub-section. Table 3.2 describes the interview sample (with the exclusion of the two interviews, the sample consists of 48 interviewees).

Table 3.2. Brief description of the interview sample[8]

Category		**No. of people interviewed**
Gender	Female	36
	Male	12
Age	65-75	8
	76-85	14
	86-95	20
	95 or over	6
Marital Status	Single (Never Married)	15
	Married	7
	Widowed	20
	Divorced	6
Ethnicity	White British	42
	Southern European	4
	Other	2
Length of stay at care home (length of period after transition)	6-9months	17
	9-12months	31
Number of participating care homes by borough (number of participants in each borough)	Inner London Borough A	5 (21)
	Central London Borough B	2 (11)
	Inner London Borough C	3 (16)

Source: Author's own elaboration.

The two interviews mentioned above had to be excluded in the analysis due to problems with validity. In one case, care home staff was not aware of a deterioration in the cognitive impairment of a resident and considered the resident as a potential interviewee [as the boundary of this research includes those who have mild cognitive impairment (MCI), as long as they have sufficient cognitive ability as assessed by the care home staff and memory of the transition period]. There was obvious inconsistency in what the resident said during the interview and consequently the interview data had to be excluded from the analysis. The

[8] The interview sample described in this table includes care home residents only, and excludes seven pilot study participants, care home staff, and residents' family and relatives who were being interviewed for extra information.

resident was not aware of the fact that she was living in a care home and her accounts of previous living and care arrangements kept changing during the interview. In the other case, care home staff were not aware of a resident's developing dementia. The resident used to have mild cognitive impairment (MCI), but went on to develop dementia, and the interview with the resident finished in ten minutes when it seemed evident that she did not have enough cognitive and communication ability and the researcher could not make sense of what she said. During the interview, she said repeatedly that her age was 199 and her daughter's age was 99 and asked the interviewer to guess her age several times. The resident was not able to understand questions (despite repeating and re-phrasing) and most of her story was out of context. In both cases, the researcher tried not to give the impression that the interviews were stopped or that there is a problem with the stories they provided. The researcher thanked the two residents for their participation, but the two interviews became inevitably short (shorter than the other 48 interviews). The accounts they provided were often irrelevant to the questions asked or lacked consistency and the researcher found it difficult to ask further questions on many of the topics explored. There were four people with suspected MCIs (diagnosed or judged by health care professionals) and the exclusion of the two interviews with people with MCIs means that only accounts of the other two older people with MCIs were used for the analysis.

The researcher made every effort to recruit a balanced sample in terms of gender, age, and the number of interviewees from each care home. However, 'the balanced sample' does not necessarily indicate the sample which consists of the same number of men and women, and the same number of interviewees from different age groups. The researcher sought to ensure that the number of people in each sub-group was enough to obtain valid accounts of care transition experience of the sub-group, but also tried to recruit the sample which can be

representative of the care home population. For example, the number of male residents in the sample is twelve, and it could be seen to some that there are too few male residents compared to female residents. Yet, as explained in Chapter 2, male residents consisting of a quarter of the sample is reasonable, considering the 2001 Census figure which shows that only 21.5% of people living in residential homes were men (ONS 2005). The ratio of men to women has even gone up compared to the 1960s (Townsend 1962). In another study, a random sampling of older people living in residential homes also resulted in women informants forming 77% of the sample (Kellaher 2000). As noted in the previous chapter, pseudonyms were used throughout the thesis when using quotations from the interview transcripts.

The researcher did not intend to recruit those with White British ethnicity only, but the residents living in the ten participating care homes were predominantly White British, which resulted in having the sample mostly consisting of White British. The resultant ethnic composition of the sample is consistent with that of the study of 593 residents in England and Wales carried out by Johnson *et al* (2010), in which 95% of the residents were identified as White British.

At an early stage of the field work, the researcher expected to have some ethnic minority groups in the sample, considering the ethnic mix in the Borough A. As there was not a single resident who fall into the category of black and minority ethnic groups, an enquiry was made to the Social Services Department in borough A regarding the under-representation of black and ethnic minority groups in residential homes. Some possible explanations suggested by the borough A were mainly concerned with differing cultural values between ethnic groups. One possible explanation is that most black and ethnic minority groups, especially those with Caribbean/Indian ethnicity, have extended family culture or family-centred culture, and they

tend to find sending their parents to a care home morally challenging. It was also suggested that people from a White British background were more likely to be single (never married) and thus more likely to go into a care home, whereas most people from ethnic minority groups tended to have families to look after them.

Evidence from the literature suggests another possibility: that there could be a kind of voluntary segregation according to the preferences of ethnic minority groups. Black and ethnic minority groups might have chosen to live in a care home where there are many residents with the same ethnic background. A finding from the study by Johnson *et al* (2010) shows that almost half of the residents from minority groups lived in one care home in London which had a separate unit for Poles.

There is also a possibility that ethnic minority groups have difficulty in accessing information on the use of residential care services. It was difficult to find data on their use of residential care, but the recent report on minority groups' use of dementia supporting services published by the Social Care Institute for Excellence (Moriarty *et al* 2011) found that there was a high level of uncertainty among black and ethnic minority groups about how to use dementia services. Considering that suffering from dementia is often a reason for entering a residential or nursing home, it could be the case that minority groups also lacked access to information and appropriate care services. However, it is not the aim of this research to compare how groups of different nationalities or ethnicity behave differently in the process of transition to residential care, and a small number of ethnic minorities could be understood as a symbolic presentation.

Residential home selection

Although ‘generalisation’ of the research findings to the whole population is not the aim of the qualitative research, recruiting participants from multiple sites can have an advantage of permitting generalisability beyond a single site (George 2002). Geographical variations in public service delivery have been discussed for some time in British social policy (Baldock 1991*a*), and there is a sarcastic term – ‘post-code lottery’ - to criticise it. The government rejected the recommendation of the Royal Commission on Long-Term Care to introduce free personal care to reduce the ‘post-code lottery’ of care provision, and alleviating variation between local authority areas remains an important task to accomplish (Baldwin 2008). The matter of variation between boroughs is important in long-term care, as it can mean variation not only in the quality of service, but also in the available kinds of services, funding options, homes, and even the take-up of Direct Payments (Baldwin 2008). Significant variations exist even between different local authorities in London (Tak 2007), and researching different boroughs of London can itself reveal meaningful research findings.

For this research, residential homes in three inner London boroughs (with one being a central London borough) were selected. Three areas of local authority level were selected because Social Services Departments, which are in charge of carrying out care assessment and provide subsidies and support for older people, exist at the level of local authority. Every effort was made to involve a similar number of residential homes from each borough.

There are three reasons for using London as a research site. Most importantly, inner London has the highest proportion of pensioners on low income in recent years (from 2005/06 to 2007/08), compared to other parts of the UK. The proportion is significantly higher, reaching nearly 29%, whereas only one more region records slightly more than 20% and all other regions record below 20% (Poverty Site 2009). Low income is defined as below 60% of

median income, and the inclusion of this criterion in the site selection is important, as pensioners with low income is the group that are most likely to receive subsidies to pay for residential care.

London is also the place where the most visible changes in social care service delivery take place. CIPFA (2009) finds that London boroughs (especially inner London boroughs) remain the highest performing authority type in terms of the provision of adult social care, according to statistics based on the Commission for Social Care Inspectorate (CSCI) star ratings, but showing a significant decrease of 23% between 2005/06 and 2006/07 in the use of residential and nursing home care. The percentage of decrease was so large that it shaped the trend of decrease in residential and nursing care across the whole of England. Instead, there was a high level of (direct) payments made to older people, £32 more than the national average, which reflects both higher living costs in London and an increase in the offering of Direct Payments (CIPFA 2009). There is a discussion on the introduction of Direct Payments in residential care and the study of older people's use of publicly-funded residential care would offer meaningful insights into users' perceptions and expectations. Another striking feature is the changes made in the proportion of external provision of residential care in recent years. London boroughs have made the largest proportion of change (an increase of 4% in a year), with external provision currently accounting for 91% (the highest in England) (CIPFA 2009).

Finally, the fact that there are 32 boroughs in London provides a good opportunity to make comparison of areas of equal position (as a borough in London) at the local authority level. It would be interesting to conduct the research with a consideration of differences between boroughs. Although there are relatively low proportions of older people living in London, as

most people prefer to move to coastal areas in Southern England (Blake 2009), inclusion of London as a research site would have an important meaning for these reasons.

The first two boroughs in London were included in order to contribute to the recruitment of a balanced sample group from different (rather contrasting) backgrounds and result in research findings that are academically interesting.

Borough A has a low proportion of the old-old (those who are aged 85 or over and who are most likely to experience transition) of 1.26%, and this proportion will remain largely similar until the year 2030 (1.42%), according to the results from an interactive mapping tool 'Ageing in the UK' (ONS 2009). There is a relatively low proportion of white British people living in the borough (less than 60%), and the borough also has one of the worst scores on 16 key poverty and inequality indicators among the 32 boroughs in London, with the only boroughs having worse scores being Hackney and Islington (London's Poverty Profile 2009). Contacts were already made with social workers who work at the social services department at Borough A, and they provided a list of residential homes and contact details they used to arrange their users' move into a care home for this research.

In contrast, Borough B is the most affluent borough in London, with lowest rate of poverty and inequality (London's Poverty Profile 2009). Nearly 80% of the residents are white (ONS 2001), and the borough also has the highest rate of high earners who earn more than £60,000 a year, compared to other local authority areas in the UK (The Guardian 2004). Among boroughs in London, it has the highest proportion of those who are aged 85 or over among the boroughs in inner London, and this will continue to rise until 2030, when the proportion is expected to reach 3.47%. The experience of conducting research with help from the Borough

B City Council in the year 2007 also helped understanding their policy and provision of services at the local authority level.

There are nine residential homes in Borough B, with one being a local authority home, one a private home, and seven run by voluntary sector bodies. Borough A shows similar composition of different types of residential homes, with one local authority home, two private homes, and fifty-one voluntary homes. Whereas these similarities make the two boroughs more comparable, there is a factor which could possibly affect the research findings. All major types of residential homes exist in the two boroughs – private, voluntary, and public homes. Many other London boroughs do not provide all three options, and quite often, there are no residential homes run by the local authority. However, the proportion of voluntary sector homes is considerably higher than the other two types, and the proportion of private homes is small, compared to other areas of England (Tomorrow's Guide Ltd 2009). Moreover, although the proportion of local authority homes is representative of the whole of England, having only one public residential home, together with one private home, means that the options that are available to older people are inevitably imbalanced.

It is not clear whether there is much difference in terms of exercising choice between the transitions that take place within the same area, but it is also not clear whether there is a difference between the experiences of the transition in different areas, especially areas with visibly different composition of the major types of care homes. Although there can be a difference between older people's experience of transition to private residential homes and to public residential homes within the same borough, the difference does not mean that older people had different choices during the transition. The experience of older people who live in the same borough and have their needs assessed by the social services department could be

more or less similar (although it can differ depending on the available places at the time of the assessment or the waiting list of a particular home), compared to those who live in different boroughs and have had completely different options for choosing a residential home.

In consideration of this, Borough C was chosen in an attempt to include a borough which provides the most 'ideal' (or well-mixed) options of residential homes to older people. Borough C has a comparable number of residential homes of twenty-eight (more homes than Borough B, but fewer homes than Borough A), with eighteen private homes, three voluntary homes and seven local authority homes. It has the largest number of local authority run residential homes among the 32 London boroughs, and there are at least three of the two remaining types of homes. The scores for the key indicators of social exclusion and poverty in Borough C also came between that of Borough A and Borough B. The inclusion of the Borough C can be interpreted as a consideration of possible influence of the different composition of residential homes on older people's experiences of the transition, and ensures that every effort is made to arrive at unbiased research findings that take geographical variations into account. Efforts were made to recruit similar number of participants at each research site.

A profile of participating care homes

The researcher first contacted the Local Authority Social Services Departments (SSDs) in three boroughs in London and received permission necessary to study details of what social workers call residential home 'placement'. As the term 'placement' connotes a passive role of service users, the term is deliberately put into inverted commas in this thesis.

The researcher then obtained care home directories from each SSD. In the directories, there were lists of care homes SSDs used to 'place' older people after carrying out assessments. As the lists included selected care homes, there are many care homes missing from the directory. Older people have the right to choose a care home not listed in the directory, although it is not common, if the services of the care home meet the needs of the older people and the cost of care does not exceed the financial limit set by the SSDs. Therefore, the researcher used a large online database on care homes, which allowed the researcher to find other care homes not listed in the directory and explore details of each care home in each local authority area in the UK. Care Homes & Nursing Homes UK (http://www.carehome.co.uk/) provides key information on each care home, including contact details, facilities and services, types of care home, registered and specialist care categories, number of rooms and residents, weekly charge guide and the latest Care Quality Commission's report and (the now discontinued) Star Rating.

Initially, all the nine residential homes in Borough B and ten residential care homes each from Boroughs A and C were contacted for the recruitment of interviewees. The selection of care homes in Boroughs A and C was based on the types of care services they provide. The researcher selected care homes that are registered to care for older people only, and did not include homes caring for people of all ages with specific disabling conditions. Care homes primarily providing residential care only were selected, and those specialised in dementia and nursing care were not included. Yet care homes which provide both residential and nursing care (with a special nursing care unit inside a care home) were included, and it was made sure that the interviewees were recruited from those who were only receiving residential care. The size of care homes was also considered in the site selection criteria, and care homes with

fewer than ten residents were not included, as interviewing a few residents in a care home with a small number of residents may result in identification of a specific resident.

A letter introducing the research with 5-10 information leaflets for potential participants (depending on the size of the home contacted) were sent to each of the 29 care homes. In some small homes, there was no older person who had moved into the home within the last one year or no new-comers who were able to communicate with the researcher. A handful of care homes were not able to participate in the research due to ethical matters as there were already other researchers studying their residents.

Eventually, initial visits were made to eleven care homes after initial contacts were made between the care home managers and the researcher. The researcher explained about the research once again to the care home managers and requested cooperation in selecting potential participants. In one care home, there was only one resident meeting the sampling criteria. The one resident was one of the two residents who could not recall the memories of transition properly due to the worsening of cognitive impairment. Consequently, there were ten care homes participating in the research. A brief description of the participating care homes are presented in Table 3.3.

Table 3.3. Description of the participating care homes (author's own illustration)

Care Home	**Borough**	**Number of Residents**	**Number of Partici-pants**	**Type of care home/ Services**	**Weekly Charge (£)[9]**	**CQC Star Rating**
1	A	48	4	Voluntary/ Residential	480	★★

[9] The rates included in the table are the official rates the care homes charged for private residents. Local authority rates usually differ from the normal rates (usually lower or significantly lower than official rates) and were decided by the negotiation between individual care homes and local authorities. For instance, the maximum rate the care home 3 charged to local authority residents was £650, which was significantly lower than their maximum weekly rate of £1,200.

2	A	128	6	Private/ Residential and nursing	530	★
3	A	25	3	Voluntary/ Residential	560-1200	★★
4	A	48	5	Voluntary/ Residential	495	★★★
5	A	60	3	Private/ Residential and nursing	520	★
6	B	25	3	Voluntary/ Residential	550-620	★★★
7	B	49	8	Voluntary/ Residential	465-722	★★
8	C	53	4	Private/ Residential	514	★★
9	C	42	5	Voluntary/ Residential	514-566	★★
10	C	66	7	Private/ Residential and nursing	550	★

Extra interviews

Additional interviews were conducted with social workers, care home managers and staff, and family members and relatives of older people in order to obtain administrative data or more detailed information about older people's care transition experiences which were not clear during the interviews with older people (their consent was obtained before the collection of extra data). The researcher was also informed of the administrative procedures of moving into a care home and the details of the administration of residential care are discussed in *Appendix A*. There was also an interview with CQC staff to understand the system of care quality control in the UK (see Table 3.4 for the details of the extra interviews). The data collected from the extra interviews was only be used in the analysis for supplementary purposes alongside the main qualitative data collected from the residents' interviews.

Table 3.4. Other interviewees

Interviewees	**Number of people interviewed**
Social Workers in SSDs in the three London Boroughs	4 (placement team: 1, older people's team: 1, review team: 2)
Care home managers	7
Care home staff	5
Participating residents' family and relatives	4 (daughters and sons: 3, other relatives: 1)
Care Quality Commission (CQC) staff	1

Source: Author's own elaboration.

The use of field notes

To help contextualise the experiences of older people in residential homes, field notes were actively made and used to assist analysis. The use of field notes as a supplementary method is supported strongly by Maas *et al* (2002), who argue that a field diary of the context is important for any study in a nursing home (e.g. notes on history of the home, a description of staff behaviours, and attitudes and beliefs expressed by staff members). This research was carried out in residential homes, but the usefulness of field notes can be justified in a similar context. In addition, the kinds of information that Maas *et al* (2002) find useful can also be collected for this research alongside other information. Active use of field notes is recommended in most qualitative research, as it often helps researchers to understand the context of the data during the analysis (Bryman 2004).

Methods of data analysis

An application of narrative analysis: thematic analysis

Thematic analysis, a prominent model of narrative analysis, was used for the data analysis in this research. Most of the processes that narrative analysis entails suggest that it is probably the most appropriate way of dealing with the data collected for this research. Narrative analysis fits the nature of this research in that it is sensitive to:

> '…the connections in people's accounts of past, present and future events and states of affairs; people's sense of their place within those events and states of affairs; the stories they generate about them; and the significance of context for the unfolding of events and people's sense of their role within them' (Bryman 2004, p.412).

All the major features of thematic analysis conform to the nature and aim of this research, as it attempts to understand older people's past experience in relation to the present, which subsequently leads to their future, and how they were engaged in the process of transition, how they reflect their memories back and how these unfold, and how they perceive themselves as a consumer and as an individual in the process. There is an element of life course approach in the method and older people who were interviewed often brought up their personal life history to make sense of their choices, expectations, thoughts or actions during the period of care transition.

Thematic analysis aims to identify and relate key themes to make sense of the data collected. The process of undertaking thematic analysis involves the identification of patterns of experiences, linking and combining related patterns into sub-themes, finding themes through abstraction of sub-themes and constructing theme-statement that can offer comprehensive understanding of the interview data (Aronson 1994).

Thematic analysis is suited to the analysis of the data for several reasons.

1. Appropriateness to handle rich qualitative data

Thematic analysis is a useful method of qualitative analysis that contributes to the conceptualisation of the data. Thematic analysis is designed to deal with data that involves rich and often lengthy qualitative data derived from people's experiences. Thematic analysis entails collecting stories and creating conceptual groupings from the data (Riessman 2005), which help researchers to understand and demonstrate 'the ways that people organise and forge connections between events and the sense they make of those connections' (Bryman 2004, p. 412).

2. Usefulness of the method to the analysis of qualitative interviews

It is the method that is often used with retrospective interviews (e.g. life history) and allows a researcher to see the process of, or stages of, development involved in certain events or experiences in specific groups of people. Thematic analysis has been widely used for studies of identity, which is the main theme of this research (e.g. Gareth Williams' 1984 study on how individuals suffering from rheumatoid arthritis manage assaults on identity and Cain's 1991 study on identity acquisition among members of an Alcoholics Anonymous group). Thematic analysis can be a useful approach to use with qualitative interviews, as it often reveals the context of people's experiences vividly. Thematic analysis as a model of narrative analysis can involve a close examination of the contents (what is said) and/or the structure (how it is said). This research places an emphasis on both the content and the structure of older people's narratives and this worked effectively for the study of older people's choice as consumers of public services in this research. Bryman (2004) also notes that Bury (2001), while criticising narrative researchers' tendency to treat the stories of participants uncritically, recognises that the social conditions that prompt such narratives and the form that the narratives take are themselves revealing.

3. Flexible use of literature and theoretical considerations at the early stages of research

Thematic analysis can be conducted flexibly in terms of its use of literature. Being informed by the existing literature is something that has been more or less disdained in most inductive qualitative research methods. However, in thematic analysis, the use of literature and the timing of doing a literature review can also vary, according to one's approach to the research question (Braun and Clarke 2006). This research takes a constructivist and interpretivist position, placing an emphasis on specific aspects of people's experience (choice and self-identity, informed by the literature) to examine underlying ideas, assumptions and conceptualisation and to discover latent themes – themes that are not descriptive alone, but go beyond it (Braun and Clarke 2006). Using literature at an early stage of the research can be legitimated, considering the nature of the research. Tuckett (2005), reflecting his research experience, argue that engagement with the literature can enhance the analysis by sensitising the researcher to more subtle features of the data.

4. A method in its own right

Not in the context of narrative analysis, but in general, thematic analysis has little been referred to as a method in its own right. The process of coding, and the way of developing themes and linking them (the recursive process) have been particularly referred to as perceived similarities with other methods of qualitative analysis. Mainly for this reason, thematic analysis has been regarded as an approach, or a series of steps of data management (coding), that is dissolved in most qualitative analysis, and has not been recognised much as an independent method (Braun and Clarke 2006). However, Braun and Clarke (2006) claim that thematic analysis should be viewed as a method in its own right, by clearly outlining what thematic analysis as an independent analytic method can entail, and suggesting possibilities for conducting thematic analysis in a more deliberate and rigorous way.

5. Manifestation of the ability to generate theory

The use of thematic analysis in theory development has not been discussed much in the literature, but there is a clear possibility that thematic analysis helps to elaborate data for the development of theory. The processes involved in thematic analysis are seen as almost identical to that of grounded theory. Rice and Ezzy (1999) even assert that the only major difference between grounded theory and thematic analysis comes from the inclusion of theoretical sampling in grounded theory, which is a unique feature of grounded theory. Kristiansen (1999), citing Strauss and Corbin's work, criticised this assertion and claimed that grounded theory places an emphasis on theory generation through developing a set of related concepts, and it does not just present a list of themes. However, although it is not the aim of the thematic analysis, thematic analysis in itself can facilitate generation of theory, as it is a useful approach for theorising across a number of cases, through constructing a typology that contributes to the development of theory (Riessman 2005). The last phase of thematic analysis suggested by Braun and Clarke (2006) aims to make an 'argument' in relation to one's research question, which can lead to the development of theory.

In spite of the usefulness of thematic analysis in this research, poorly conducted thematic analysis can have several limitations. Thematic analysis can be described as poorly conducted, if the analysis is weak or unconvincing, or if there is a mismatch between the data and the analytic claims that are made about it (Braun and Clarke 2006).

The role of a researcher should not be overlooked in conducting a rigorous thematic analysis. Some approaches to qualitative data analysis often put more emphasis on the transcribed data itself than the researcher's ability to carry out the analysis. For instance, there has been a constant emphasis on concepts 'emerging' from the data (Braun and Clarke 2006), rather than

on researchers' ability to actively engage in the interpretation of the data. The role of the researcher in the analysis is described in a passive way in some qualitative analysis, and important (and sometimes even abstract) themes are treated as being already formed and residing in data, with comparably less focus on researchers' role in interpreting the data, and synthesising codes and themes to elaborate a theory. What has to be stressed for researchers carrying out narrative analysis is their active engagement in the process of analysis, so that the researchers can avoid pitfalls such as the one pointed out by Bury (2001): that analysis of narratives of adversity is biased in a sense that researchers' being uncritical of the data consequently leads to them being seen as attempting to convince the audience in a particular way. 'Being uncritical' in this sense means interpreting data without consideration of underlying ideas and assumptions in participants' stories. The researcher attempted to be critical by paying attention to both the contents and the structure of the interview accounts. It helped the researcher to better understand the context of the narratives.

The use of Computer-Assisted Qualitative Data Analysis Software

This research used ATLAS.ti, one of the most widely-used Computer-Assisted Qualitative Analysis Software (CAQDAS), to assist the analysis of the interview data. The main functions of CAQDAS include text retrieval, text management, coding, complicated and customised searching, linking categories and theory building. Most CAQDAS packages fall into one of the five categories: code and retrieve packages, code and theory building packages, text retrievers, textbase managers and conceptual network builders (Spencer *et al* 2003). ATLAS.ti is fulfils most of the functions that are categorised above (Spencer *et al* 2003), but the use of ATLAS.ti in this research is limited to initial coding and data retrieval and management. In this research, ATLAS.ti served the purposes of tagging and retrieving

text segments and adding comments to texts using field notes in order to assist the thematic analysis of the interview data.

The reasons for the limited use of the CAQDAS are related to the nature of the tasks the CAQDAS packages are able to carry out. The use of CAQDAS can result in the researchers' role being minimised in the process of analysis. For example, some argue that CAQDAS helps researchers manage qualitative data and enhances the transparency of the process of analysis (Bryman 2004), but others point out that some of the code and retrieve packages allow 'cut and paste' of transcribed data, which can lead to losing the context or location of the material (Ritchie *et al* 2003). Likewise, the effectiveness of the use of CAQDAS still remains contested.

With regard to data management and retrieval, however, CAQDAS packages have clear advantages. Indexing, search and retrieval, and linking notes to coding are examples of using CAQDAS as an organisational tool at early stages of the data analysis (Cassell *et al* 2005). The data transcribed can be retrieved promptly and managed efficiently with a CAQDAS package. The processes involved in data management include the identification of initial themes within a data set (‘patterns’ in this research), labelling or tagging the data, sorting the data by theme and concept, and summarising the verbatim material (Ritchie *et al* 2003). Using ATLAS.ti, the researcher was able to incorporate many different field notes with the interview data by adding memos to the text. Data retrieval was also made easier through sorting the data first by participating care home and later by conceptual group the interviewees belonged to. The view that software is just an aid to the organisation of the material, but not an interpretive device, has been put forward by King (2004). Efficient, but

not de-contextualising, data management is also possible through CAQDAS, as long as the researcher is aware of the context during the data management (Bryman 2004).

In addition, ATLAS.ti is a programme that can assist thematic analysis effectively. ATLAS.ti, compared to other popular software packages, facilitates coding in an accessible and effective way and has strong search and retrieve functions. Lewis (2004) argues that, whereas some academics may have concerns with coding in NVivo (what she termed 'quirky node concerns'), coding can be easily done in ATLAS.ti. Also, ATLAS.ti's 'Code Family Management' is a useful function, as it permits researchers to record and treat a family of codes as single code, and use it in the subsequent analysis. Moreover, although most other CAQDAS packages have search and retrieve functions, one of the major strengths of ATLAS.ti is in its powerful tool for searches and queries to identify text pattern in the primary documents. Constructing complex queries through Object Crawler (Lewis 2004) clearly helped carrying out early phases of thematic analysis. Overall, the controlled use of CAQDAS helped to bring out the context of the data more efficiently, without risking de-contextualisation and fragmentation of the data.

Methodological limitations

There are some possible limitations of research methods employed in this research, and they are the limitations that frequently reside in qualitative research or social research as a whole, rather than problems that are unique to this research.

First, there is a limitation that originates from the size of the sample used in the research, and the possibility of generalisation of the research results. Forty-eight is not a particularly small

sample size in qualitative research, but there is a possibility that it might be seen as small. The fact that the sample is not representative of the total population of older people with experiences of transition can also sound problematic to some who value 'generalisation' of research results. However, it is not the aim of this research, and, in fact, of qualitative research, to prove that the research findings can be applied to every relevant case, to the whole population of older people. What this research seeks to achieve is generalisation within the cases through in-depth understanding of older people's experience and development of typologies that can inform the theory and the relevant literature.

Second, there can be a problem that comes from the voluntary nature of research participation. Interviewing only those who are willing to take part in the research is a prerequisite to conducting social research. Nevertheless, there could be some degree of self-selection operating which can lead to having a biased sample and certain themes being under- or over-represented. One may expect that it would be only older people with happy memories of care transition that comes forward for interviewing. Yet, the interviews with older people confirmed that people do come forward when their memories are traumatic and wanted to talk about how difficult it was for them to cope with the care transition.

Third, sometimes the nature of the retrospective interview allows people to reconstruct their stories. This was addressed in the research by repeating similar questions and conducting extra interviews. The researcher also attempted to conduct a rigorous analysis of the stories told by older people and the possible reasons behind the story-telling through the analysis of both the structure and the contents of the interview accounts.

A consideration of ethics

Ethical issues become more important in social science research if the research has a sensitive topic or involves those who are vulnerable. Ethical considerations form an important component of this research in that sense, since the contribution of vulnerable older people as research participants is at the centre of this research.

This section considers ethical issues that may arise during the data gathering process. A special importance is attached to the process of informed consent and the role of the researcher. These are the two issues which need to be dealt with using particular caution.

Informed consent and competency of the research participants

As Jokinen *et al* (2002) rightly point out, informed consent is not a single event. It would rather be proper to say that a researcher is 'maintaining' informed consent of the research participants throughout the research, rather than 'getting' it once at the start. One of the important principles in research ethics is that research participants can withdraw their participation from the research project at any time. This principle itself proves the need for constant re-negotiation of informed consent.

In this research, there is more consent to be maintained throughout the research: informed consent from the research participants (older people) *and* cooperation from the residential homes where the participants reside. The process of maintaining informed consent was expected to keep the researcher sensitive to the participants' reactions and to allow the research to be carried out in a more flexible and smooth way (Jokinen *et al* 2002).

There are no fixed rules about obtaining informed consent. However, Ratzan (1980) identifies three general necessary conditions under which informed consent should be obtained:

a. The research subject must freely volunteer to participate
b. The subject must be mentally competent
c. The subject must be informed of all the likely consequence of the research, including the risks, benefits, discomforts and compensation (p.5).

What matters most in this research in relation to informed consent is the 'competency' of research participants. Maas *et al* (2002) find that 'many residents of nursing homes have some form of dementia…or can no longer manage their own affairs due to cognitive and/or physical functional losses', and point out that study designs that involve a representative sample of older people are often compromised due to the difficulties of including older people with cognitive and physical functional losses. Some even argue that asking the residents to participate in the research is improper, as institutionalisation is already a burden to them (Goldstein 1978, cited in Ratzan 1980). It is likely that there are also residents with cognitive and physical functional losses in residential homes, although those who live in residential homes are expected to have fewer cognitive and physical functional problems than nursing home residents, and residential homes differ from nursing homes to the extent that older people do not enter residential homes when they are reaching the end of their life or when death is imminent (George 2002). The number of residents who have cognitive or physical difficulties would be smaller in residential homes when compared to nursing home residents, but it was thought that consideration of those who were less competent should take place. Not only from the perspective of conducting research with a representative sample, but also from the perspective of ethics, not involving those who are less competent can be discriminatory in itself. Moreover, by involving only those who are competent, this research

is limiting its scope as it does not consider the choice of older people with less cognitive ability during the transition.

However, whether participants have the cognitive ability to take part in the research is important, as it is crucial to ensure meaningful consent by the research participants in studies involving older people to induce meaningful results. If older people's cognitive ability to participate in the research is proved, they can be treated like any other class of competent research participants, as autonomous agents (Ratzan 1980). Ratzan (1980) refutes the view of seeing participation of institutionalised older people as improper, and criticises this for being rooted in paternalistic thinking. It is argued that involving older people is not a problem, once the autonomy of the mentally competent, elderly research participants is recognised (Ratzan 1980). In this respect, the Mental Capacity Act 2005 has little relevance to this research, as it aims to protect people who cannot make some decisions for themselves. To make matters clear, the researcher also made an enquiry to the Social Care Research Ethics Committee of the Social Care Institute for Excellence about the need for extra ethical screenings for this research. The researcher was informed that there was no need for extra screening, since this research did not involve older people who lacked the capacity to consent.

Recall of memory is an essential part of carrying out retrospective interviews, but patients who are suffering from dementia are particularly forgetful and experience disorientation of time and place, due to losing memory of recent events (Ratzan 1980). It was therefore impossible to involve them in this research. Nevertheless, there is a possibility that those who are suffering from mild cognitive impairment can still recall their memories (i.e. those who started to get forgetful of some details of very recent events).

Therefore, this research did not seek to necessarily exclude those who were suffering from minor cognitive impairment, and intended to include all those who were sufficiently mentally competent and who agreed to take part. Judging whether the research participants were able to participate in the research inevitably depended on medical reports, hourly reports kept in residential homes and accounts of residential home staff who encountered the residents every day.

One thing that had to be borne in mind was that it could take a relatively long time to get informed consent from the participants, compared with other studies which do not involve older people, and this was true for this research. Maas *et al* (2002) warn that researchers should be prepared to spend a substantial amount of time on the consent process with older people. Indeed, it took longer than the researcher originally planned to get the consent from older people and conduct interviews. The initial process of recruiting research participants took longer as the research required cooperation from both the local authority SSDs and individual care homes. It was also not uncommon that interview appointments were cancelled or rescheduled depending on older people's state of health (both physical and psychological) on the day of the interview.

However, although this research was conducted in residential homes, important steps to make the residents engage in the research remained more or less the same: making sure that the researcher worked in cooperation with the home staff and overcame the possible reluctance and sceptical attitude of older people. The research objectives and background were explained fully, so that the home staff and older people would agree to cooperate despite the increased interruption of routine (see Maas *et al* 2002).

In addition to the matter of competency, there can be another matter which should be considered when researching older people. There is a possibility that some residents could have hearing or vision problems, even if they do not have cognitive problems (Maas *et al* 2002). To resolve this matter, the consent form was produced in large letters, and help from the home staff was requested if it had to be read out loud (as the researcher's engagement at this stage could be seen as putting pressure on them). The researcher ensured that she spoke clearly and loudly enough for the participants to properly engage in the interviews throughout the research.

Consequences of research: risks and benefits

To minimise any risks and maximise benefits to research participants, it is essential that research participants understand about the background and the nature of the research (Jokinen *et al* 2002). There was a full interpretation of the research objectives and its design, and any meanings of the words or phrases used in the research. Questions or open-ended statements that were used during the interviews were also interpreted by the researcher in a common-sense way to make sure that the interviewees understood what particular aspects of their experience the researcher is bringing forward.

It was also ensured during the research that the interviews were conducted in places where the interviewees were most comfortable and at the preferred time of the interviewees, to help them feel comfortable to tell their stories during the interviews. It was also considered that extra protection might be needed during interviews with vulnerable older people (Jokinen *et al* 2002). Every interview schedule was reviewed by residential home staff, and they were

alerted about the presence of the researcher and the scheduled meeting with the residents before each interview started.

This research can be potentially beneficial to those who participate in the research, and furthermore, to those who will live in residential or nursing homes – those who will experience the transition. It might be the case that the interviewees do not see any short-term or long-term benefits for them immediately. However, having ensured that every effort is made to help interviewees find it comfortable to tell their stories, this research can act as a kind of 'therapy' (Reissman 2005) which facilitates them to speak their thoughts and experience, and obtain psychological comfort and regain their sense of self. It was ensured by the researcher that the interviews took place at the time and place older people found convenient to tell their stories to the researcher in the manner that allowed them to feel comfortable.

As Langellier (2001) put forward, some people, particularly those who are marginalised, 'get a life' by telling and writing their stories. The burgeoning therapeutic culture was one of the factors that triggered research interest in narrative. In the long run, what is found in this research can suggest new ways to help older people make a smoother transition, and can further inform both social policy and its practice. There is a possibility that older people who may experience another transition (to other residential homes or a nursing home) can benefit through the improved transition procedure (although the experience of the subsequent transition can differ from the first transition).

Anonymity and confidentiality

Anonymity and confidentiality are two very important topics in research ethics. This research tried hard to guarantee the anonymity of the participants by assigning pseudonyms. Confidentiality was also secured through conformation to the 1996 Data Protection Act. Personal information that was collected from the interviews was used exclusively for this research, and was not used for any other purpose. Also, direct quotations were not used in a way that allowed the interviewee to be identifiable by a third party from reading the quotes. It was made sure at the time of the interview that the interviewees understood that their anonymity and confidentiality of their information is guaranteed.

Previous experience of interviewing older people

The role of the researcher is particularly important in studies involving older people. Jokinen *et al* (2002), based on two ethnographic research experiences of researching children and the elderly, put a strong emphasis on the role of the researcher:

> The researcher has to respect the informant's humanity and ensure their autonomy, and be sensitive to their expressions and gestures in a reciprocal interaction throughout the research process (p. 165).

From the stage of obtaining informed consent, the researcher should actively communicate with research participants and residential home staff, while remaining sensitive to their reactions. The researcher has experiences of interviewing older people for two qualitative studies (for the final dissertation for the first degree and the masters' degree), with one of them involving older people who were engaged in informal caring. Topics relating to their own care plan and their cared-for persons were included as part of the research. The previous research experiences and the interview skills obtained during the research helped in her

communication with the older people and in making them feel comfortable during the interviews in this research.

In summary, this chapter discussed the two key concepts used in the research, choice and care transition, and showed how the analytical frameworks were applied in the research to explore the research questions. It also looked into detail the research methods employed in the research, namely, qualitative retrospective interviews and thematic analysis. Ethical matters were dealt with at the end of the chapter, reflecting back the researcher's previous experiences of interviewing older people for research purposes. Before presenting research findings, the next chapter introduces the administrative procedures involved in the transition from community care to residential care in order to aid understanding of the research findings.

Chapter 4. Older People's Experiences of Care Transition: The Formation of Conceptual Groups

This chapter deals with how older people experience the stages of care transition, namely initiation, exploration, choice making and adaptation. This chapter first describes the administrative procedures involved in older people's care transition. While exploring how older people coped with each stage of the transition, it explains how the data from 48 in-depth interviews with older people were analysed. It presents patterns (i.e. codes) related to the interviewees' experiences of care transition that were found during the thematic analysis of the data and how they were interpreted to form sub-themes and main themes[10]. The patterns are first divided into four categories of personal, care related, care home related and local authority related. Then, they are re-arranged in order to show how they are related to each stage of the care transition and are explored in detail.

The analysis of the data shows that there are four broad types of older people in terms of their experiences of, and their approach to, the process of care transition. This grouping remains consistent when looking at other aspects of care transition explored in this research (findings on other aspects of care transition are presented in Chapters 5, 6 and 7). After looking at patterns in detail, there is an illustration of how the four conceptual groups were formed, followed by a description of differing experiences and key socio-demographic characteristics of each group. The final section is devoted to the discussion on the nature of the care transition, based on older people's perception on their move into a care home. There is a

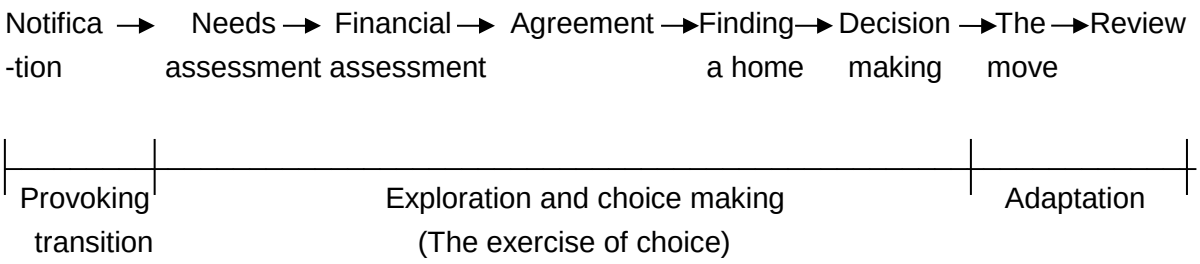
[10] 'Patterns', 'sub-themes' and '(main) themes' are terms that are used in thematic analysis. Initial codes (key factors affecting care transition) found in the transcripts are called 'patterns' and they are inter-linked and condensed to form 'sub-themes' and, eventually, reach a more abstract level (themes).

presentation of findings on types of changes the four groups experienced during the care transition and the merits and demerits of living in a residential home, using the analytical framework developed.

The administrative procedures involved in the care transition

A brief exploration of the administration of residential care will aid the understanding of the findings on older people's experiences of care transition which are presented in this chapter and the subsequent chapters (please see Appendix A for more detailed information). The administration of local authority-funded residential care involves the eight stages outlined in Figure 4.1. Following the notification of the applicant's care need, an assessment of the applicant's needs is undertaken by a social worker. Older people's needs are assessed and classified based on the Fair Access to Care Services (FACS) Guidelines (see Table A.1. for details). Older people's needs are classified into four categories of low, moderate, substantial and critical needs, and the three local authorities participated in this research funded care only for those who were assessed as having substantial or critical needs. The level of funding older people are entitled to receive differs depending on their financial circumstances. If they have capital below the eligibility threshold of £23,250, they are sent a letter containing the findings from the assessment and asked to sign the letter as a sign of their agreement. Once the agreement is made, older people can start finding a care home. Older people can move into any care home (often, in their local area) as long as the care home they choose meets their needs and the financial limit set by the local authority. After the move into a care home, the first review is carried out by a social worker six weeks after the move to see whether older people are adapting well and receiving care for that meets their needs. Then, annual reviews are carried out every year.

Figure 4.1. Older people's transition from community care to residential care- timeline



Source: Author's own elaboration based on interviews with social workers

Patterns affecting older people's experiences of care transition

The thematic analysis of the interview data identified patterns which were related to older people's care transition experiences. The term 'patterns' means codes that were found in the accounts of interviews with older people. Table 4.1 presents the key patterns that were linked to older people's experience of care transition. The patterns are divided into four categories depending on whether they reflect personal, care related, care home related or local authority related accounts of the transition experience.

In order to study how these patterns were related to older people throughout the process of care transition, the patterns are re-arranged to reflect the way they are associated with each stage of the care transition (see Table 4.2). It clearly shows that there are different patterns relating to each stage of the transition from community care to residential care (the stage of exercise of choice was split into two stages of exploration and choice making). The way each pattern was related to older people's experiences also varied from pattern to pattern.

The dynamics of the patterns involved in each stage of care transition are uncovered in the following sub-sections. The patterns presented in Table 4.2 will be examined in detail in terms of how it affected each stage of care transition.

Table 4.1. Patterns: key factors affecting older people's care transition experience*

	Personal factors (A)	Care related factors (B)	Care home related factors (C)	Local authority related factors (D)
1	Education	Care history	Proximity to family/relatives	Number of care homes in the LA
2	Religion	Care need (self-perceived)	Administrative procedures	Weekly charge
3	Gender	Care need (perceived by others)	Care home facilities	Financial limit set by the LA
4	Marital status	Care need (assessed)	Care home cleanness	Social workers' belief/ work ethic
5	Having adult children	Problems with carers	Care home star-ratings	Availability of bridging care
6	Family structure	Length of exploration	Care home routine	LA support for home care/ carers
7	Difficulties with coping with housework/ cooking	Exercise of choice in residential long-term care	Quality of care	Extra home care provided by the LA
8	Occupational history	People who helped care transition	Quality of other services	Information for users
9	Health status (diagnosed)	Availability of bridging care	Outings arranged & allowed	Recommendation from LA
10	Health status (self-perceived)	Informal family support	Weekly charge	Vacancy situation
11	History of illness	Informal peer support	Personal belongings allowed	Waiting time
12	Mobility	Volunteers' support	Degree of communal living	Alternatives to residential care
13	Family problems (including domestic violence)	Availability of Local Authority (LA) domiciliary care	Degree of sharing facilities	Being allowed to move to a care home in another borough
14	Personal network (PN)	Availability of informal care	Paying top-up fee (by family)	The timing of the move
15	Family relationship/structure	Knowledge of residential care	The size of the room	Assessment of needs
16	Hobbies	Care-related information	Interaction with staff	Assessment of means
17	Emotional changes	Desired type of care/living	Temporary stay/short-term stay	LA eligibility criteria
18	Personality	Levels of care experienced	Visits to care homes	LA block contract
19	Loneliness	Frequent changes of carer	Staff: resident ratio	
20	Privacy			
21	Willingness to exercise choice			
22	Recommendation from PN			

23	Living arrangements
24	Lifestyle
25	Having a pet
26	Perception of a care home
27	Participation in activities sessions
28	Personal belongings to take in
29	Self-acceptance of the need
30	Concerns over security and safety
31	Abuse or neglect
32	Other problems threatening security of individuals

*Factors relating to economic resources were not identified much during the process of the analysis, partly due to older people's lack of awareness of financial arrangements relating to their care (this research is set out to explore older people's first-hand experiences and perceptions) and partly due to the limited impact of financial resources on their experiences of care transition. All interviewees had similar economic resources in order to qualify for free (or very low cost) residential care and had their care fees covered by local authorities (LAs).

Source: Author's own elaboration

Table 4.2. Patterns: key factors affecting each stage of care transition (rearranged)

Initiating Transition	Exploration	Choice making	Adaptation
Health status (diagnosed)	Care related information	Proximity to family members	Exercise of choice
Health status (self-perceived)	Alternatives to residential care	Distance to home/ familiar area	Feelings of 'in control'
History of illness	Education	Care home facilities	Knowledge of a care home life
Mobility	Occupational history	Care home cleanliness	Hobbies
Family problems (incl. domestic violence)	Knowledge of residential care	Care home services (specialised)	Administrative procedures
Problems with carers	Personal network (PN)	Care home star-rating	Care-related information
Abuse or neglect	Family structure	Weekly charge	Care history
Marital status	Marital status	Care home rules	Care home routine
Having adult children	Religion	Outings arranged & allowed	Emotional changes
Availability of LA domiciliary care	Willingness to exercise choice	Personal belongings allowed	Health status (self-perceived)
Availability of informal care	Life style	Having a pet	Mobility
Care need (self-perceived)	Personality (introvert/extrovert)	The size of the room	Self-acceptance of the need
Care need (perceived by others)	Living arrangements	Care home routine	Informal family support
Care need (assessed)	Self-initiated care transition?	Degree of communal living	Family relationships
Loneliness	People helping care transition	Degree of sharing facilities	Informal peer support
Other problems threatening security of individuals	Health status (diagnosed)	Vacancy situation	Personality (befriend with others)
Perception of a care home	Health status (self-perceived)	Waiting time	Participation in activities sessions
Difficulties with coping with housework/ cooking	Mobility	Care-related information	Volunteers' support
Extra home care provided by the LA	Being allowed to move to a care home in another borough	Recommendation from PN	Interaction with staff
LA support for home care	Financial limit set by the LA	Recommendation from LA	Staff: residents ratio
Frequent changes of carer	LA block contract	Temporary stay/short-term stay	Religion
Concerns over safety and	Available care homes	Visits to care homes	Personal belongings allowed

security			
LA eligibility criteria	Weekly charge	Length of exploration	Quality of care
Assessment of means	Willingness & affordability to pay top-up fees (by family)	Social workers' belief/ work ethic	Quality of other services
Assessment of needs	Gender		The timing of the move
	Number of care homes in the LA		Privacy
	LA information for users		Volunteers' support
			Degree of sharing facilities
			Degree of communal living
			Outings arranged and allowed
			Levels of care experienced
			Availability of bridging care

Source: Author's own elaboration

The initiation of care transition

The initiation of the care transition was related to older people's need for residential care. The transition from community care to residential care was triggered either by older people themselves or by others around them, depending on whether it was themselves or others who saw the need for residential care. The need for residential care was judged primarily based on older people's deterioration in health and its impact on their daily lives. Mobility was also considered as it was closely linked to older people's ability to perform daily tasks and household work.

In about two-thirds of the cases, the move into a care home was suggested by people around the older people, including carers, family members, friends and social workers, as was found in other studies (Townsend 1962; Phillips and Davies 1990; Allen *et al* 1992). However, still, there were a significant majority of older people who initiated the transition themselves. The actual provision of local authority-funded residential care was affected more by diagnosed health and/or assessed needs rather than self-perceived health status and needs. This is not surprising, considering that the need for residential care was formally assessed by social workers in all the cases studied. The local authority funded care was only available to those with substantial or critical care needs and all the interviewees were receiving financial help from local authorities with paying for their care. This triggers the question of 'whose' views are taken into account in the context of involving older people and offering them choice in residential care (Clarke *et al* 2007). This is discussed in detail in Chapter 5.

Deterioration in health status may well be considered a prerequisite for publicly-funded residential care. Nevertheless, there were six exceptional cases, which involved older people

who were abused or neglected in their own home physically and/or mentally. The threat to their safety and security was rooted in family problems (including domestic violence), troubles with carers or verbal and physical abuse inflicted by those within their close personal network. Their safety needs were considered seriously in the local authority needs assessment and were prioritised by social workers.

Informal care arrangements and the availability of informal care were included in the assessment criteria for local authority funded residential care. Availability of local authority funded domiciliary care also played an important role, as some older people had to move into a residential home because they could not receive proper publicly-funded domiciliary care.

Most of those who initiated the care transition themselves were living alone, like other interviewees, and they often said that feelings of loneliness were also a reason for their move and that care home life mitigated the feelings. They also had less negative images of a care home than those who did not initiate the transition themselves. Yet it did not mean that they preferred residential care over community care. Whether the move was self-initiated or not, the interviewees had a shared problem before the move – difficulties in preparing meals and coping with housework. The difficulties in coping also made them start considering about the life in care homes. There were also other health-related issues which drew social workers' attention, including addiction problems.

Exploration

Older people's exercise of choice in residential care starts from their exploration of available care options, as exploration precedes the actual choice making. What factors limit or facilitate

active exploration? In relation to older people' exploration of available options, information was the single most important element that influenced older people's attitude for and behaviour of exploration. However, having 'genuine' choice was often difficult for older people for several reasons, including the lack of alternatives to residential care and the awareness of the alternatives, the lack of knowledge and understanding of the long-term care system and the format and the quality of the information available.

First, older people's exploration did not usually lead to finding alternatives to residential care. It was found that not many older people were aware of the options regarding alternatives to residential care such as extra care housing or more intense domiciliary care. This was partly because of the lack of alternatives actually available to older people. Most of them were not informed of these alternative options by their local authority professionals. Some of the social workers who were interviewed for this research said that the provision of alternative services was often not possible due to financial and/or practical reasons (e.g. extra domiciliary care being too expensive or the provision of extra care housing being rather patchy and uncommon in their local authority area). Older people's understanding of the long-term care system and their direct and indirect experiences of long-term care (such as knowing someone who lives in alternative facilities or having looked after a member of their family living in a care home) were also limited. Consequently, in most cases studied, older people's exploration only involved searching for care homes with available residential places.

Choice of a care home was, however, still an important aspect of choice in residential care and, accordingly, the search for available homes was something that had to be carried out with special attention. As discussed in Chapter 2, choice of a home represents three different types of choice regarding the use of residential care – choice of who (professionals), what

(services), and where (the locus of service provision). Information was still the most important element that limited or expanded feasible options of care homes for older people. Access to up-to-date information was also important as care home entrance was often affected by the availability of vacancies. Many interviewees, however, believed that they themselves and their fellow residents were 'not told enough' about what to look for and what was available, as found in other studies (Allen et al 1992, Barnes and Prior 1995, Boyle 2013). Considering the research evidence relating to the lack of information provided to self-funders (see Henwood 2011; LGiU 2013; NAO 2013), it seemed that limited information was something most users of residential care experienced, regardless of their funding status. The interviewees' lack of information was mainly because the relevant information only often existed online and large-print versions of booklets were hardly available.

Many interviewees, regardless of their socio-demographic background, felt that their access to helpful information was limited. Nevertheless, the level of information older people actually had was affected by various elements relating to their educational or occupational history. During the exploration stage, older people initially utilised their knowledge of long-term care and the system of public service provision to obtain information on local authority funded residential care. This includes how the publicly-funded long-term care works, who are eligible, who to contact to request assessment, names of care homes in the borough they lived in and so on. Older people who were more highly educated than others or who were involved in the labour market during their life were better aware of the services available to them and the ways to contact local authority Social Services Departments. Those who worked as public servants or worked in areas relevant to residential care (e.g. nursing) also had better idea of how to access local authority services.

Older people's marital status, family structure, religious activities and personal network also affected their collection of information and exploration of care homes in general. They often collected information from people in their personal network (including friends, former colleagues and neighbours), relatives, medical practitioners or church members. They received varying levels of information and help from others, particularly from their family and relatives. Overall, those who had low level of mobility or serious health conditions received more help than those who did not. Those who helped with finding the information utilised their own network of people to obtain the relevant information and it allowed them to have information from the network that was significantly enlarged from their own.

The role of family could also be important in terms of offering the scope for more choice by paying top-up fees. Among the 48 cases studied, information on top-up fees was available in 37 cases. Older people themselves were hardly aware of financial arrangements relating to their care, so the researcher made additional enquiries to individual care homes. Among the 37 interviewees, 8 of them were covered by top-up fees. Three of them arranged the care that required top-up fees themselves, but the other five interviewees were not involved much in the decision making and residential care involving the payment of top-up fees were arranged by the family.

Gathering of information and visits of individual care homes were usually performed simultaneously by older people themselves and others around them. Nevertheless, in some cases, exploration of care homes was entirely carried out by others. Indeed, some older people preferred to accept others' choice. The most preferred deputies for older people were their daughters. As a result, marital status and family structure became particularly important during the exploration stage. Local authorities also provided some basic information which

introduces the way to apply for publicly-funded residential care and the names of local homes, but the amount of information passed onto older people was also limited.

Older people's willingness to exercise choice was also important. Their willingness to do so was enhanced when they lived independently and/or initiated the care transition themselves. Interestingly, older people's age and health little affected them being active. Although older people with more serious health conditions received more help from others than those with less serious health conditions, both biological age and diagnosed health status was not necessarily correlated with older people's attitude to, and behaviour of, exploration. Among the research sample, there were some cases of older people in their nineties or in poorer health conditions than others being active throughout the period of care transition. This challenges the biological theories of ageing which interpret ageing as the process of decline (Harris and Tanner 2007) and the assumption that the old-old would clearly be more frail and dependent than younger older people (Trydegård 2000).

Older people's exploration of care homes was also affected by elements related to the variation in administration and practice at local government level, including differences in local supply of residential care and weekly charges, the maximum amount supported for individual service users and varying policies on inter-borough or inter-regional moves.

Choice making

What are the elements that older people actually considered when they are making a choice? The elements considered at the end of the process of the exercise of choice were rather practical. The pattern that appeared most often in their local area during the analysis was the

location of a care home. Moving into a care home in their local area was important for some older people as it gave them the sense of familiarity and stability. However, proximity to family members was considered far more important for many older people, consistent with the findings in other studies (Phillips and Davies 1990; Kellaher's 2000). It thus became a major stressor to some older people who moved into a care home that was located far from their close relatives.

The majority of the patterns in terms of choice making were related to features of care homes. Rather than trying to find ways to explore the quality of services, the facilities in care homes or cleanliness of care homes were considered first by older people, as found in the literature (Nolan and Dellasega 2000; Sales *et al* 2005, cited in Fotaki *et al* 2005). The elements older people considered important fell into the category of 'outcomes of maintenance or prevention', as defined by Qureshi *et al* (1998) or 'process outcomes' (Glendinning *et al* 2006). Care home rules or routines were taken into account as well and they included meal and sleeping times, frequency of outings, amount of personal belongings they were able to take in and rules on having a pet. The size of the room, although not varying much within a care home, often determined the amount of personal belongings to take in and it was important for some people to bring big musical instruments or meaningful furniture.

There were some limiting elements in making a choice, however, such as a lack of vacancies, weekly charges exceeding the local authority limit or long waiting times. Some of these elements exerted their influence continuously from the exploration stage. Others' recommendation of a particular home affected older people's choice a lot, especially if the person who made the recommendation was someone close to them or someone with religious authority. Those who had few people around to help them relied on social workers (at least to

some extent) in terms of getting information and/or receiving recommendation of specific care homes. If there were block contract homes in the borough they lived in, they were one of the first homes to be recommended by social workers, as they were, from the perspective of social workers, care homes that met certain standards in terms of the quality of care and other services.

Some older people made visits to the care home they considered moving into and were able to gather sufficient information to make a judgement of the home through the visits, as Fotaki *et al* (2005) found. A small number of older people had made visits to the home where they were living, but sometime in the past as a request of a resident. Those visits formed their prior knowledge of the home and helped them to make the choice to move in. Some older people took trial options such as a short-term stay and this gave them the opportunity to gather the most rigorous information one could collect. The longer older people spent time in the care home they chose, the easier it became to make a choice and the higher their satisfaction with their life in the care home.

Adaptation

Regarding older people's adaptation to the new care and living environment, choice affected older people's adaptation significantly regardless of whether it was exercised or not. Those who exercised active choice felt the sense of being in control of their life, acquired knowledge of care home life and felt some satisfaction with care home life relatively easily. By contrast, those whose choice was denied or ignored made an undesired move to a care home, or made a move to an undesired location, without prior knowledge or proper preparation for the move. They often felt that they had no control over the course of the care

transition and found it difficult to have any affection towards the care home where they were living. As a result, they were still in the transitional state at the time of the interview.

Health, especially self-perceived health, was a sensitive topic for older people. It was found that how older people perceived their health status was more important than their diagnosed health status, as found in Vaillent (2002). Older people were particularly concerned about sensory dysfunction, as it significantly limited the types of activities they could do in the care home. It was also related to the matter of maintaining continuity with their previous life. It meant a lot to older people to be able to continue enjoying reading newspapers, listening to radio, playing musical instruments or participating in religious services. Mobility also affected older people's perception of self-perceived health to a great extent. Not being able to walk, read or hear was taken more seriously than, for example, having symptoms of illness that needed continuous medication. Those who did not suffer from sensory impairment or a low level of mobility were more likely to adapt faster and experience a positive transition than those who did.

Those who adapted well to the new environment had something in common – that they accepted the need for residential care. Acceptance of the need motivated them to exercise choice and/or adapt to the care home environment. Receipt of proper peer and family support also affected older people' care home life considerably. Peer support helped older people to gain knowledge and information about care home life and family support provided older people with both emotional care and advocacy. Older people's receipt of informal family support was affected by their marital status and family relations. The role of volunteers has not been dealt with much in the literature, but support from volunteers, particularly young

volunteers, also helped older people in terms of giving them a greater sense of community and the feeling of connectedness to the wider society.

There was little evidence on the link between older people's care transition experiences and their personality in the existing literature and no strong link was found in this study. However, some of those who were extrovert experienced a positive transition through active participation in activity sessions or frequent conversation with others. Nevertheless, there was a significant minority of people who preferred to spend time alone for most of the day and enjoyed being solitary. They adapted well without frequent interactions with other residents or with the staff. Frequent interaction with staff was mentioned by some older people as an element that helped them feel relieved about living in homes. Yet, many older people found that the care home staff were busy most of the time and that their conversation with the staff was sometimes cut short. The staff to resident ratio was also found to be low.

Some of those who had difficulties in adapting hardly accepted that they had the need for residential care. Their denial of the need, together with their lack of involvement and preparation made it difficult for them to adapt. Those who had difficulties in adaptation tended to rely on religion the most.

Having explored the key patterns and how they were related to each stage of the care transition, we now turn to discuss how they were condensed to form sub-themes and themes and how different sets of patterns, sub-themes and themes were involved in explaining variations between individuals' experiences of the transition. The variations resulted in finding conceptual groups that emerged from the interview data.

The formation of conceptual groups

One of the main attributes of thematic analysis is that it entails the creation of conceptual groupings from the qualitative data. The grouping enables us to see the connections between themes (or events) and understand the way that people interpret the connections (Bryman 2004). In the discussion of consumerism in public services, the first taxonomy of social care users was developed by Baldock and Ungerson (1994) in their study of stroke patients and their carers. Their findings illustrated that the service users had different approaches to consumerism and different welfare identities in the mixed economy of care.

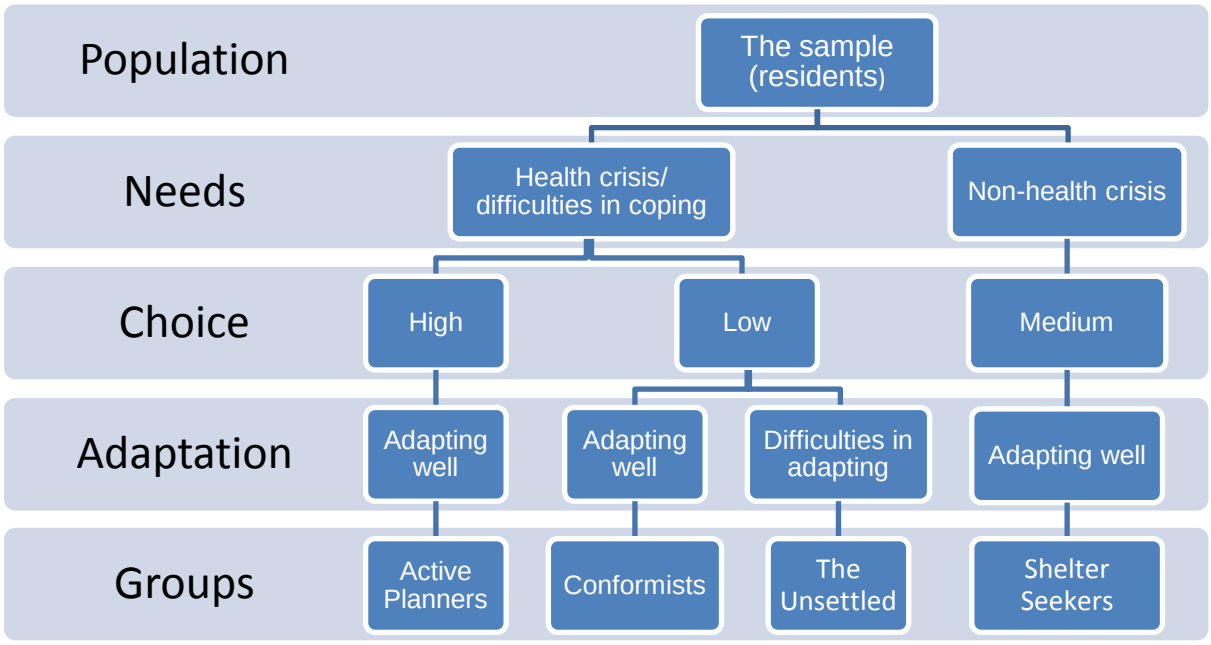
As has been explained above, the experiences of the older people who participated in this study varied significantly at each stage of the transition. There were also notable differences between the interviewees in all the main criteria explored using the analytical framework; in their experiences of adapting, their exercise of choice, their experiences of elements of a positive transition and their perception of care home life. The varying needs and experiences of the interviewees were echoed by Deakin and Wright (1990, p. 10) that 'consumers are not a monolithic category with clearly defined interests'.

In this study, differences in older people's experiences are presented in the findings in relation to four distinctive conceptual groups. They emerged during the analysis of the interview data and were named Active Planners, Conformists, The Unsettled and Shelter Seekers. The names of the groups were created and assigned by the researcher in a way that reflects the representative characteristics or unique experiences shared by those who belong to each group. It should be noted, however, that the conceptual groups were formed inevitably on the basis of broad similarities found among the participants' experiences. In this

study, the taxonomy helps us to understand users' different needs and experiences of choice in residential care and to identify groups of service users who have been hidden or largely ignored in the literature so far. Their experiences would inform the discussion of the concept of choice and its application in policy and practice.

Figure 4.2 summarises how the four groups were formed. The figure also explains the major differences between the four groups, as their experiences differed in terms of their need, their exercise of choice and their adaptation to the care home environment.

Figure 4.2. The formation of conceptual groups (simplified)



Source: Author's own illustration based on the results of thematic analysis of the data

Figures 4.3, 4.4, 4.5 and 4.6 show theme charts developed for each group. The codes (e.g.

A29, B6, etc.) used in the figures are the ones in Table 4.1 and can be matched against the table. Each code denotes a pattern which was codified in Table 4.1. The figures show how the key patterns were related to sub-themes and how sub-themes formed the main themes, which represent each group's experiences of care transition.

As can be seen from Figure 4.3, Active Planners spent the longest time among the four groups on exploration of available care options and of individual care homes. They were actively involved in the decision making process. They believed that residential care was the best choice for them and they felt that they were still in control of their life. They enjoyed a sense of 'continuity' and largely maintained the same lifestyle after the move into the care home. They had relatively rich information on care homes compared to others and, as they knew about the care home they moved in, they were satisfied with living in the care home.

Figure 4.4 illustrates Conformists' experiences of care transition. It is clear from the figure that their active use of peer support and family support resulted in their positive experiences of the transition. They accepted their need for residential care and, on the whole, they were satisfied with the services provided in the care home. As they did not know much about a care home life, they suffered some effects of the transition. However, the effects faded away as they actively shared their feelings with their family and sought advice from their peer residents.

The Unsettled residents' experiences are shown in Figure 4.5. The care transition of the Unsettled started from others' recommendation and most of the Unsettled moved into a care home without accepting the need for residential care. They also had negative perception of care home life, partly due to their lack of knowledge of, and their prejudice against,

residential care. The negative perception was reinforced by their experience of having their choice denied. As their move was an undesired one, they often experienced conflicts with family members and sometimes it led to the cessation of informal support. They found it difficult to adapt to the care home environment and ended up ‘putting up with’ the difficulties.

Shelter Seekers’ care transition experiences, as illustrated in Figure 4.6, implies positive traits of care homes. Shelter Seekers who had their well-being threatened in their own home moved into a care home in order to be separated from the traumatic past. They gained the sense of well-being both emotionally and physically and recovered their sense of self. The move into the care home was their choice, although it was recommended by social workers, and they felt safe and protected in the care home.

Figure 4.3. **Theme Chart – Active Planners** (author's own illustration)

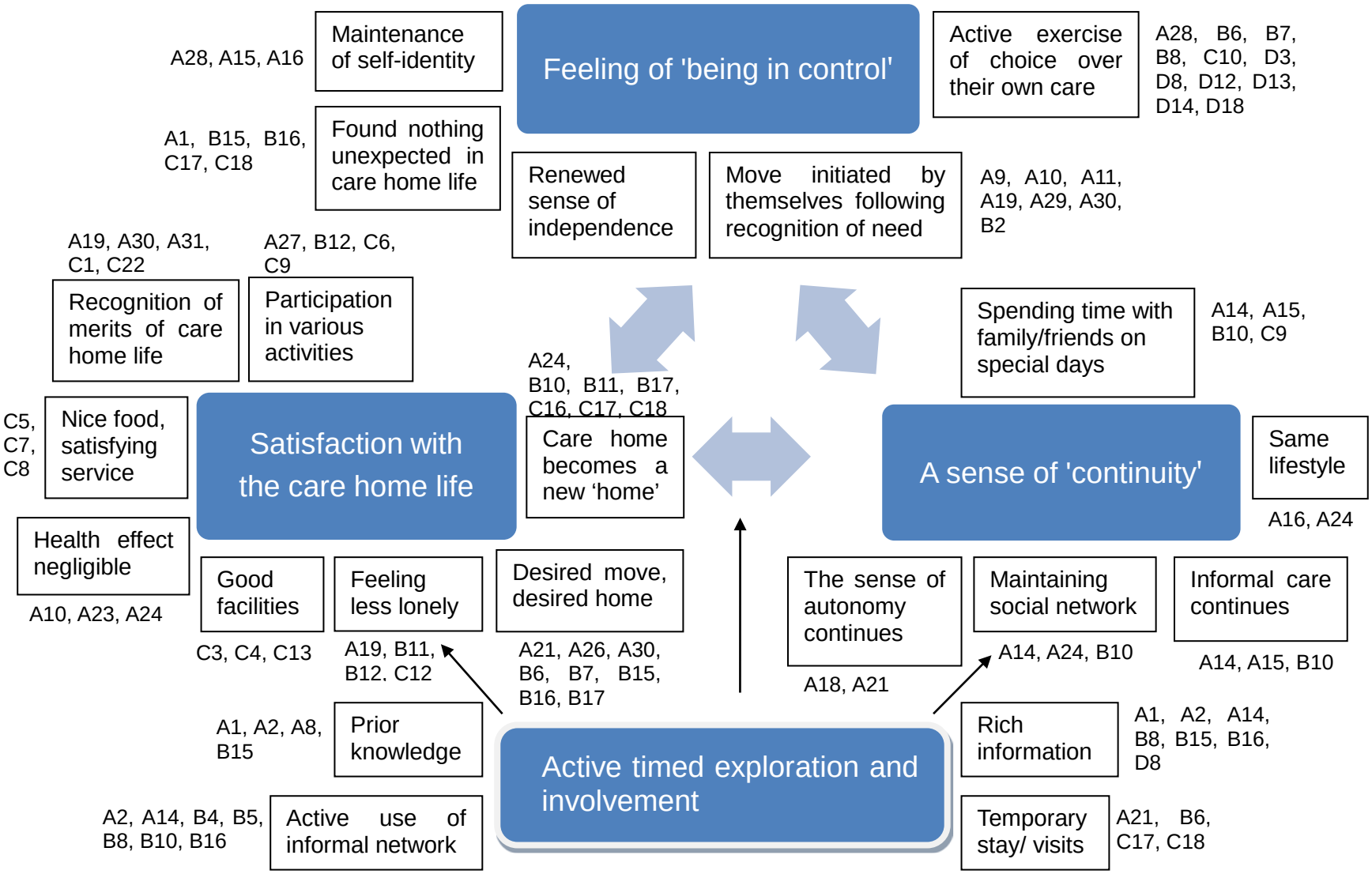


Figure 4.4. **Theme Chart – Conformists** (author's own illustration)

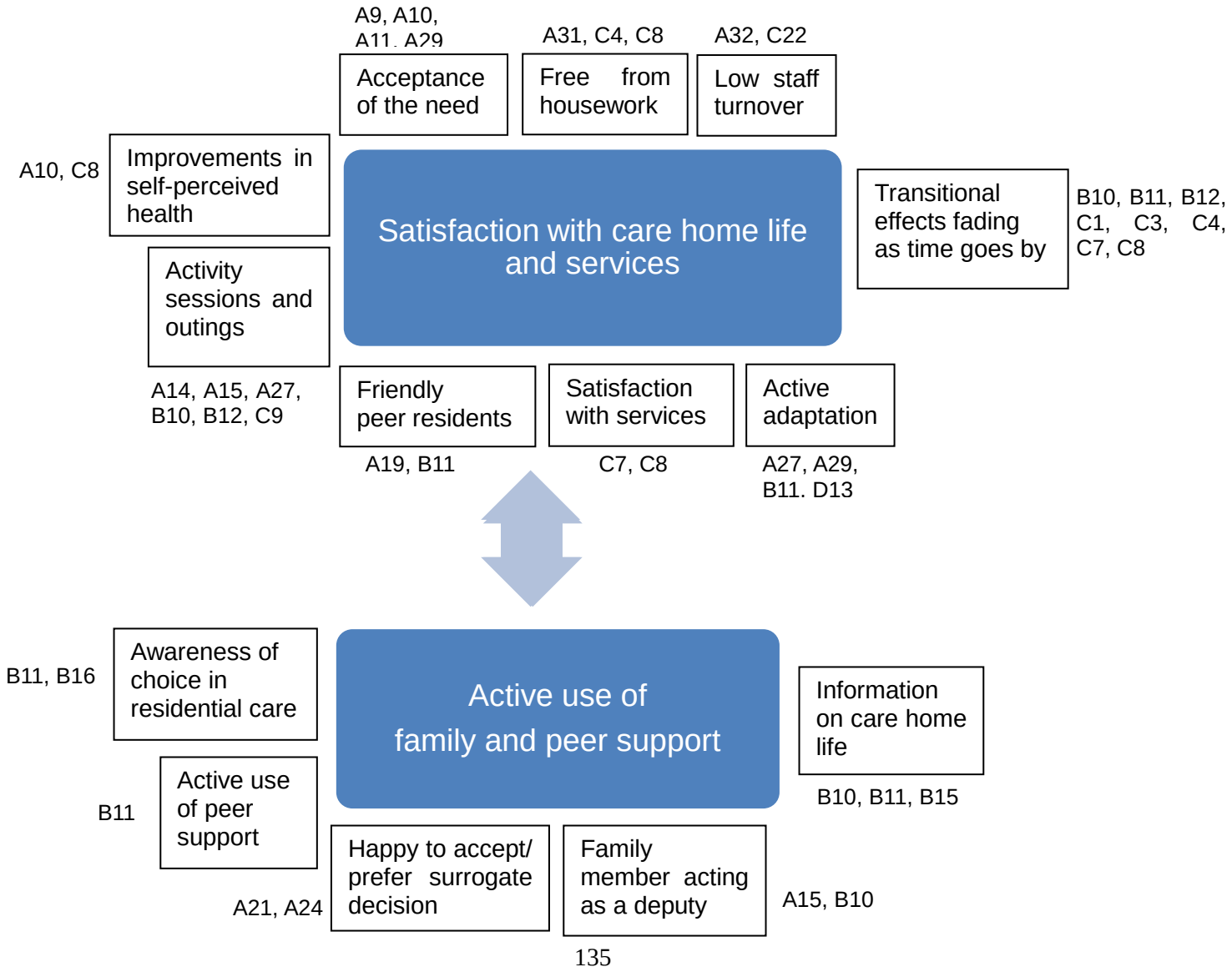


Figure 4.5. **Theme Chart – The Unsettled** (author's own illustration)

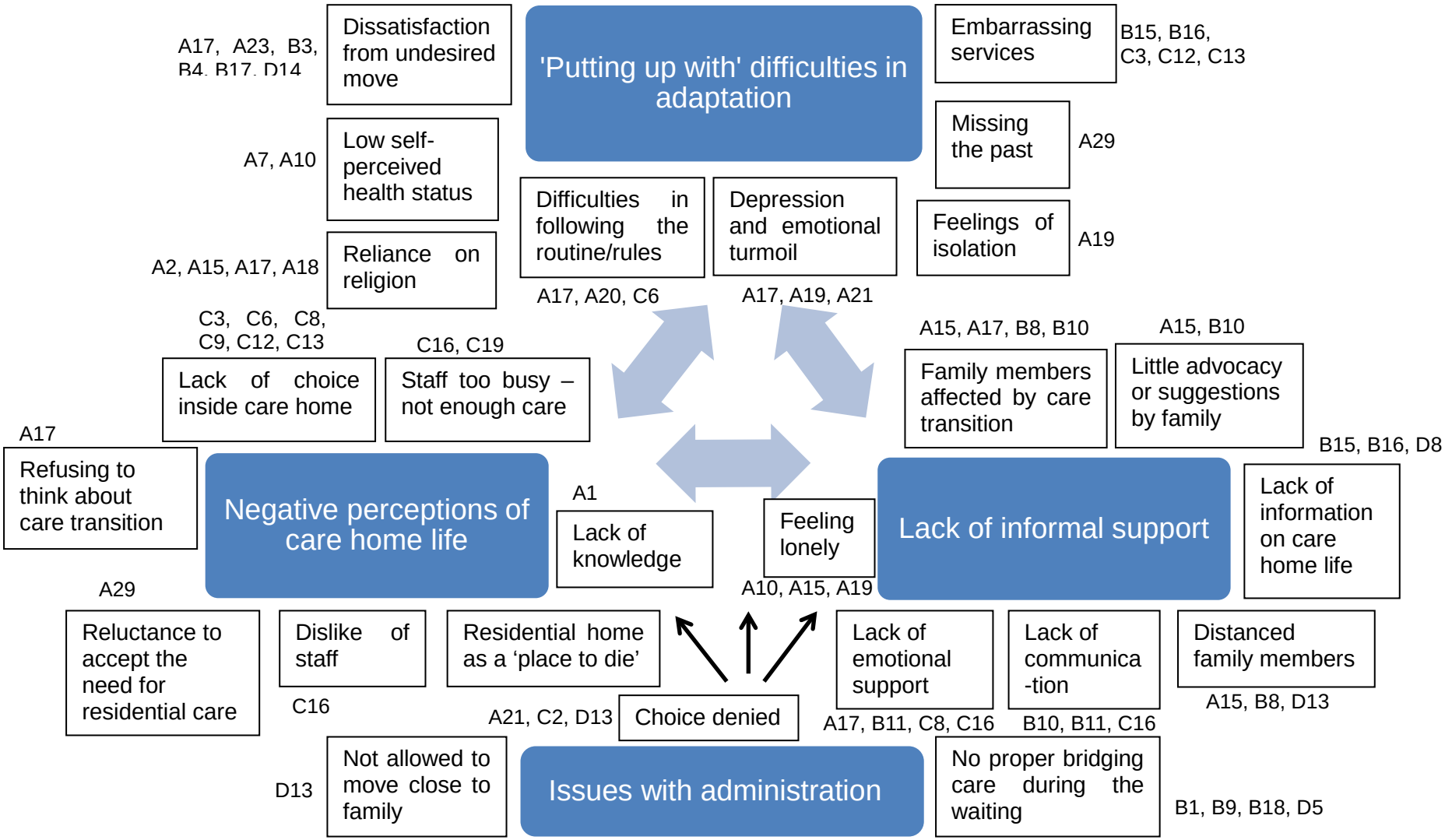
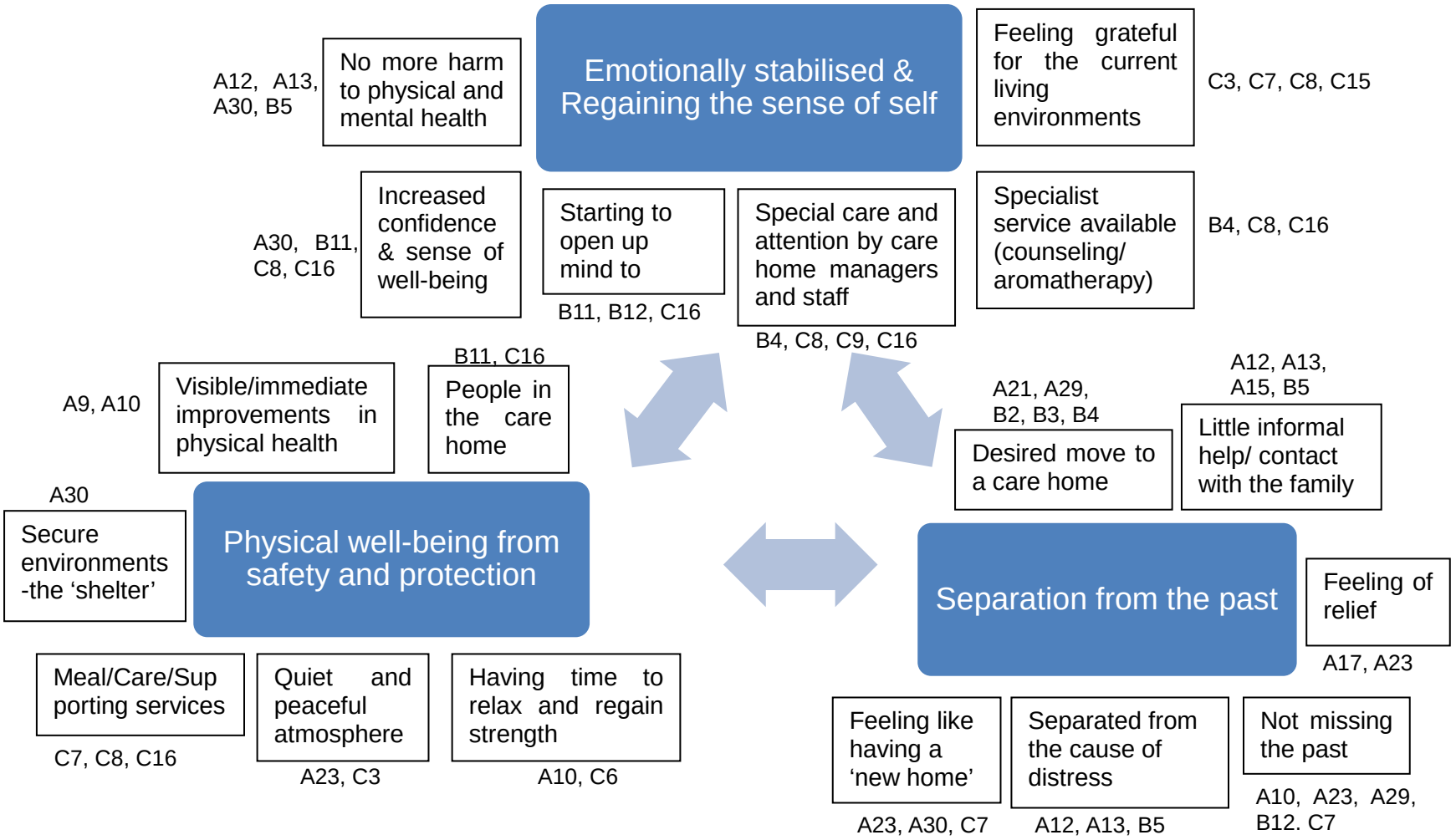


Figure 4.6. **Theme Chart - Shelter Seekers** (author's own illustration)



The table below describes key characteristics of the four conceptual groups. Active Planners were involved actively in the process of care transition and used their personal network to collect relevant information. Conformists had little choice during the period of care transition, but showed how active adaptation can lead to positive transition experiences. It is interesting to note that the group of Conformists includes those who chose not to exercise choice. The Unsettled often moved into a care home against their wish and had problems with adapting to the care home environment. The fourth group, Shelter Seekers consisted of those who experienced problems that seriously threatened their sense of well-being in their daily life. They were satisfied with living in the home.

Table 4.3. Typology of older people experiencing care transition

Cluster	Characteristics
Active Planners	Actively engaging in decision making process by exploring available options, seeking relevant information, exercising choice and planning forward. In doing so, there is active support from family and social network. It is often the case that they take trial options (e.g. prior visits, short-term temporary stay etc).
Conformists	Conforming to the new environment uncritically and positively accepts current circumstances of one's own. The process of becoming a Conformist can be seen as a passive choice due to little involvement in decision making process during the care transition, but their acceptance of their own care needs and their positive (and often active) adaptation help them make a positive transition. This group includes in part those who had little time to exercise choice (due to sudden illness, fall etc.), those who simply trusted and accepted others' decisions and those who felt reluctant to come into a care home at first.
The Unsettled	Experiencing relocation trauma or have problems with adapting oneself to the new care environment. Awareness of available care options is low. The concept itself is not meant to be completely contrary to Active Planners, but those who were suffering from the transition were found to be those who had no

	choice or little choice. Those who fall into this cluster include the ones who failed to conform to the new environment due to forced entry or undesired move.
Shelter Seekers	Moving into a care home in search of the security and protection that a residential care setting can provide. Largely having particular reasons (needs) for the transition (e.g. family trouble, domestic violence, elder abuse). Their needs are prioritised by the local authority professionals. When making the transition, their reliance on the local authority social services departments is the highest among the four groups. This group of users of residential care have not been identified in the literature so far. Care transition is often decided and takes place quickly due to the nature of their needs, but the transition entails the active choice of older people themselves.

Source: Author's own elaboration.

The remainder of the chapter examines how the patterns identified above relate to each of the four groups of older people.

Active Planners

Active Planners often initiated the care transition themselves as they felt the need for residential care on several occasions, including having no one near to care for them when their needs became intense, feeling less secure living alone, and feeling lonely and having social needs as well as care needs. They were not proponents of residential care, but they had a less negative image of residential care than other groups of people, especially the Unsettled. They conducted a lengthy exploration of the options available to them with the help from relatives and friends and made a decision with relatively rich information. Active Planners' participation in choice making challenges the stereotype image of older people found in the literature and the research evidence that reported their passiveness in the use of public

services (see Townsend 1962; Phillips and Davies 1990; Allen *et al* 1992; Nolan *et al* 1996; Roberts and Chapman 2001; Glendinning *et al* 2008).

On average, Active Planners had educational qualifications that were higher than the three other groups. It gave Active Planners the idea of the social care system. They were thus able to receive formal support from the local authorities for their exercise of choice at the right time. The combination of informal and formal support enabled Active Planners to prepare for the transition. They often took trial options such as a temporary stay or visits to a care home and this gave them confidence and satisfaction with the choice they made. Their adaptation to care home life was not completely easy or without any concerns, but they found their life in a care home fulfilling in terms of enhancing their autonomy, receiving satisfying services and maintaining continuity with the past.

Figure 4.3 illustrates how the themes are formed out of sub-themes and how they interact with one another to demonstrate the situation for Active Planners.

Conformists

Conformists had a clear recognition of their care needs and therefore accepted the move without much reluctance, despite the fact that the choice regarding the move was often not made by themselves. In fact, some Conformists preferred surrogate decisions. This finding is consistent with the argument put forward by Dowding (1992) and Barnes and Prior (1995), which challenged the assumption that exercise of choice is necessarily valued by users. Baldock and Ungerson (1994) also identified a group of users who were satisfied with what they were offered. For Conformists, informal family support continued after the move. They

also used peer support actively and acquired important information on the care home where they lived from other residents.

Conformists were largely satisfied with the quality of the services provided in the home and tried to adapt actively by participating in activity sessions or outings. The active adaptation of Conformists showed the possibilities for a positive transition without active choice. Some of them mentioned that they had a clear sense of improved health. They also felt that transitional effects were fading as the time went by.

The theme chart 4.4 describes the Conformists' experiences of care transition.

The Unsettled

For the Unsettled, the narratives of their experience of the care transition were predominantly pessimistic. The majority of the Unsettled had a relatively low self-perceived need and a negative perception of a care home. They were reluctant to move into a home and also did not have the chance to consider alternative option. The transition was often suggested by other people around them and the choice over the move was also made by others. The Unsettled sometimes experienced deterioration in family relations during the transition period. They often remained at the transitional state for a long time, frequently for over six months (i.e. due to difficulties in adapting, they could not get out of the transitional state at the time of the interview with the researcher). Their experiences of care transition fell in line with the typical cases of traumatic and stressful transition explored in the literature (Tobin 1989; Victor 1992; Nay 1995; Biedenharn and Normoyle 1991).

Figure 4.5 shows the main themes and various sub-themes extracted from the patterns, and how they interact to describe the care transition experiences of the Unsettled.

Shelter Seekers

Figure 4.6 presents the transition dynamics of Shelter Seekers, a group of older people who had an exceptional reason for moving into a care home.

Shelter Seekers' experiences of care transition were unique in terms of the fact that it was made in a manner that enabled them to become separate from the past. Their move to a care home was triggered by problems that threatened their sense of security such as abuse, neglect and serious troubles with their carer. Social workers, neighbours or friends initiated their move, but the choice to move into a specific care home was made by the Shelter Seekers themselves. Due to the nature of their move, they had little informal support from their family but they valued emotional stability and physical well-being which came from the secure care home environment. The unique needs and experiences of Shelter Seekers have been neglected in the literature.

The nature of the transition from community care to residential care

This section explores the nature of the transition from community care to residential care on the basis of older people's experiences and perceptions of the changes the transition involved. In doing so, the differences in the experiences of the four groups are compared and contrasted.

There are some differences between the four groups in terms of their socio-demographic backgrounds (see Table 4.4).

Table 4.4. Key socio-demographic characteristics of the four groups (averaged)[11]

Groups (number of people)	Age	Education [12]	Mobility	Length of exploration	Marital status	Gender
Active Planners (17)	81	Level 2&3	Medium-high	4-5 months	Mostly single or widowed	Mostly female(12)+ some male (5)
Conformists (14)	86	Level 1&2	Medium-low	Little self-exploration (2-3 months by deputy)	Mostly widowed	Similar number for male (6) and female (8)
The Unsettled (11)	86	Level 1	Medium-low	Little self-exploration	Varied	Mostly female (10)
Shelter Seekers (6)	72	Level 1	High	< 1 month	Mostly married	All female

Source: Author's own elaboration.

Contrary to the negative evidence from the literature, Active Planners formed the largest group of all, followed by Conformists. There were six Conformists who delegated their right to choose to their family members or relatives. Interestingly, all the surrogates were women. Considering that the older people in the three other groups were also helped mainly by their daughters, daughters-in-law, sisters, nieces and social workers (who were mostly female), there was a tendency for residential care (as in other areas of social care) being arranged significantly more by women, as well as being provided and used more by women, than men.

[11] The numbers in the table is not an attempt to quantify the qualitative data, but serve as additional information that may help the reader to have some idea of the sample. The list of the interviewees can be found in Appendix E.

[12] Information on the levels of education qualifications used in the table can be found at: http://www.statistics.gov.uk/census2001/profiles/commentaries/people.asp

Older people's experiences of multiple changes following the care transition

Table 4.5 summarises the major differences between the four groups in relation to their experience of the care transition and their adaptation to it. As explained in Chapter 3, the changes older people experienced during the transition period were clustered into four categories: environmental, emotional, relational and physical. Each group experienced different changes or adapted differently to the same changes, and some changes affected a particular group more than other groups.

The most obvious and visible change older people went through was in the living and caring environment. It took some time for older people to adapt to environmental changes, such as changes in the type and the intensity of care they receive, the place in which they live and receive care, the people around them, the personal space and belongings allowed to them, and the way of living itself.

The Unsettled and some Conformists felt that the new environment brought significant changes to their privacy (sharing a toilet/bath and receiving some personal care services that involved close contact – e.g. bathing). This conforms to the literature which discussed loss of privacy and lifestyle (Nay 1995, Iwasiw *et al* 1996, Pearson *et al* 1993). Active Planners, on the other hand, were able to adapt in a relatively short time as they often had first-hand knowledge of residential care gained from prior visits and experience of staying in the care home during the trial period.

Table 4.5. Older people's experiences of multiple changes following care transition

Type of change	Details of change	Notes
Environmental	● Type of care provided – residential ● Provider of care – care home staff ● Place of living and receiving care – care home ● Amount of personal belongings-significantly reduced ● Way of living – communal life	- Environmental change was shared experience of all groups. Most residents were satisfied with the care service, but some Conformists (temporarily) and most of the Unsettled found it difficult to adapt to communal living, mainly due to lack of knowledge/information.
Emotional	● Embarrassment ● Depression ● Nervousness ● Loneliness and isolation ● Calmness and serenity ● Anticipation ● Compound emotional effect – continuously occurred as a result of other changes	- Negative emotional changes often associated with not being prepared emotionally to move in, most undergone by the Unsettled, some by Conformists. - Calmness and serenity experienced by Active Planners, Shelter Seekers and some Conformists. -Anticipation experienced by Active Planners and Shelter- Seekers
Relational	● Establishing new relationships – meeting new residents and staff ● Family relationship deteriorated ● Family relationship improved ● Existing social network loosened ● Maintaining the network of close friends	- The Unsettled experienced deterioration in family relationship - Conformists experienced improvement in their family relationship - Most residents found their existing social network loosened - For Shelter Seekers, there was no more room for change in family relationship (that had already deteriorated for a long time) - Establishing new 'relationship' in care home was not easy for most residents, however (relations remain at a superficial level) - Active Planners kept their network of close friends the best
Physical (Health Effect)	● Physical health deteriorates suddenly and unexpectedly ● Physical health deteriorates gradually (in many cases, natural progress of the existing illness) ● Existing health conditions started to get better	- Gradual health deterioration - Sudden health deterioration - mostly due to the symptoms of 'tension release', differently experienced by some Active Planners and the Unsettled. - Health status largely remained unchanged for Active Planners - Shelter Seekers experienced most improvement in their health

Source: Author's own elaboration of research findings.

Emotional change was the change that affected older people deeply and constantly. For the older people interviewed, the most difficult change to cope with was not the most obvious (i.e. the environmental) change, but the emotional change that sprang from the other three types of change (physical, environmental and relational changes). As older people attached meaning to every change they experienced and interpreted the changes in their own way, every change had emotional consequences. Therefore, the Unsettled residents were most affected by emotional change, since their experience of the care transition was the harshest.

Active Planners, Shelter Seekers, and some Conformists demonstrated calmness and serenity as a sign of accepting the changes. Anticipation (in a positive manner) was mentioned mostly by Active Planners and Shelter Seekers whose transitions were most desired.

Relational change was the one which affected the residents slowly, but continuously over time, for good or ill. Many interviewees said that they hardly noticed the change during the early stage of the transition, as relational change does not occur all at once. For example, the number of visits from family members, relatives and friends declined gradually and became fixed as weekly, fortnightly or monthly visits. This could be understood as the ‘social loss’ (Nay 1995; Patterson 1995; Wilson 1997).

On the other hand, for some Conformists who experienced conflicts with family members over their care home entrance, there was a restoration of family relationships as they adapted to the new environment. The Unsettled experienced deterioration in their family relationship, mainly because that their family members found it difficult to see them constantly not being able to adapt. Some of the Unsettled were not able to move into a home close to their children and relatives. It was difficult for their children and relatives to come and see them, due to the

distance. The adaptation became a painful experience for both the Unsettled and their family members. As Dellasega and Nolan (1997) found, the quality of care transition older people experienced also affected their carers and other family members.

The majority of older people did not find it easy to establish new relationships, partly because they did not think that establishing true relationships was possible inside the care home. The residents referred to each other as another ‘resident’ or a ‘service user’, and did not see each other as a ‘friend’. They used the word ‘friend’ to describe only those who were already in their personal network before the move into a home. This was partly the reason why older people particularly valued visits from their family members, relatives or old friends, as the ‘social’ aspect of their care home life was often completed with outsiders’ visit.

Regarding the physical change, the change could take place in three ways: sudden deterioration, gradual deterioration or improvements in physical health. Sudden deterioration in health status was detected from the accounts of both Active Planners and the Unsettled, but the causes of health deterioration were of different kinds. Many Active Planners were those who maintained independence before moving into a home. After the move, they realised that they did not have to make efforts to manage everything on their own. They said that they felt like experiencing a loss of energy from their body from the time they realised that they were free from the housework. Sudden deterioration was experienced by the Unsettled as well, but the reason behind this was their losing affection towards life. They said they were not particularly willing to live actively or autonomously, but were just putting up with the life that was given to them.

Conformists abided by the rules of the care home and were largely satisfied with the services they received at the care home. They experienced gradual improvements in their self-reported health status. Shelter Seekers did not have the chance to look after their health before the care transition, and therefore benefited from the transition the most. Overall, Active Planners' health status largely remained the same, with some experiencing improvements and some undergoing sudden deterioration. Their health status was on average better than many other residents from the start. Even the health status of those who experienced a sudden deterioration was not much worse than most Conformists or the Unsettled.

Older people's perceptions about living in a residential home

In addition to the discussion on older people's experiences of changes the care transition entailed, there was an in-depth exploration of older people's perception of care home life. It was explored through asking older people what they thought as merits and demerits of living in a care home compared to living in the community (see Table 4.6). The four conceptual groups also had different views on the merits and demerits of their life in a residential home over living in their own home, while sharing some similarities.

Table 4.6. Merits and demerits of living in a residential home over living in their own home

Merits	**Demerits**
Low staff turnover Carers kept changing in both formal/informal care before moving in, frequently experienced by all groups. Older people had to explain all about their needs to new carers prior to care home entrance. Having the same carer every day makes for stability and continuity of care.	**Routine – meal and sleeping times** Older people found it difficult to follow the 'routine' in a care home – keeping meal times and sleeping times, whereas they used to eat and sleep whenever they wanted to, when they lived in their own home. ● Most challenging to Conformists and The Unsettled

Safety and protection Older people were nervous about locking doors and had a fear of crimes or abuse, when living alone and/or in their own home ● Most valued by Shelter Seekers whose own safety was threatened at home	**Communal living** The attributes of communal living were unfamiliar to older people and sometimes embarrassing ● Most challenging to The Unsettled who still found it difficult to adapt to the nature of communal living
Convenience – free from housework, especially from preparing meals The fact that someone is doing the jobs that older people found increasingly challenging to do – preparing meals and doing the household chores – made them feel relieved ● Most valued by male residents, and Conformists who were satisfied with the service.	**Restricted social life** It was difficult for older people to maintain their social life in a care home, as it was not possible for them to invite friends, have a party or have some friends sleeping over. ● Most challenging to Active Planners
Reduced loneliness Older people felt less lonely in a care home, surrounded by other residents and staff, compared to when they lived alone ● Most valued by Active Planners to whom this was one of the reasons for their decision to move into a home.	**Superficial relations** Older people from all four groups thought that the new connections and social network created inside the care home tended to be shallow and superficial, and found it difficult to make real 'friends' in the home.

Source: Author's own elaboration of research findings.

One of the biggest merits of living in a care home for older people was low staff turnover. Older people valued the fact that they were receiving care by the same staff every day, because carers used to keep changing when they lived in the community, whether using paid or unpaid care. They also felt insecure due to the change of carer as, for them, the new carers were strangers. Those who received formal care (paid care) experienced the problem with changing caring arrangements significantly more than those who only received informal care. There are currently no specific national guidelines to regulate constant changes in the arrangement of carers, although some private agencies set relevant rules themselves apply to their service. Some of the interviewees thought that there have to be some regulations introduced to enable them to receive community care in a secure environment. Older people

were also relieved that the care home environment would protect them from any potential harm or crime that might have occurred if they had remained living alone.

Convenience was also enjoyed by many residents. The fact that they did not have to prepare meals every day or look after their household was a relief for many interviewees. The moment of the care transition was at the time when they found it increasingly difficult to carry out some ordinary tasks in daily life. Preparing meals was challenging, especially to male residents, and it was difficult for them to think about the nutritional values of a meal.

Older people (especially Active Planners) found that their feelings of loneliness decreased after moving into a care home. Living in a care home with other residents made them experience the bustling sound and the sense of belonging.

However, there were some demerits of care home life which made it more difficult to adapt for older people. Changing their lifestyle according to the care home routine was the most difficult thing for older people to cope with. Each resident had their own preferred meal and sleeping times, but they have to make compromises in order to keep to the rules. One of the interviewees described the process of adapting to the daily routine as something similar to losing an old habit. Some Conformists and the majority of the Unsettled found it most challenging as they did not expect this routine before they moved in, due to insufficient information.

Older people found their social network loosened after moving into a care home. They talked to their friends or close relatives on the phone, but talking over phone was limited in terms of maintaining the existing relationships. Some care homes only had one or two phones

available to residents in the reception area. Sometimes, older people had to queue to use it. Some Active Planners used to invite friends to come over and let them stay over a night before the move into a home. It was not possible to do this in the home and there were even cases of some friends and family members visiting the care home at the ‘wrong time’ (during the outings or meal times). However, Active Planners regarded the restricted social life as a trade-off that was necessary to receive the type and the quality of care they needed.

Another disadvantage of living in a care home was about establishing new social contacts. Older people across the four groups thought the new connections created in a care home were shallow and superficial in nature. They thought the new connections were created based on mutual needs rather than affection or common interests, which had played an important role in their making friends before they came into a care home.

There are some other merits or demerits of care home life which are not mentioned in the table. They were related to specific services provided in individual homes and the availability of the service varied (often limited). Some care homes had a prayer room and/or visiting priests every Sunday to support their residents’ religious life. The support for religious activities was valued particularly by the Unsettled who relied upon religion most. However, in the majority of care homes the researcher visited, religious activities were not adequately supported. Some older people also mentioned activity sessions. Most Active Planners and some Conformists enjoyed activity sessions arranged by care home and thought these sessions provided them with a chance to learn new things, interact with other residents and maintain a healthy lifestyle.

What was frequently mentioned by the interviewees across all four groups as a demerit of living in a care home was short contact time with the staff. The level of care provided in the care home was clearly more intense than the one provided in the community. Nevertheless, older people felt that the level of interaction with carers decreased in the care home. Many interviewees said that all the staff members were too busy to talk to them even if they wanted to, or they cut off the residents' words during the conversation and disappeared quickly to do other work.

The four groups displayed marked differences in all other main criteria explored using the analytical framework; in their experience of adapting to changes following care transition, their exercise of choice during the care transition and their experiences relating to elements and processes that constitute 'a positive transition'. The differences between four groups are explored further in the following chapters (Chapters 5, 6 and 7).

Conclusions

Older people's experiences of care transition consisted of a series of changes in different aspect of their life. It was found that some of these changes took place simultaneously (e.g. environmental changes and emotional changes) and some occurred with a time gap between them (e.g. changes in their health status and family relationships occur at a slower rate than other changes). Some changes persisted over time (e.g. emotional/relational changes) and some other changes had a short-term effect on older people's lives (e.g. environmental changes). These older people had different ways of coping with the changes, but they all agreed that the changes were significant enough to be called life-changing experiences.

It was found that in about two-thirds of the cases studied, the care transition was recommended by others around them including family members, friends or relevant professionals. This finding may seem to conform to the evidence from other studies (see Townsend 1962; Phillips and Davies 1990; Allen *et al* 1992) which found older people to be passive during the transition process. However, older people's needs and their transition experiences were complex and diverse and there were a substantial minority of older people who were actively involved throughout the process of care transition. Reflecting the differing needs and experiences between the interviewees, the researcher identified four broad conceptual groups that emerged from the data. About a third of the interviewees initiated the care transition process themselves and they formed the largest group (Active Planners). They participated actively in the process of transition by expressing their preferences and making choices, and they clearly represented cases of a positive transition. This challenges the widespread view on older people, which sees older people as passive recipients of welfare.

Thematic analysis of the interview data found that there were considerable differences between the other three groups of Conformists, the Unsettled and Shelter Seekers, despite their being rather passive in terms of initiating the care transition process. In fact, two of these three groups, Shelter Seekers and Conformists, became active during the period of decision making or adaptation. Shelter Seekers had unique needs arising from their suffering of violence, abuse or other troubles with their family members or carers. For them, care homes were places which provided them with safety, security and an enhanced sense of well-being. The cases of Shelter Seekers have not been discussed in the literature so far, but the findings from this research suggest that there can be a new positive role for care homes in meeting the needs of older people. The study of older people's perception of care home life also revealed other advantages of residential care over community care, adding to the

literature which has recognised a positive role for care homes (Tobin 1989; Johnson *et al* 2010; OFT 2005). The advantages of residential care (e.g. being cared for by the same staff) were related to chronic problems in the provision of community care. Repetitive changes in their care arrangements and feelings of insecurity were often the major concerns for older people when they were living in the community.

There were various elements which affected older people's experiences of care transition, including several socio-demographic factors mentioned in other studies. In particular, older people's education, their occupational history and family structure affected their level of knowledge of the long-term care system and their information-seeking behaviour. The difference in the level of their understanding of the care system and the amount and quality of information influenced older people's exercise of choice. This finding shows that there is a room for certain socio-demographic factors to make differences in older people's receipt of the same public service. However, contrary to the widespread belief, older people's age and their diagnosed health status did not seem to affect their exercise of choice and their overall experiences of care transition. The researcher found that some interviewees who were older and/or more fragile than the other interviewees were actively involved in the process of care transition with some help from their family, friends and relatives. This finding challenges the longstanding claim that older people are in an unfavourable position to exercise choice due to their age and health conditions (Trydegård 2000) and suggests the possibilities for their becoming autonomous choosers in relation to public services. Also, the amount and the quality of information older people were able to obtain were considerably limited and this finding suggests that access to good quality information in a user-friendly format should be secured to help older people making more genuine choices in long-term care.

Chapter 5. Older People's Exercise of Choice during the Care Transition: Exploration of Individual Groups

The concept of 'choice' cannot be separated from older people's care transition experiences, as it is closely related to the whole process of the transition from community care to residential care. The initiation of care transition, the exploration of available options, decision making, the move to a care home and adaptation cannot be studied without the discussion of choice.

Following the discussion on the nature of the care transition in Chapter 4, this chapter explores the nature of user choice in residential care. It then turns to examine older people's exercise of seven different types of choice in residential care (discussed in Chapter 3) and the context of user involvement and choice making for the four conceptual groups. With the focus on choice, the dynamics behind each of these groups' care transition experiences are unveiled. Relevant findings are presented in a manner that enables one to look at the individual groups' transition experiences in detail.

The nature of choice in residential care

Prior to the discussion of the types and the degrees of choice that older people exercised, it would be helpful to explore the nature of choice in residential care.

Residential care has been considered as an area where choice can be applied effectively, considering that there is strong support for choice from both users and professionals (Clarke *et al* 2007) and also that the collection and understanding of the relevant information requires

less professional knowledge than in other service areas (e.g. health care). Choice in residential care has also been considered beneficial to users, since, as the name 'personal social services' implies, their needs are more personalised than the users of some other services. The nature of residential care allows the users to have trial options (such as temporary trial stays) as well.

While the concept of choice was valued and desired by a great majority of the interviewees, the exploration of the nature of choice in residential care also suggests a somewhat different picture. The interviewees' experiences illustrate some of the shortfalls of choice in residential care, including its inflexibility and the relative importance of the first choice made by users. The nature of user choice inevitably differs between service areas, since there are service-specific factors that play a major part in shaping the service provision in each area.

The interviewees' experiences of care transition suggest that choice in residential care is often one-off and non-retractable. This is not unique to residential care, as has been pointed out by Greener (2009) who found that choice in other services, including education, is also made only once in most cases. There were two key reasons for older people's ending up making one-off choices in residential care: difficulties in adapting to the new care home environment and administrative issues that limit older people's chances of moving into another home. Regarding the former, it was found during the interviews that older people hardly even consider relocation, since they found it too much for them to move into another care home and start the whole adaptation process all over again. Even the Unsettled expressed unwillingness to consider a second move. This was partly due to their aversion to the idea of residential care itself and the assumption that moving into a new care home would not solve their problems in adapting to the care home environment. However, it was also due

to their fear of undergoing the stressful processes of the transition again. The move between care homes is also known to be accompanied by stressful and traumatic experiences (Chenitz 1983; Reed *et al* 2003; Ryff *et al* 2002). Considering that most of these older people living in residential homes have health and care needs that require extra help with the maintenance of their daily life, choice in residential care, quite understandably, is more likely to become non-reversible.

Older people's accounts also indicated that sometimes the move between homes was restricted by complex administrative procedures. Older people and their relatives unanimously said that it would not be easy to make a request for relocation to the local authority, even if there was a desire for older people to move into a new home. First, it would be difficult to find a vacancy in a care home in their local authority area. Second, it would be difficult to ensure that the care home fee was not higher than the financial limit set by the local authority. A majority of the older people interviewed were also unwilling to make their family members and relatives pay any extra fee (the top-up fee) in cases where the care home fee exceeds the local authority limit. Last, and most importantly, the move into another care home would not be made available on the basis of their feeling of dissatisfaction. Interviews with social workers confirmed that older people would have to justify clearly their requests for relocation and the justifications for relocation were often about the types of services that each home provided, rather than something related to their personal feelings or satisfaction. Additional enquiries to the social workers who were interviewed in this research found that the number of cases of relocation were very small (less than ten) in most boroughs in a given year and, in most cases, the reason for the relocation was related to care homes not being able to meet older people's needs properly (e.g. due to the closure of a care home or specific care services not being offered in the care home). The percentage of people who experienced

relocation in year 2011 in the three local authorities studied ranged between 2% and 4% of the total number of older people who used the local authorities' 'placement service'.

Older people's experiences of the transition to residential care implied that what Hirschman (1970) termed 'exit' (i.e. a change of service provider or a withdrawal from the service provider-recipient relationship) was not a viable option for them. Older people perceived their choice as an almost irreversible one, for both practical and administrative reasons, and thought it would be difficult to switch to another provider until their needs changed and they required different types of service (e.g. nursing care). The difficulties involved in the switch of service provider mean that choice in residential care might give its users less power and benefits than were expected originally. (A more detailed discussion of the impact of choice follows in chapter 6). This also emphasizes the importance of making a good choice in the first place and leads us consider the level and the scope of the choice that is on offer. How, then, can older people utilise choice in residential care?

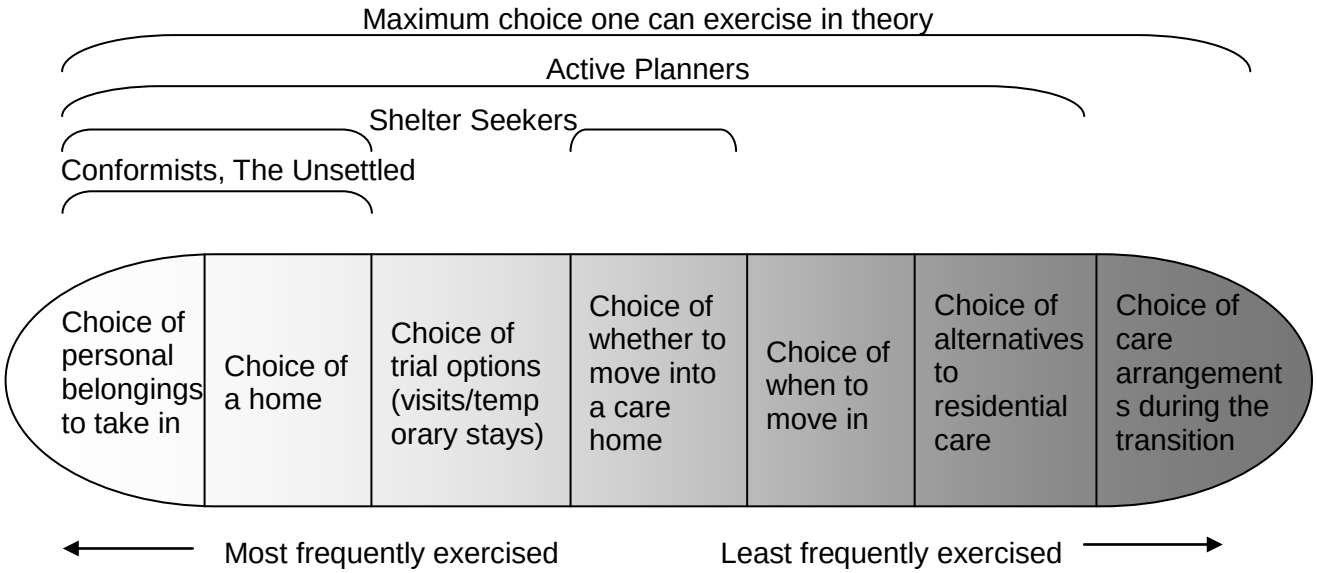
Older people's exercise of choice during the care transition

The four conceptual groups showed clear differences in their choice exercising behaviour. Figure 5.1 enumerates seven types of choice in residential care in order, from the most frequently exercised choice to the least frequently exercised choice.

The seven types of choice were further divided into three groups according to the level on which they operated. The highest level of choice relates to the decision over whether to use residential care itself. Having analysed the interview data in relation to the concept of layers of choice (discussed in Chapter 3), the varying levels of choice are illustrated in Figure 5.2.

The types of choice that involve the highest level of choice are choice of whether to move into a care home and choice of alternatives to residential care. In a wider context, both represent the choice of whether to use the service (choice over the use of service itself). In the middle layer, there are three types of choice relating to the way the service is provided (specifics of service) – choice of a home, choice of when to move in and choice of trial options. At the bottom level, there are two types of choice regarding the use of additional services – choice of personal belongings to take in and choice of care arrangements during the transition. These types of choices are exercised after the decision to use the service has been made.

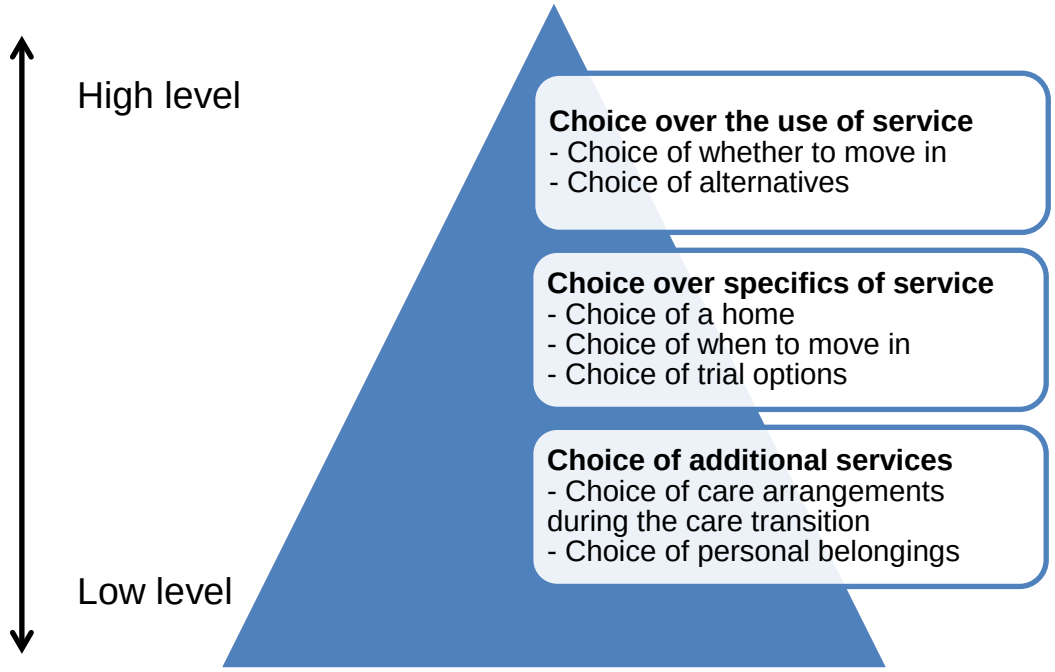
Figure 5.1. Maximum choice exercised by each group over the care transition



The type of choice that was most frequently exercised was the choice of personal belongings that older people brought with them into a care home. This was the lowest level of choice available to service users during the care transition, which people could only exercise after making a decision to enter a care home (see Figure 5.2). The actual choice about the use of service that most of the Conformists, the Unsettled and Shelter Seekers were able to make

was the one about which home to go into. However, the number of options (homes) available for those three groups was often limited to two to three. This might be seen as an improvement, since Phillips (1992) found that few public sector residents were given two or more options regarding their choice of a home. Yet, the number of options was too small to allow them to have meaningful choice and the available homes were often not their preferred homes.

Figure 5.2. Layers of choice applied to older people's care transition experiences (regarding their use of residential care)



Source: Author's own illustration (this figure was also included in Chapter 3)

The second most frequently exercised choice, the choice of a home, was made across all groups, but the degree of choice exercised differed between the four groups. Active Planners had the largest number of options (3-4 care homes on average)[13]. There were not many Active Planners who looked into more than 5 homes, but the maximum number of homes

[13] Exploration of care homes means exploration of selected homes, as exploration of individual care homes took place after evaluating the list of care homes and relevant information.

explored by an Active Planner was 9. On the whole, Conformists and the Unsettled exercised little choice over the use of residential care. However, some Conformists were able to exercise some choice from the middle of the exploration stage. Their participation began after they realised and accepted their need for residential care. They received information which was already evaluated and selected by others around them and thus their choice was limited. Some Conformists simply did not want to exercise choice, as Boyle (2013) found, and let others around them do the exploration and make surrogate decisions. Some of the Unsettled who lived alone and did not have family or relatives around had to choose themselves, but the choice was often made between two homes suggested by social workers. It was not a real choice from their perspective. Shelter Seekers' choice of a home was usually between two to three care homes from among the list of homes they received from social workers.

Choice of trial options was the next most frequently exercised choice, but trial options such as visits or short-term stays were utilised mainly by Active Planners. There were three reasons why the three other groups had little choice over the trial options. First, some of the interviewees had no time to take a trial option. For instance, Shelter Seekers needed a prompt transition as their well-being was threatened in their own home. Shelter Seekers themselves did not see the need to take trial options as it was too obvious to them that there was a need for residential care. A few Conformists moved into a care home following a crisis and had little time to take trial options. Second, some other interviewees were simply not willing to take a trial option. Six Conformists were not interested in exploring care homes themselves and they transferred their right to choose to their surrogates. A few other Conformists and most of the Unsettled did not want to think about the care transition itself (and were not eager to explore possible options). Last, a couple of Unsettled residents were not even made aware

of their permanent move into a care home. One of them thought the move was temporary and the other one was informed of the move at the last minute.

Choice over whether to move in or not was associated with the issue of who initiated the care transition, and thus in most cases applied to Active Planners only. However, Shelter Seekers also exercised an active choice to move into a home, although the move was mostly suggested by social workers. The choice over whether to move in was the most fundamental choice the service users could have, because all of the other types of choice were contingent upon it. This choice was particularly important in the discussion of a traumatic transition, since the lack of choice led to the Unsettled residents' experiences of stressful care transition.

Choice of when to move in could not be made in most of the cases studied, as found in Townsend's (1962) study. It was mainly because the timing of the move depended on a vacancy in a desired care home. Only some Active Planners were able to exercise this choice to some degree, as they started to plan the move early. They listed their names on the waiting list long before their transition, and for that reason, they were able to move around the time they desired.

Choice of alternatives to residential care was hardly 'exercised', and only 'explored' by some Active Planners. Active Planners were aware of the existing alternatives to a care home, such as extra care housing or assisted living. Nonetheless, there was very low awareness of alternative options among the other three groups. Fox (2011) also reported that the supply of accommodation by some small-scale schemes such as Shared Lives, Home Share or other micro enterprises keeps changing and remains unstable. As the interviewees who experienced difficulties in adapting thought the difficulties were related to the nature of communal living,

it seemed that their experiences could have been improved if they had had the chance to consider other care options, including smaller size housing with intensive care provision.

The last type of choice, choice of care arrangements during the care transition, was seldom exercised by any of the interviewees. Older people rarely had a chance to participate in care arrangements during the period of care transition. There was a shortage of bridging care between community care and residential care and it led to older people's experiences of sudden change in the caring environment and their subsequent maladaptation.

There were some other types of choice which were mentioned by a few older people during the interviews, but not included in Figure 5.1 or in the analytical framework. They include the choice of the length of stay in a care home (whether the move was temporary or permanent) and choice of methods of communication (whether older people had the necessary and desired communication about their care transition with people they wanted to share their stories). Regarding the length of stay in a care home, some older people chose to move in permanently themselves and a great majority of older people were at least aware of the fact that they were going to a care home to live there permanently. However, there was a resident who had believed that his move to a care home was temporary and was told so by others at first. Allen *et al* (1992) also found some older people who thought, or hoped, that their move was temporary. The resident who believed that his move was temporary, but had his expectations unrealised, was distressed significantly more than those who knew their move would be permanent.

In terms of who to communicate with to discuss the care transition, most interviewees' range of communication were limited to those with their family members, relatives or friends in

their inner circle. Active Planners were an exception in that they sought help and information extensively, talking to different groups of people (even including former colleagues or clients). An important point here is that, except Active Planners, most of the interviewees did not choose who to communicate with and get information from, but were given information from others regardless of their will. The information given to older people reflected others' preferences and opinion. There was little room for older people to be involved. It seems that information collection that is led by older people is required in order to meet their needs properly.

In the remainder of the chapter, there is an exploration of individual groups' experiences of choice during the care transition.

Active Planners

The most notable difference between Active Planners and other groups lies in the degree of exploration prior to moving into a home and their exercise of choice. Being an Active Planner entailed intensive exploration of choice in long-term care and active participation in decision making.

Active Planners and their exercise of choice

Evidence from the literature suggests that older people living in a residential home hardly ever asked to come into a home themselves (Townsend 1962; Sinclair 1988; Allen *et al* 1992). It was mainly because of the negative images attached to homes and the continuous policy

developments in the last decades against 'institutionalisation'[14] of the elderly. Choice in long-term care was very limited even if the care transition was provoked by older people themselves. So far, the image of older people in residential homes was as passive recipients and even victims of care services.

However, in this study, Active Planners were the most prominent type of service users among the four types, forming the largest group of all. Active Planners initiated the transition themselves according to their care needs and, moreover, they were keen to explore available options. Active Planners' experiences resemble that of self-funders reported in the literature (Netten *et al* 2001; OFT 2005). The options explored by Active Planners even included the ones about receiving more intensive community-based care. As discussed above, it would be important if living in a care home is becoming a choice itself, not to mention having a choice of providers or choice of time, as outlined in Le Grand's (2007) conception of choice in public services. Active Planners' preparation for the move started early and this provided room for their exercise of choice over the timing of the move.

Active Planners' participation in the exploration stage is well illustrated in the verbatim quotation from an interview presented below:

> *Researcher: How did you decide to come to a care home?*
> *Interviewee: It becomes a matter of necessity. Either you have to get somebody to live with you or you go into a home. And, um, I thought about it for a long time. I thought of other homes and have gone in into them in person to look at them and liked this one. And this one was also recommended to me by my vicar, who is the parish vicar here, um, and I never looked back.*
> *Researcher: So it was your decision, not anybody else's?*
> *Interviewee: Oh, no, it was my decision, yes. And my friends helped me to move. (Vivian, 76)*

[14] The term 'institutionalisation' was put into inverted commas as the researcher tried to avoid its usage due to it carrying a negative connotation (see Ungerson 2002).

The active exploration of care options could be partly understood as changes in behavioural consumption patterns arising from modernity. People living in contemporary Britain are used to having diverse options and exercising choice in the consumption of goods and services (Giddens 1994; Greener and Powell 2008). Active Planners frequently made reference to their familiarity with making choices in daily life while they were explaining why they wanted more choice in long-term care and in public services in general. Many said things such as 'everything is about choice' or stressed that they were used to 'make choices everyday'. The fact that 'Active Planners' formed the largest group of all may mean that people are used to the type of living in which consumer choice is emphasised and the autonomy of individuals is valued.

It was also clear that Active Planners not only prepared for the care transition themselves, but also asked for or received help from various groups of people around them. Social networks as a form of social capital are also an important part of contemporary living and the use of personal networks in times of difficulty was part of their life. The number of people who helped them in their care transition varied between groups, with Active Planners receiving help from the largest number of people (around 4 people on average) and Shelter Seekers from the smallest number of people (around 2 people on average, typically including a social worker and the person who reported the Shelter Seekers' problem to the local authority). Their active use of social networks does not necessarily mean, however, having stronger social networks than others. It was the way they used the network to collect information and to exercise choice that differed from the other groups.

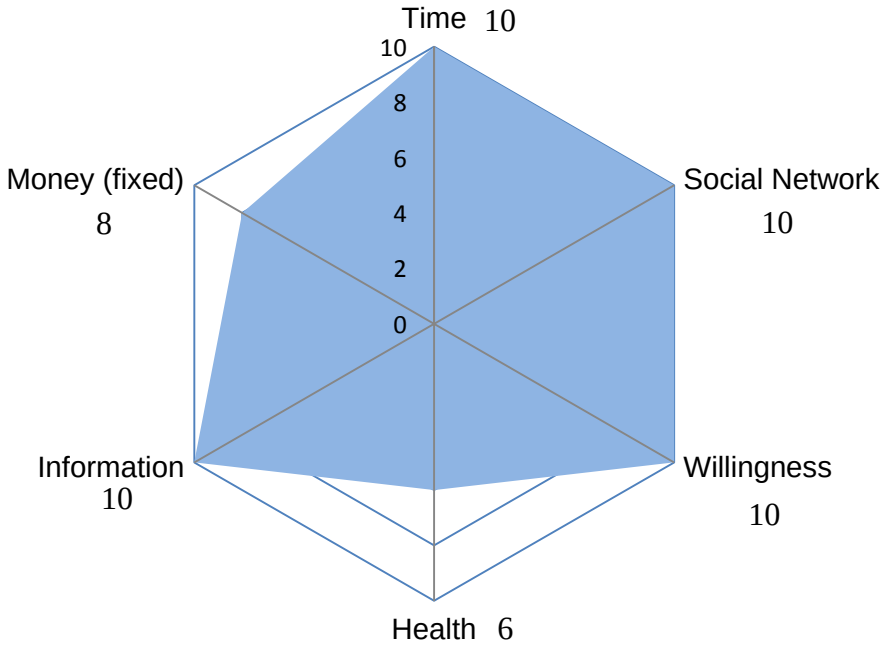
The active use of all available resources, including time, information and social networks, ensured that the choice to move in was made slowly and prudently enough to make them feel

confident in their decision. Figure 5.3 shows the resources Active Planners had for their exercise of choice during the care transition. Six elements were found to be crucial in older people's exercise of choice: time, money, information, mobility, willingness (to participate) and social network. Regarding financial resources, the amount supported for individuals differed between local authorities, but there was a mix of older people from all three local authorities in each of the groups, except the Unsettled (this group only consisted of those from Borough A and C). The value of the financial resources (money) was thus fixed at 8 for all groups except the Unsettled[15], as older people found some care homes not available for consideration due to expensive weekly rates. Although local authorities paid individual care homes weekly charge that was often lower than the rate self-funders paid, financial constraints made it impossible to look for some expensive, but well-managed and popular, care homes. The scores in the figure reflect the level of each resource older people had based on their interview accounts; 2=very low, 4=low, 6=moderate, 8=high, 10=very high.

Active Planners had the highest possible level of resources in terms of time, social network, information and willingness. Active Planners were not particularly in good health, but, on average, they had a slightly higher level of mobility than the other interviewees. Nevertheless, it seemed that the level of mobility cannot be a measure of their ability to exercise of choice as there were some Active Planners who had the level of mobility which was more limited than the rest of the interviewees. There was no buyers' remorse (Schwartz 2004) or any other adverse effects of choice in Active Planners' experiences of transition and they were satisfied with their choice and the fact that they had exercised choice.

[15] For the Unsettled, the value was fixed at 6.

Figure 5.3. Level of resources for exercising choice – Active Planners (averaged)



Source: Author's own illustration

Awareness of other care options such as assisted living and extra care housing was also the highest among Active Planners. It was the result of intensive information-seeking and their genuine interests in finding available care options for them. Active Planners had social needs as well as care needs and this was one of the reasons for their choosing residential care, not its alternatives. The Active Planners' experiences illustrate that there are some older people who were substantially benefitting from positive traits of residential care. Johnson *et al* (2010), OFT (2005) and Victor (2005) also recognised that care homes can play a positive role in meeting the needs of older people. As shown in the verbatim quotation below, some Active Planners preferred residential care to other alternatives because they thought the residential care option would meet their needs better:

> *I suppose I can have more independence there but this suits me. I lived in a nice flat, but I wasn't really sorry to leave it, 'cause I knew I couldn't manage on my own. (I) kept falling down...I didn't want to live alone. I know that there's a lady and two children in my old flat. That's alright. Ha-ha (Sue, 82).*

Some Active Planners visited care homes where their friends or relatives were living and had a chance to look around and listened to stories about the care home life. Short-term temporary stay was the leading path to care home entrance and was regarded particularly useful by Active Planners since it allowed them to experience what it was like to live in a care home prior to the actual move. Having this 'trial period' played an important role in deciding whether to stay at home and receive extra care or moving into a residential care home. How Active Planners experienced the trial options are described well in the following quotations:

> *My daughter was gonna stay (in my flat) and I was going down to the care home. I thought I am going to be tearful and I am coming back. I got really back but I realised it just hadn't bothered me. You know, as I realised, I really came back and to come out of the flat [but], it didn't worry me at all. (Elizabeth, 80)*

> *I came here for a short period and then I got stronger, I was able to look after myself, you know, but I decided to stay here, because it's comfortable and it's very very good to be here...people are very nice. So that's what I did. It's a pleasant place to be. We've got a lot of flowers at the moment 'cause it's my birthday. We're like a family (Rose, 68).*

Some interviewees pointed out that one-off visits and short-term stays are completely different in that 'people living here can see things they can't see when they are just visiting' (Joanna, 87). An insider's view, it is argued, can be very different from that of outsiders. Those who only made visits before the move, however, did not appear to be less satisfied than those who took the temporary stay option.

Active Planners' prioritisation of needs and their adaptation

Active planners had a clear reason for moving into a care home, which made them provoke the transition themselves. They often prioritised their needs and considered the need for more intensive care in a secure environment as a top priority. Being able to justify their care home entrance was an important element for their adaptation. In a similar context, Chenitz (1983)

and Nolan *et al* (1996) also found that the possibility for 'legitimation' was important for older people who were moving into a care home.

The reason for Active Planners' care transition was related to deterioration in physical health, sometimes combined with loneliness or being widowed. One of the interviewees provided a detailed account of how she felt the need of extra care and decided to do something about it. It was also clear from what she said that Active Planners were used to seeking available services to meet their needs and receiving informal help from their personal networks in daily life.

> *R[16]: When did you feel the need to move in?*
> *I: Well, chiefly because I had a number of falls, minor falls, really...but I fell on the street on one occasion, and on another occasion, I had joined, what is it called, BUPA, scheme, you know what I mean, a scheme for elderly people, and um, it's the scheme where you have a thing like this around your neck. And if you fall, you just ring that and some, the people in the help centre get in touch with certain people you've known, and one night, this happened to me, I fell in the bedroom, It was very frustrating, because I was in the bed room just inside the door, and there was the telephone was ringing and it was on the other side of the bed. and I couldn't get myself round the bed to answer it. I was manoeuvring back and forth and couldn't get the-....and it turned out that both people I had named to come and rescue me were out so the rescue people had phoned me directly to say coming. And it wasn't until one of the neighbours got home from wherever she's been and discovered that I was needing help. They got in touch and came and got me and you know, took charge, and she came over as well, but you had to have two neighbours or friends with keys who could get in if necessary. So after that, I felt I really must do something (Mary, 81).*

Their reasons for care transition justified the choice they exercised and made them consider difficulties during the adaptation period as minor problems. Hence, their attitudes towards adaptation were optimistic.

> *I suppose there are the odd little things I'd like different, but you can't have everything (Vivian, 76).*

[16] 'R' denotes the researcher, 'I' denotes interviewee.

Active Planners were able to adapt to the care home environment faster than the three other groups as they knew what to expect while living in a care home. Having the prior knowledge of care home life helped them to adjust and accept the changes quickly.

> *There's nothing I didn't expect. With me, I am perfectly alright. Everything here is alright. So I am very fortunate (Chris, 75).*
>
> *You have to go by certain rules, you know, which is fair enough (Debra, 83).*

Active Planners' shared experiences, namely, their self-initiation of the move, their active exercise of choice and their relatively smooth adaptation is illustrated well in Anne's experience (see Box 5.1).

Box 5.1. The case of Active Planners – Anne's experience

Anne had been suffering from degenerative arthritis for years before moving into a care home. She was living alone and moving up and down the steps was particularly challenging for her. She found it increasingly difficult to walk as the pain became severer. She said that, if it was only the pain, she could have lived alone for at least a few more years.

Anne started to consider the residential care option seriously after she noticed her vision problems, including the fact that her sight was growing dimmer. Anne had lived alone all her life and was used to making decisions on her own. It was important for her to be prepared for any future crisis, as there was no guarantee that friends and relatives would be there to help her if anything happened. She once worked as a nurse and took changes in her health seriously. It seemed evident to her that managing alone would not be a possible option and she requested an assessment from the local authority Social Services. Initially, she was entitled to receive home help service twice a week and received help with some housework and shopping, but she had to ask for extra help from her neighbours and felt lonely and insecure about living alone. She also experienced changes of her carer several times in a few months and she got tired of explaining her needs to them. She thought she would need continuous care in the secure and protected environments of care homes. She consulted about the residential care option and was assessed again for the move into a home. She said she knew someone living in sheltered housing, but did not think the option was appropriate for herself as she wanted to have carers around all the time and did not want to live alone.

She was informed by the social worker that she would be able to move into a care home inside the borough she was living in, or, if she wanted, into a care home in some other parts of the UK. She preferred a small care home located in her local area and the Social Services provided her with the names of the homes in the locality. Anne let those in her personal network know that she was moving into a care home and asked for their advice and help in exploring individual homes. Her

relatives did not live close to her, so she relied mostly on her neighbours and church friends. She visited three care homes with her friends and spent some time talking to the residents and looking around the facilities and the room that she might be moving into. She also asked about additional services provided in the care home and the rules of the home. There were no specific booklets or reports that helped her in making the choices, though.

Anne chose a home which was clean and which did not require substantial change in her pattern of living - there was a small kitchen for residents to make simple food or tea and less strict rules on sleeping times. Anne said that she was very satisfied with her choice. She also found it a bit difficult to part with some of her belongings, but she did not experience any problems except for that. In the home, she felt secure and properly cared for. The only drawback that she found was relating to her social activities - she could not invite friends and neighbours to her place anymore and she was not seeing her friends that often after the move. However, she accepted this as a trade-off. Anne stressed that there were no regrets as the decision to move in was made entirely by herself based on what she felt she needed.

Care transition and side effects

Self-reported occasional depression or health deterioration was common across the four groups. However, what made Active Planners different from the rest was the way they perceived their health conditions. They were trying to see their conditions and emotional changes as objectively as possible and they were able to tell whether the problems they had were caused by the care transition or by factors rather irrelevant to being in a care home. For instance, as illustrated in the quotation below, those who had been suffering from chronic illness said that worsening of symptoms and their psychological consequences had nothing to do with their care transition:

> *I don't think coming here has done that. I think it's the fact that I had to put up with what I had wrong with me. I think it's [the] effect of that (Elizabeth, 80).*

A few Active Planners also said that feelings of depression were something that had existed all their life and something which were already familiar to them:

I suppose I had the odd patch where I felt very down...but I think that's just something that comes on you sometimes, you know, and I very rarely feel like that. I try not to anyway (Amy, 96).

Some Active Planners experienced feelings of exhaustion or powerlessness in their body just after the move. Almost all Active Planners were those who used to manage on their own independently and some of them recalled that it was when they realised that most of the ordinary household tasks that they were used to carrying out had been transferred to care home staff and that they did not have to be anxious about making mistakes in everyday life.

Active Planners and a positive transition

One may think that Active Planners were those who had fewer prejudices against a care home or who had preferences towards residential care over other care options. Yet some Active Planners wanted to live in their home as long as possible, if they were able to do so. They were not proponents of residential care. Rather, most Active Planners were great proponents of choice. They constantly emphasised why choice was important in this highly individualised ('free' and 'individualistic', in their terms) society. The essence of the argument was that individuals have different thoughts and needs, and should be allowed to choose different options accordingly.

Having more choice is good.
You should have choice in everything, really (Brian, 71).

R: Do you think it is good to have choice in public services?
I: Yes. In everything, yes. Because you are an individual and you got your own souls and ways of thinking, ways of doing things...you don't need to be told by someone else (Debra, 83).

Active Planners had a sound understanding of the choice mechanism, including what was important and needed for their exercise of choice and what kind of formal and informal help was available or unavailable to ordinary older people. While telling their stories to the researcher, they even used other choices in public services as examples, such as school choice or patient choice. Those who had grandchildren knew better about school choice and explained about the experiences of their sons and daughters. Some expressed a concern about inadequate information provided to service users and emphasised the importance of users' access to sufficient information:

> *There's plenty of choice there, but people don't always know about it because they don't look into it. I think they should have choice but I don't know how, when people apply for this sort of institutions, whether they give them guidance, you know, enough guidance, whatever. I think they should have choice, though (Sue, 82).*

It has been argued that choice has the power to make people content with their decision simply by exercising it (see Schwartz 2004; Le Grand 2007; Lent and Arend 2004) and it seems to be true when reflecting on Active Planners' accounts. However, it does not mean that the exercise of choice is the single most important thing in the care transition. Having analysed the interview data, it seems that there is a limit in the degree of satisfaction that purely comes from the exercise of choice itself. Active Planners often used both their exercise of choice and the quality of the service they received to judge their satisfaction with their care home life. Quality of care and services, care home facilities and physical environment, peer support and informal support from families, relatives and friends were all important elements that contributed to positive experiences of the care transition. Visits from families, relatives and friends were highly valued, as found in the literature (Cooney *et al* 2009; Dellesega and Nolan 1997).

> *I love visitors, and somebody is always coming in to see me. Sometimes they*

come when they are not welcome, but it works out very well, really. The system is pretty good here (Rebecca, 94).

Active Planners' use of residential care can be described as what Wagner Report (HMSO 1988*a*) termed 'a positive choice'. During the period of care transition, Active Planners reached the point where they could consider the care home they belonged to as their new home. It means that every part of the care home, including the people around them, the services they were using and the environment they were living in, had been accepted and became a part of their life.

As far as I am concerned, this is home now, to me, and my friends are welcome here, and I think so...I don't envy, or I dont' want to move any way. (Jennifer, 88)

Why were there no Unsettled Active Planners?

As this research does not involve a uniform sample of residents, those who took part in the interview were from different social and educational backgrounds and had different personalities. One may well expect variations in care transition experiences of individuals, ranging from negative to positive experiences. Moreover, as well as some arguments for choice made by the proponents of user choice, there are numerous claims made against extending user choice, exemplifying the adverse effects of choice (Schwartz 2004, Iyengar 2010, Salecl 2010). Indeed, there were certain minor variations even between Active Planners in their experiences of care transition. However, interestingly, there were no unsettled Active Planners among the residents interviewed. It would be difficult to generalise their experience of a positive transition to the wider population, but it is possible to find plausible explanations for the absence of unsettled Active Planners. Six possible explanations are examined below in detail.

First, Active Planners' thorough exploration prior to the move helped them considerably in adapting to the new environment and hence there would not have been a room for maladaptation. A majority of Active Planners experienced what it is like to live in a particular care home, through short-term trial stays, one day visits or respite care. They also actively participated in collecting information on care home environment. They knew what to expect and, therefore, living in the new care environment would have hardly come as a shock to them.

Second, there could be some selection effects and the Unsettled Active Planners could have not been detected. All the interviews were carried out with those who spent at least six months in a care home – those who 'survived' after the transition. Conducting of retrospective interviews was inevitable as interviewing those who are just starting to experience the care transition or those in the process of the transition would have been risky and unethical, as discussed in Chapter 3. Tobin (1989) found that those who moved in voluntarily and perceived the new care environment as ideal were most likely to survive intact through one year. To some degree, this research could be seen to explore cases of moderate/successful transition, as those who were distressed the most (across all the conceptual groups) may have died already.

However, responses to enquiries made to individual homes and social workers confirmed that there were few cases of deaths of new residents. Most people who died in the participating care homes were those who spent a considerable amount of time (at least over 1-2 years in most cases). Some social workers who participated in this research also said that unexpected deaths were not uncommon amongst those suffering from certain chronic diseases (e.g. Motor Neurone Disease). A care home manager also remembered a death of a resident soon after the

move, but it was associated with an undesired move into a care home and the resident's experiences seemed to resemble that of the Unsettled.

Third, there could be a possibility that some Active Planners have moved to another home. Considering that Active Planners were those who were most autonomous and most prone to exercise choice, it is likely that they moved to another care home if they were not satisfied with their initial choice. However, this does not lead to a conclusion that residents in other groups would have given up completely their right to request relocation to another home. The existence of the Unsettled movers calls into question whether they were just being passive in moving into another home and decided to endure all the stressful living conditions. It was found in the interviews that even those who were least able to exercise choice before the transition (mainly the Unsettled and Conformists) recognised the importance of choice after the initial move. It was evident from the interviews that none of them have ever thought of moving again to another home. Why did not the older people even question the possibility of moving to another home?

To explore cases of residents' relocation to a second home, additional enquiries were made to care home and social workers. Nevertheless, as discussed in the first section, the number of cases was very small (less than ten) in most boroughs in a year. The literature (NAO 2013) also suggests very low switching rates (choosing to switch home). The power to switch the provider, the so-called 'exit' (Hirschman 1970) option, seemed not to be a possible option for the older people interviewed (The coping mechanism of the interviewees in the absence of 'exit' is explored in Chapter 7).

Fourth, Active Planners' not being distressed about the move could be explained by their satisfaction with their choice, which could have been 'created' through psychological processes such as cognitive dissonance or adaptive expectations. Cognitive dissonance and adaptive expectations are self-justifications of past decisions (Epstein and Kopylov 2005). When one's experience of certain things does not meet one's expectations, someone tries to reduce the dissonance between the reality and expectations by changing their attitudes and behaviour, as illustrated in Festinger's (1957) accounts of a group of people who believed in eschatology (a pseudo-religion). It is possible to assume that Active Planners could have found it easier to change their perceptions (attitude) than to complain and move into another home or go back to the community. Yet, it would be unlikely that their satisfaction was a pure creation because they were able to say clearly 'why' they were satisfied with the care they were receiving in the care home they were living in at the time of the interview.

Next, older people could have been satisfied with the fact that they made the choice themselves. Satisfaction from their exercising of choice could be greater than some features of care home life to which they found difficult to adjust. It is widely argued in the literature that choice exercising itself is a way of expressing self, is meaningful on its own, and gives satisfaction to those who exercised it (see Iyengar 2010 and Schwartz 2004). Indeed, Active Planners were content with the fact that it was their choice to move into a care home. However, at the same time, they were also satisfied with the services they were receiving in the care homes they were living in. It was difficult to see from the interview accounts that the advantage of exercising choice offset any dissatisfying features of the care homes studied.

The last possible explanation contradicts to the fifth explanation and is related to the adverse effects of having too much choice. Here, 'too much choice' means too many options, not too

much right to choose, in order to describe well the arguments in the original references. Schwartz (2004) discusses the adverse effects most comprehensively, and he linked them with the feelings of regret (buyer's remorse), opportunity cost (or trade-off), and missed opportunities. Iyengar (2010)'s famous 'jam experiment' also found that people were more likely to make a choice when they were given a reasonable number of options than many options. Salecl (2010) also discusses the concept of choice in relation to post-decision regret and disappointment. Yet, the experiences of older people were different from what is often referred to as having 'too much choice' (too many options). It was found that the number of options being offered to most interviewees was limited and therefore there was little room for the adverse effects – which could be a reason why Active Planners were able to be satisfied with their choice. Purely talking about the number of options, many interviewees encountered two to three options in most criteria of care transition, especially to do with the types of care they would like to receive and the number of care homes they could choose from. The lack of options was the result of care home seeking in the local authority area with limited funding. All interviewees from Boroughs A and C made a choice between two to three homes, if there was any choice given to them. Even some Active Planners explored a maximum of a handful of options. In this situation, it is difficult to say that people were paralysed by having too many options and found it too stressful to make a choice.

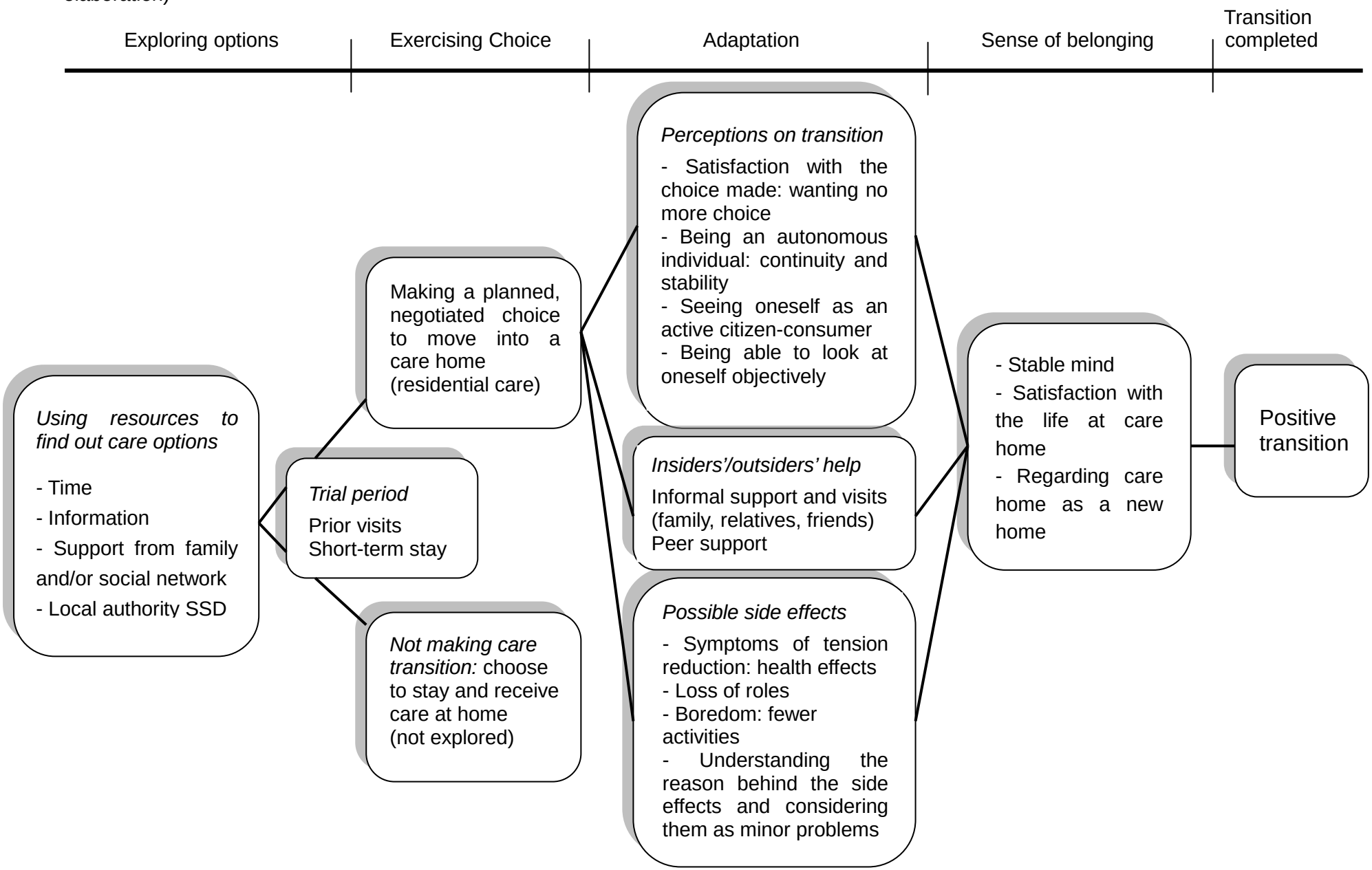
However, this explains little some other Active Planners' experiences. There were six Active Planners (who were living in Borough B) who had a considerably larger number of options than the rest. These Active Planners were allowed to move outside their borough and the amount of funding they received from their local authority was greater than other residents. In their experiences, it was difficult to find a sign that they were distressed about having too many options or regretting their choice after the move. When being asked about the possible

experience of adverse effects of having too many options, they strongly rejected the possibility and stressed that they never wished that they had been given less options. The reasoning behind Schwartz' (2004) arguments was based on three unfortunate effects that having many options can entail: more efforts to make decisions, more chance of making mistakes, and more severe psychological consequences for the mistakes. Other arguments against choice (Iyengar 2010; Salecl 2010) were presented in the same vein. However, for the six Active Planners, the move into a care home was such an important decision in their life and that they never regretted exploring a number of care homes in different areas. They thought that it was worth spending their time and energy on exploring different care options and care homes and believed that their through exploration helped them feel confident about their choice.

There was another reason for the lack of negative experiences of choice or adaptive expectations, which was related to practical benefits of choice older people gained. It is dealt with in detail in the next chapter.

The dynamics behind Active Planners' care transition and their exercise of choice in long-term care are summarised in the diagram below (see Figure 5.4).

Figure 5.4. **The process of care transition and choice making in residential long-term care - Active Planners** (author's own elaboration)



Conformists

As the term ‘conformist’ symbolises, the second group of interviewees demonstrated the cases in which older people had not exercised much choice, but were adapting to care home life well.

Conformists’ exercise of choice and their adaptation

Conformists had a considerably shorter period of exploration before moving into their care home than Active Planners, with less chance of exploring options themselves (see Figure 5.5). Care transition was often provoked by others around them and information on available care options was also collected by others on their behalf. Their reliance on family members, friends and relatives could be intentional (trusted others and let them do the exploration), unintentional (simply not motivated to seek information as the care transition itself was a reluctant option) or inevitable (if the transition was provoked by a sudden fall or if they had limited time to explore due to any other ‘crisis’). In most cases, Conformists did not have much information on the care home they were moving into, or knowledge of care home life, during the period of exploration, as shown in Josephine’s accounts below.

> *I: This is the first care. She [Josephine’s daughter] used to come every day, that was when I first did a hip. Then I did it a second time and of course it made it a bit worse. She couldn't be...she was with me but there was not much she could do. So she sorted out for me. me family. me grandson.*
> *R: So, you didn’t know about this care home until you moved in?*
> *I: There was a mention of it. My daughter and grandson, they found out about it to see what was here and how far... (Josephine, 91).*

Another interviewee also had little idea about the care home and the care she was about to

receive at the time of the move.

> *I was going to be walking less and less. I was living on my own....I received the disability living allowance and an alarm bell from the Social Services. I didn't have any other help, until one day I just couldn't take step and someone came to stay the night and I came here the next day (Helen, 86).*

Some Conformists were not particularly willing to participate in at the time of transition and let others do the exploration for them. Those Conformists who transferred their right to choose to trusted others firmly believed that their surrogates would make the best choice possible for them. This finding conforms to the literature that recognises the possibility that users are not necessarily valuing choice (Dowding 1992; Baldock and Ungerson 1994; Barnes and Prior 1995). The existence of Conformists shows us that active exercise of choice was not an option for some older people and it makes us question whether older people are fully prepared for changing their expectations and adapting to choice mechanisms, as Baldock (1997) argues. It also hints that the delivery of personalised care will only be possible by getting away from putting pressures on people to make choices, another inflexible one-size-fits-all approach to service provision. Box 5.2 presents the experience of a Conformist who preferred not to exercise choice during her care transition.

Box 5.2. The case of Conformists – Victoria's experience

Victoria never imagined herself being in a care home in her life. However, after she had a hip fracture on her way out of the bathroom, she started to need assistance in carrying out some activities in her daily life. Her legs had become weaker and she ended up needing fairly intensive care. She was living with her husband, but her husband was not in good health, either, so it was not possible for him to provide care for her. Some friends from her church used to come and help her with doing shopping and housework. It was her daughter who suggested the move into a care home. Her daughter lived in Chichester, so she was not able to come to see Victoria very often and she was worried about her. The residential care option was something that Victoria had never thought of, but she agreed to contact the local social services. During the period of assessment and consultation, she realised that the level of care she need was high, something that would be equivalent to

residential care.

A few weeks after the assessment, another social worker came and told her that she could provide her with the information on local-authority funded residential care, but she asked the social worker to consult about everything with her daughter and that she would be happy to accept any decision that was made by her. Victoria herself did not even attempt to read everything in the small booklet that she was given from the social services. It was because of her belief that her daughter would know her preferences and make the best choice for her. She recalled that the most difficult thing about the transition was to accept the need for residential care, not making up her mind about transferring her right to choose to her daughter. She said that she did not have much fear about the care home life (partly due to her belief in the choice made), although she felt a bit nervous about the move itself. All the conversations about the care transition took place between her daughter and the second social worker (who was in charge of the arranging of the residential care) and she herself was informed about this briefly from time to time. She did not think that her involvement would have resulted in the making of better choices and she even felt relieved that someone who is credible, her daughter, could help with all the complex and difficult decisions and processes. She also needed time to choose personal belongings to bring with her, to talk about the transition and the life after transition with her husband and to think about things to sort out before the move. She thought, however, that some more information on the home that she was moving into (e.g. care home rules and facilities) could have been useful.

Victoria was satisfied with the level of care and protection provided in the home, as she felt the need for intensive care before she moved in. She also found it convenient that she did not have to worry about the household chores/tasks, which had become difficult for her to cope with. She found activities sessions in the care home helpful and often had conversations with other residents in the home. She thought she had adapted to care home life without many problems. Her daughter fetched her anything she needed from home or anything she wanted from a shop. Sometimes her daughter came with her (Victoria's) husband and the three of them spent some time together. She was content with her life at the time of the interview, for she believed that she was receiving the care she needed and that the move into the home had improved the life of everyone involved. There were some inconveniences relating to living in a big house (and losing privacy), sharing facilities and keeping the meal and sleeping times. However, she thought that the care home life was beneficial for her in many ways.

As illustrated in Figure 5.5, the level of mobility Conformists had at the time of the move was lower than that of Active Planners. In some cases, their low level of mobility affected their exercise of choice (e.g. in the case of a sudden fall or any other sudden health conditions that triggered the move). However, in most cases, having a level of mobility that was lower than Active Planners and deteriorating health conditions did not necessarily mean that the

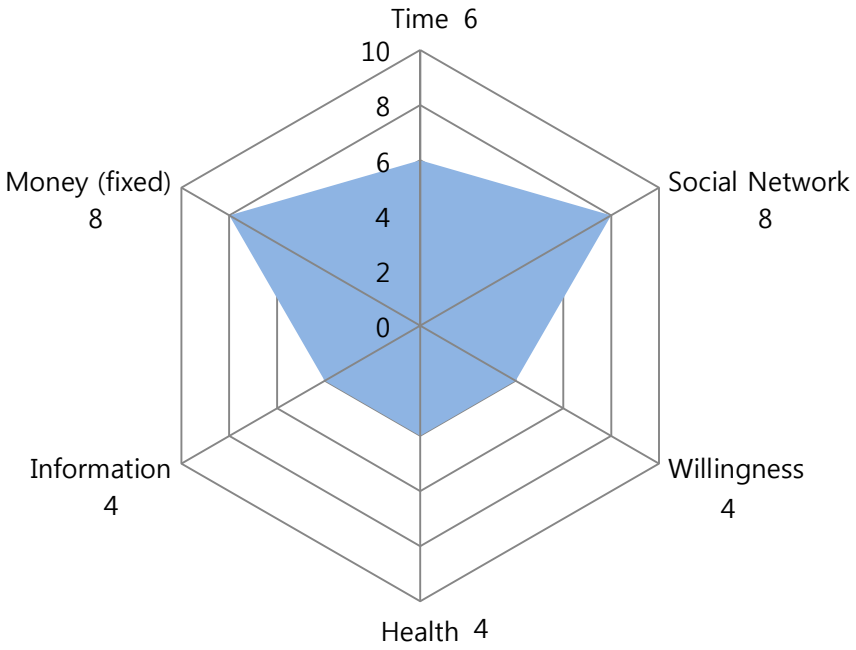
interviewees did not have the ability to participate in decision making. It was confirmed by the care home managers and staff that all Conformists, at the times of the move and of the interview, had the cognitive ability to communicate, read and listen, understand and think through the possible options, and those who did not undergo crisis were also able to move about themselves. This means that the Conformists' lack of participation in choice making took place on a rather voluntary basis and this contrasted with the experiences of the Unsettled, who longed to have their say but had their choice neglected or rejected.

The choice exercised by Conformists during the care transition would be best described as a partially negotiated choice. In this way, slightly less than half of the Conformists were able to have the chance to express their thoughts from the middle of the exploration stage, after they recognised and accepted the need for residential care. Although limited choice was exercised, involvement in the decision making made them feel that it was partly their choice to move in.

> *I didn't feel any pressure to come. My daughter, she thought I needed some extra care. She found some care homes in this area and it was my own decision from then (Emily, 82).*

There was no chance for Conformists to explore any alternatives to residential care, unlike Active Planners, mainly due to their lack of awareness of such options and limited participation in choice making. At best, they were able to express their views about the options (care homes) that were already filtered by others who suggested and helped their transition.

Figure 5.5. Level of resources for exercising choice – Conformists (averaged)



Source: Author's own illustration based on research findings

Prior knowledge of a care home was important for adapting to the unfamiliar environment and there were a few cases, although not many, who had care home life explained to them by care home staff, community nurses or social workers.

> *Care home staff came to home and explained what it's like and gave me some time to think about moving in. It was up to me (Mark, 88).*

Nonetheless, most Conformists did not have enough knowledge of what it is like to live in a care home and some Conformists said that some of the services provided in the home were something they had not thought of. Being washed by others or sharing facilities with others (e.g. queuing to go to the toilet) was a strange experience to them, at first. However, they were able to accept the circumstances they were in and tried to adapt and think positively. Most Conformists said they had felt worried or anxious about the new life in a care home

before the move, but also professed themselves largely contented with the services and the new living environments and said that they became more confident as the days went by.

> *I suppose I was. I was anxious because it is a different way of living, really, isn't it? Being looked after all the time. But they do everything, really, for me here (Matthew, 86).*

> *What can I say...How can I explain? Will it be alright, and will I be alright? And...when I came, as each day goes, you feel more confident, shall I say? And you get to know the staff and (pointing to a portable alarm bell on her neck) I've always got this. If you want anything... I've been learning to go a bit better. Not a lot, you know, but I've got my frame. That helps (Victoria, 87).*

Conformists tended to consider problems that arose during the transition period as normal, natural ones that could happen in any new living environment. They were making efforts to accept the problems as part of the adaptation process and were not trying to avoid the problems they faced. It took considerable time (several months) to adapt, but they tried to familiarise themselves with the new environment each day.

> *My brother went round for me to look at other places, and I trusted him to get somewhere where I would be ok. And I get on alright. I suppose, it took quite a few months, you know, to get used to being in here. But it's like anywhere, you have to get used to things. I am quite happy here. I know that some people, when they come here, they hate here. I didn't feel like that (Emma, 77).*

The main difficulties that Conformists had were mostly related to health problems, including going blind and not being able to read, and not being able to move and walk properly, rather than other chronic conditions they had. Conformists, like Active Planners, were able to distinguish transition effects from the worsening of their health conditions, which would have occurred anyway regardless of the transition experience.

> *Now I can't read...I used to love reading and reading newspapers and everything. But I can't do it now 'cause I can't see the prints. I can see the headlines, but I can't read the stories under it. Oh, it's horrible… macular degeneration. The*

> *doctor said you won't go blind, but you will never read again. I felt like she'd hit me over the head. It's awful to be told that, that you will never read again. I've read since I was a little girl. All my life I've read books, I love reading and I can't do it now. That's what hurts me the most. It's got nothing to do with being in here. It would have happened to me anyway, wherever I was. That's what makes me [feel] I am happy (Emma, 77).*

Another problem that Conformists encountered was boredom. Boredom was the problem that came up consistently during the interviews with all four groups. Conformists, like Active Planners, were keen to take part in activities organised by care homes, including exercise sessions, arts and crafts sessions, quizzes, concerts and outings, but spent most of the day without doing anything except watching a television. It was partly due to the lack of activity sessions and partly due to the concentration of the sessions in the mornings.

> *They have activities...we have an activities lady, Kelly. She's very nice. She likes us to go- we have to move down round the corner into a room to do what she calls activities - we just sit in a circle and we do sort of arm exercises and leg exercises you know things like that. She's good you know, keeps you and do quizzes and things like that. I like quizzes. Well then we come back and have our lunch, then, nothing else to do. And that's why, some of them, what they do, we go down into the lounge and sit and most of them nod off to sleep. Oh, I can do that easily. Nod off, going to sleep. Too easy, yeah (Margaret, 87)*

It seemed that whether one becomes a Conformist or becomes an Unsettled newcomer mainly depended on one's attitude towards, and perception of, the care transition experience. However, Conformists and the Unsettled showed important differences in two more dimensions. First, there was a difference in the degree of peer support they received. Conformists actively engaged with other residents who had lived in the care home longer than they had. Peers were able to tell vivid stories about living in a care home and give practical tips to the newcomers from the resident's perspective. Peer support was important, also because residents were often left by themselves in the lounge due to the lack of staff.

> *Jenny upstairs, she's a hundred. She's marvellous, marvellous. She helped me a lot (Emily, 82).*

Second, there was a difference in personal characteristics (whether one is introvert or extrovert, or, whether one likes to befriend with others or not). The difference in personality has been constantly referred to in the literature as a major cause for people having different transition experiences (see Tobin and Lieberman 1976; Mills 2010). The findings of this study suggest that there is a possibility that personal characteristics can affect the adaptation experience, although the link was rather weak and was only found between the Conformists and the Unsettled. The older people's personality partly affected their acceptance of their own needs and circumstances, their participation in activities sessions and their interaction with other residents. There were several Conformists who hinted that they were the type of people who tended to accept new changes relatively easily.

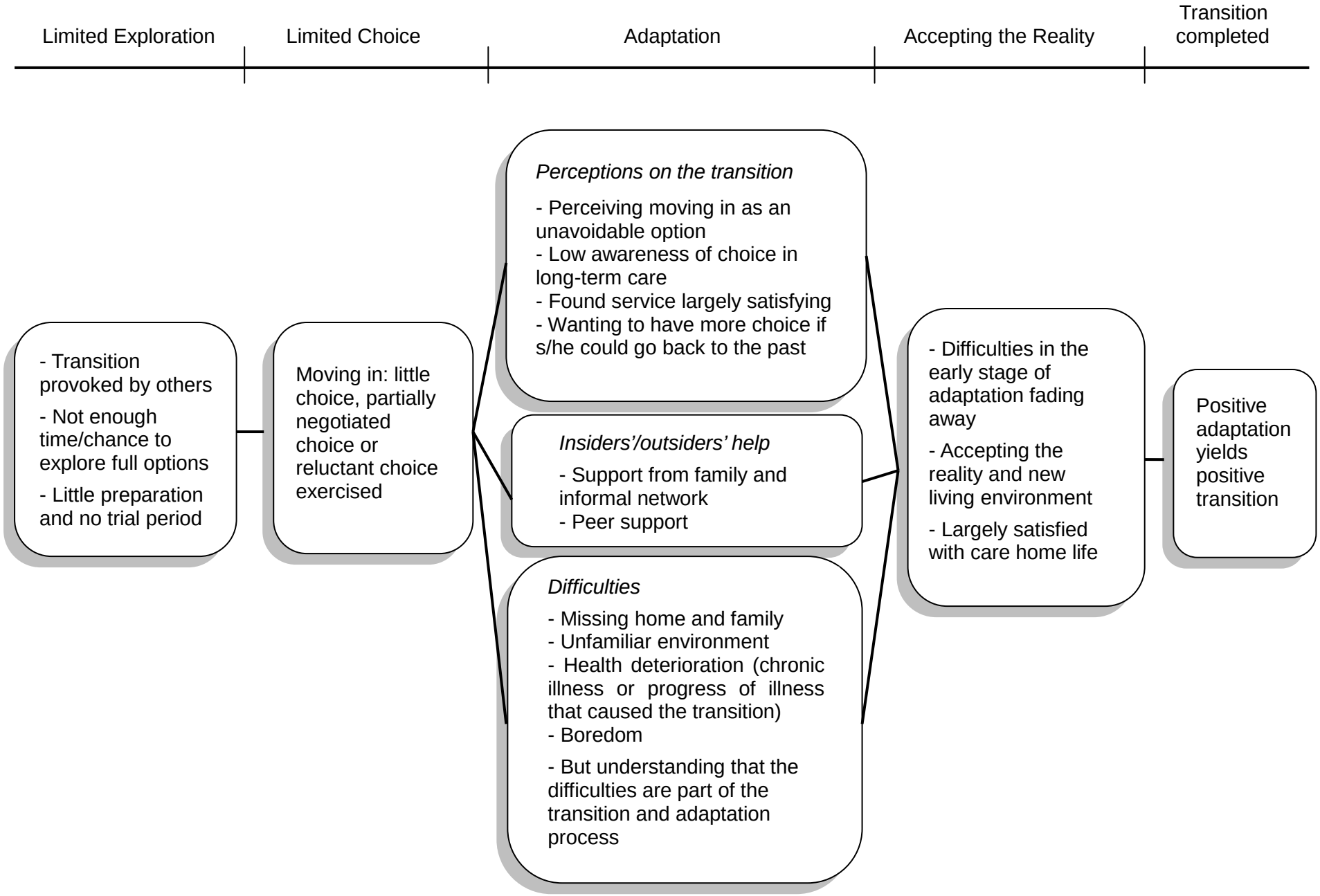
> *I think I was sort of a person who can accept the circumstances that I am in. You know...a person who doesn't really likes change very much, but when it's necessary, yes, I can accept it and try to adjust (Helen, 86).*

At least, all the Conformists interviewed were able to accept their care needs and perceived that the move into the care home was an inevitable, but the right thing to do. However, although Conformists were satisfied with their life and the services provided in care homes, they could not reach the stage where they could find the image of home in the care homes. It was the major difference from Active Planners. Their perception of care transition was positive, but they missed the life they had before.

> *Oh, no, (coming to a care home was the) last thing I was gonna do. Now I thought I couldn't manage. Now I look back, and how did you manage? We don't know. I mean, I used to have lots of visitors who used to come especially from my church used to come and help me do things for me, you know, do a bit of shopping or come do a bit of housework, things like that, you know (Victoria, 87).*

Conformists were able to make a positive transition, although their participation in the decision making process was limited. Their active adaptation enabled Conformists to have a positive transition experience (see Figure 5.6 for the summary of Conformists' experiences).

Figure 5.6. **The process of care transition and choice making in residential long-term care – Conformists** (author's own illustration)



The Unsettled

'The Unsettled' denotes those who had not had much choice in their care transition and had considerable difficulties in adapting to care home life. What is called 'the relocation trauma' was experienced by most of the Unsettled newcomers. As found by Reed *et al* (2004), their transition experiences did not involve their participation. The Unsettled residents' experiences conform to the findings from other studies, which often emphasise older people's feelings of loss and suffering (Nay 1995; Lee *et al* 2002; Chenitz 1983; Tobin 1989; Biedenharn and Normoyle 1991; Victor 1992). Their stressful experiences resembled the ones described by Townsend (1962), and for them, residential care was the 'last refuge' (Townsend 1962, 1981).

The Unsettled and their exercise of choice

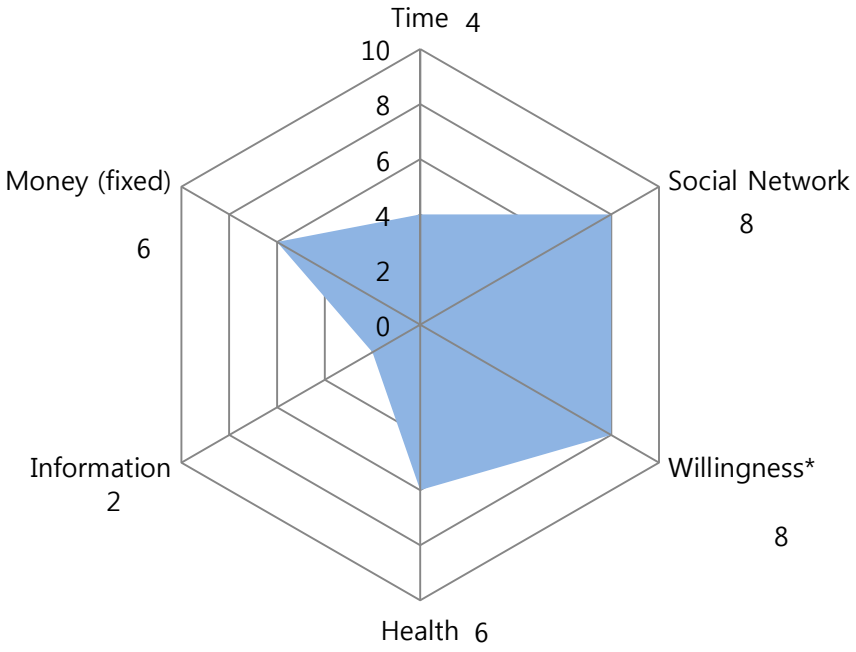
The Unsettled residents' move was initiated and arranged by their family, relatives and social workers, confirming the findings from other studies (Davies and Nolan 2003; Lee *et al* 2002). There was little room for them to involve from the early stage of the transition. Figure 5.7 shows the level of resources the Unsettled had at the time of the move. The Unsettled had transition experiences that looked similar to Conformists' experiences, since their move was also initiated by others and there was not much time for them to prepare for the care transition. They had a similar health status and a similar number of people who helped them in the transition when compared to Conformists. However, the degree of choice they exercised was lower than Conformists, mainly because the exploration of the home and available options was often entirely carried out by their family and relatives. Conversation about the move was exchanged between the main informal carer (or family members) and the

Social Services Departments, not between older people and the Social Services. The information obtained by the family and relatives was not properly passed on to older people. From the perspective of the Unsettled, the 'help' from the family and relatives was something they did not desire. Also, the average amount of financial resources that was available to the Unsettled was lower than the three other groups. There was no one in the group of Unsettled who was supported by the local authority that provided the highest level of funding (among the three local authorities studied).

The Unsettled residents' lack of choice, however, was not the result of their unwillingness to participate in the transition process. Rather, it was related to having their choice denied or neglected and this experience made them severely distressed even after the move. Their experiences resembled what Nolan *et al* (1996) described as a 'fait accompli' type of move. This contrasts sharply with the experiences of Conformists, who preferred not to exercise choice or who accepted choices made by others. The majority of the Unsettled were willing to, or even eager to, exercise choice, although many of them did not know how to exercise choice before they moved in. This was reflected in the degree of willingness (to exercise choice) older people expressed at the time of the interview (see Figure 5.7)[17]. Also, the amount of time they had before the move was the time that was needed for administrative reasons. When compared with other groups' experiences, the level of resources the Unsettled had was visibly low on all aspects, except their willingness to exercise choice and the (unwanted) help from social network.

[17] The degree of willingness here reflects an approximation of their willingness, based on their thoughts and their experiences of attempting to exercise of choice at the time of the interview.

Figure 5.7. Level of resources for exercising choice – the Unsettled (averaged)



Source: Author's own illustration based on research findings

At the time of the interview, they were aware that they could have exercised choice by listening to stories from some other residents who participated in decision making. Most of them were aware of the importance of choice and said they would have exercised choice 'properly', if they had known how to do it. The mentioning of exercising choice 'properly' was due to the two most common experiences of the Unsettled – having their choice of home denied and having their choice to remain in the community (the choice of whether to use residential care) neglected. 6 of the 11 Unsettled residents were only interested in the highest level of choice, which was choice of whether to use residential care or not. It was because many of the Unsettled were those who did not wish to come into a care home. As far as they could remember, alternative care options (housing with care) were not even discussed during their care transition, although they could have been more appropriate options for them. The Choice Review Survey 2012 (Boyle 2013) also found that not having any real alternatives as

one of the biggest barriers to choice for users in social care. Seeing the experiences of the Unsettled in the context of the layers of choice, it was clear that the only choices available to the Unsettled were the ones at low level.

Table 5.1 summarises the incidences that triggered traumatic experiences of the Unsettled. Six of the Unsettled experienced undesired move into a care home, despite their resistance to the idea of residential care. Their experiences suggests that the principle of the Wagner Report (HMSO 1988*a*), that no one should be required to change their accommodation in order to receive services which could be provided in their own homes, was being ignored in practice. Additional three Unsettled residents had their choice of provider disapproved by their local authority. One other resident initially believed that he was staying a care home temporarily, but later realised that the move was permanent, as was the case found by Allen *et al* (1992). The other one resident was almost excluded from the decision making process from the early stage of the care transition and was nearly 'informed' of the decisions made near the time of the move. The next section deals with major barriers to choice which were closely related to the experiences of the Unsettled – in particular, the nine residents who experienced either an undesired move or limited choice of provider.

Table 5.1. Experiences of the Unsettled that triggered a traumatic care transition

The incidence that triggered a traumatic transition	**Number of residents experienced**
A forced entry into a care home (denied of a choice of whether to use residential care/the right to stay in the community)	6
Not being allowed to move into a care home that is near to their relatives and close friends (choice of a home rejected)	3
Being told that the move would be temporary, but had to stay permanently (initially hesitant to move into a care home)	1
Lack of consultation on all types of relevant choices; the decision to move in was made by others and later informed to the resident	1

Source: Author's own elaboration.

Barriers to choice

As is presented in Table 5.1, the Unsettled experienced a traumatic transition due to the lack of choice in their care transition, particularly the limited choice of a home and choice over the use of residential care itself. The researcher identified three major barriers to choice, which contributed substantially to their stressful experiences; their lack of information, local authority differences and the tightening of eligibility criteria (see *Appendix A* for the details of administrative procedures involved in the care transition). These barriers affected the Unsettled the most, but also influenced other groups' experiences of choice making to some degree. In order to explore the nature of the undesired move and the lack of care home choice in more detail, additional enquiries were made to social workers who were interviewed by phone or email[18] and this helped the researcher to investigate the last two barriers in more detail, local authority differences and changing eligibility criteria.

The experiences of the Unsettled showed how the lack of information and of awareness of the long-term care system could affect negatively the whole process of the care transition. The Unsettled thought that they were not told enough about their right as a service user and about available options both in residential care and in long-term care in general. As discussed in Chapter 5, this is related to the fact that relevant information was not provided in a user friendly format, but also linked to the lack of help and advice that were available to them during the transition and the practice that did not encourage their involvement. Considering that even Active Planners had to rely almost solely on those in their personal networks for data collection, it would not be too much to say that a great majority of users of residential

[18] Older people's cases were anonymised and personal details were omitted. Cases of undesired moves were shared with social workers in a way that made the story tellers unidentifiable.

care would have been affected by the lack of information that is officially and openly available.

A more practical reason for older people's having lack of choice was related to administrative and systematic factors. Local authority differences in the delivery of residential care formed a barrier that contributed to the traumatic experiences the most. The three local authorities which participated in the research showed considerable differences in their policies and practices relating to the provision of residential care.

The most visible differences between local authorities lied in their level of funding and their application of eligibility criteria. Although older people who participated in this research could not recall or did not know the amount they were entitled to at the time of the interview, it appeared that the low level of funding significantly limited the scope of choice for the Unsettled. The differences in the level of funding were rooted in a more fundamental problem in the delivery of social care - the long-standing problem with the resource base of social care (see Wanless 2006; Lymbery 2010; Humphries 2013; Lewis and West 2014). Regarding the former, there was a considerable differences in the maximum amount of funding available to individual users – in other words, the amount of 'voucher' granted to individuals. Interviews with social workers working in the three boroughs revealed that the amount of funding allowed for a single user can differ up to about £170 a week. Borough B was paying up to £620 for a single user per week, but Borough A was only paying up to £450. The difference was large, even considering the local differences in the care home fees, the cost of land and running a care home. The level of funding was mostly influenced by the financial circumstances of each local authority. The logic of the voucher system lies in securing equity by issuing vouchers of the same amount to meet the same needs. The difference in the value

of the voucher thus directly affected the degree of user choice. In this study, the number of options available to older people was affected by the level of funding. Despite the fact that the number of care homes in Borough A were about five times the number of homes in Borough B, those in Borough A explored a smaller number of homes than those in Borough B.

There was an importance difference between the local authorities' application of eligibility criteria. Despite the attempts to promote consistent eligibility criteria (e.g. the Fair Access to Care Services Guidelines), the interpretation and the application of the eligibility criteria largely relied on individual local authorities, as Baldwin (2008) found. As Clarke *et al* (2007) points, there was an uncomfortable relationship between user needs and the choice agenda. The difference in eligibility criteria had been exacerbated by financial difficulties the local authorities were facing (see Humphries 2013) and the consequent tightening of eligibility. At the time of the interview, two of the three local authorities were considering, or already moving towards, focusing on those with the highest level of needs, 'critical needs', as reported by ADASS (2012). This implies that older people's exercise of choice can be seriously affected by the long-standing problem of shortage of social care resources and the resultant rationing of scarce resources (see Lymbery 2010). Caring only for those with critical needs would undermine the key aims of social care - extending user choice and promoting prevention.

The Unsettle residents' experiences of a forced move can also be understood in the context of cost containment, as an attempt to meet users' needs with limited resources. The constant tightening of the social care budget led to the provision of residential care based on economic efficiency and resulted in undesired moves, which lacked older people's agreement and any reflection of their preferences. Social workers who were interviewed admitted that there were

cases where they had to initiate forced moves, even if older people themselves did not want to move in. Undesired moves took place when (relatively) intensive care needs arose and when residential care was considered to be a cheaper option than community care. It is clear from the experiences of the Unsettled that these undesired moves not only broke the commitment to extending choice and promoting ageing in place, but also seriously affected the quality of life of the older people involved in these moves.

There will be a further constraint on the funding for residential care due to the recently introduced requirements that limit local authorities' spending on residential care to less than 40% of their social care expenditure (Land and Himmelweit 2010). There is little doubt that the provision of publicly-funded residential care will be more focused on those who are already facing crisis, leaving little room for them to become involved and to prepare for the move. This can lead to an increasing incidences of forced moves and, at the same time, make the choices of those who can really benefit from residential care (e.g. Active Planners and Shelter Seekers) being compromised.

There were some other differences between local authorities, in terms of their policy on cross-boundary moves and regular reviews. All 37 interviewees from Boroughs A and C were only allowed to move into a care home in the borough they were living in, while those in Borough B were allowed to move into any care home in the UK, even to a home in Scotland. Cross-boundary moves were allowed in principle as long as they meet the needs of users and the local authority financial limit. Nevertheless, three Unsettled residents could not move into homes they chose. Proximity to their family, friends and relatives were far more important than proximity to where they lived (see also Philips and Davies 1991), but all their requests were rejected by their local authority. Social workers and care home managers also said that

cross-boundary moves are not common, confirming to the literature (Allen *et al* 1992). There was one interviewee from Borough C whose request to move into a home in another borough was successful. Her son told the researcher that he had to contact the local authority tens of times (for nearly two months) to persuade them to support his mother's move into a home near his place. The three Unsettled residents, who did not know much about the system and/or have a family member to help, found it distressing to have their choice denied and were affected by the consequences even at the time of the interview. Considering that the occupancy rate of residential homes has been fluctuating around 88-89% in recent years (Colliers International 2012), if the restriction on cross-boundary moves continues, there is also a danger that some care homes will start to cream-off users with less complicated needs. As Spicker (2012, p. 10) argues, 'it is not enough to have independent providers; there also have to be competition and multiple purchasers'.

The local authorities' allowing of cross-boundary moves was also related to their review policy, which was also affected by the level of resources that can be spent on regular reviews. Social workers visit care homes and carry out three reviews in the first year of a user's move into a care home and conduct reviews annually from then onwards. Social workers who were interviewed said that disallowing of cross-boundary moves were often justified on the grounds that reviews involving long-distance journeys are costly both in terms of time and financial resources. Some local authorities, however, chose to cooperate with other local authorities and carry out reviews on behalf of each other.

There are some other local differences which can have further impact on older people's exercise of choice during the care transition – notably, the supply of residential care and local authorities' making block contracts. The fact that the number of residential care providers

varied substantially between local authorities, with some local authorities in London having less than ten homes and some having more than a hundred, poses a potential risk for a greater variation in user experiences. Boyle (2013) also reported on the shortage of diverse range of providers in some areas. Moreover, as has been pointed by Knapp *et al* (2005), some local authorities maintained the old system of block contracts and notified users of the names of the block contract homes. In Borough A, where the amount of funding for a single user was the lowest among the three boroughs, it seemed that users often ended up in one of the block contract homes, as they were clearly one of the homes that were 'affordable' to them. Although the impact of block contract on user experience was rather inconclusive (four of the seven Unsettled residents in Borough A were in block contract homes), there can be a disparity in the degree of user choice and provider competition between local authority areas.

Table 5.2 gives an idea of how many interviewees from the three participating boroughs were included in the four conceptual groups. As can be seen from the table, there was no Unsettled among those living in Borough B. It would be difficult to conclude from the figures that living in a specific borough necessarily increases a possibility of being an Unsettled resident, Nevertheless, it is notable that those who were living in the borough where choice and flexibility were ensured more than other boroughs tended to enjoy more positive transition experiences.

Table 5.2. The four groups of interviewees broken down by their local authority area

	Borough A	**Borough B**	**Borough C**
Active Planners	6	6	5
Conformists	6	4	4
The Unsettled	7	0	4
Shelter Seekers	2	1	3

Source: Author's own elaboration.

The Unsettled and their adaptation

It was common among the Unsettled to say things such as ‘I didn’t choose this care home’ or ‘I didn’t know what to expect’. More than half of the Unsettled did not wish to come into a care home and this affected their adaptation to the care home environment.

> *It was a bit upsetting. I suppose it wasn't a case of making up my mind whether I would leave home or not. It's all just happened. I thought it was going to be temporary but it wasn't (Colin, 83).*
>
> *It's just strange, isn't it? If you know what I mean…I didn't know what to expect (Catherine, 86).*

The Unsettled found it more difficult to adapt than any other groups. The fact that they did not know much about care home life meant that they encountered unexpected living environments and some of them felt as if they were suddenly placed in a strange place. The difficulties they had ranged from embarrassing services (e.g. receiving a shower) to complying with care home rules (e.g. keeping meal times, going to bed too early).

> *R: What was the most difficult thing to cope with?*
> *I: I think being washed by people, I didn't know. You know, I had a friend used to come and washed the bits I couldn't reach you know she was coming once a week and do my back and that was ok. But being washed by somebody you don’t know well…I think that was the hardest thing (Katie, 87).*

> *I think sharing a toilet is one of the difficult things, really. Just now, when I was waiting for you…We had a lunch at...what time was it, 12.30, I suppose. It was quite early today, and everyone was queuing up in front of the toilet immediately after the meal. I was getting worried because I was supposed to meet you at 1'oclock and it's half past one. So that can be a bit awkward (Sylvia, 78).*

Having to follow the routine was particularly difficult for some of the Unsettled. This illustrates the point that it would be important to give choice to older people living in care

homes, since some difficulties would be mitigated by enabling them to take more control of their life in care homes.

People who became the Unsettled as a result of moving into a care home were aware of the importance of choice and most of them wanted to have had more choice, but they still did not know much about available options in long-term care at the time of the interview.

> *I don't think people are made aware enough of it, because (it) wasn't until I got here, really...and you know, that would have helped me very much. I don't think people are made aware enough, they are not told enough about things. You find it by accident mostly (Laura, 85).*

There was a constant comparison of the life in the past and the present and the psychological resistance towards the new environment made it even harder for the Unsettled to adapt.

> *I wish I was at home, not here. I'd sooner be home, really, with children and grandchildren (Catherine, 86).*

The difficulties of adaptation experienced by the Unsettled who experienced a pressured move into a care home are presented in Box 5.3.

Box 5.3. The case of the Unsettled – Erica's experience

Erica had lived alone all her life, but had started to be looked after by her sister since she had a stroke. She felt that her body was getting weaker and weaker and found it increasingly difficult to move about. Her sister, who looked after Erica for at least five years, had experienced various health problems and depression and had started to find the caring challenging. A short period of respite care did not help much and her sister thought she would not be able to continue caring. Erica felt sorry for her sister and agreed for her to contact the local authority for help. Erica said to the social workers who assessed her and her sister's needs that she wanted them to send someone to look after her for a few hours a day.

However, contrary to her expectation, the social worker suggested a move into a care home. Erica

rejected the idea immediately and expressed her dislike of homes, but she was told that there would be no choice due to financial reasons. She had never seen herself as needing residential care, as she was not suffering from any mental health problems and she could walk about using a zimmer frame. She also had a fear of care homes. She asked social workers to send her a carer within their financial limits, but she was told that the number of hours she would get would not be enough to meet her needs. The social worker said that residential care would be the only practical option for her. Erica thought that she could manage in the community with a little extra help, but, after about a month, she was 'informed' that she was moving into a home. She was not properly informed of some important information until a few days before the move, including the name of the home and the facilities in the home. She realised later that the decision was made between her sister and the social worker. She almost felt betrayed and could not understand how her sister could do that to her.

As the move was an undesired one, and an unnecessary one from Erica's perspective, she could not live her life fully the care home. The new living environment and the services in the home were things she did not expect and she was not motivated to make efforts to adapt, either. She was not interested in talking to other residents and participating in activity sessions. The only thing she wanted at the time of the interview (10 months after the move) was to go back to her old place. She barely managed to put up with the life in the care home, still feeling upset that she was excluded from all the decision making processes and fearing that she might have to live in the home for the rest of her life.

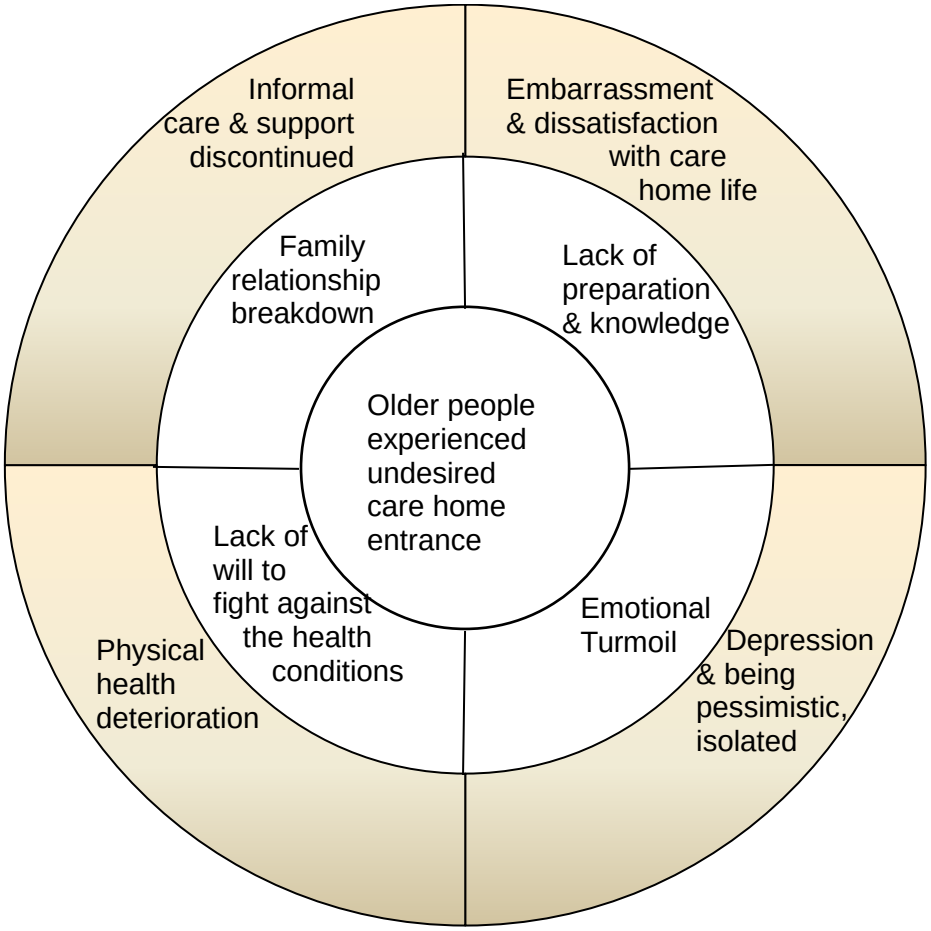
Figure 5.8 summarises the consequences of the undesired move experienced by the Unsettled. It is visible from the figure that the Unsettled had a complex set of consequences which affected their emotional, physical and relational well-being.

The Unsettled ended up deciding to ‘put up with’ living in a care home, albeit having similarities with Conformists in the degree of participation in decision making. The Unsettled lacked the will to live actively in care homes and to fight against their existing health conditions.

> *You've got to put up with it, isn't it? As long as I live… I don't like it very much here. No (Clara, 92).*

I don't like it here very much. I actually give it [adaptation] up (Adrian, 72).

Figure 5.8. The consequences of undesired care home entrance



Source: Author's own illustration based on research findings.

It was difficult for the Unsettled themselves to have any feeling of improvement in their transition experiences after deciding to put up with the care home life. The care home managers and staff also noticed little signs of improvement. Some relied on religion for peace of mind while trying to get on with the life.

If I can't get on with it, oh, please God... We just get on with it as best as we can (Sylvia, 78).

However, there was often no service (usually provided by a visiting priest) or a prayer room in care homes. Of the ten participating homes, only three had a prayer room or Sunday services for the residents. The home managers interviewed said that support for various religions and religious activities had been rarely discussed in their homes.

Family support seemed to have prominent importance for the Unsettled as well as the other three groups, but it was found that the Unsettled did not have family relationships as intimate as those of Active Planners or Conformists. In some cases, the conflicts between the family members and the older people regarding the move made them feel distant from each other and affected the family relationships. In some other cases, Maladaptation of the Unsettled sometimes affected their family and those who suggested or helped their care transition and made them feel guilty, worried or depressed. Care home staff were spending extra time caring for them and their family members. It was found that visits from families were sometimes discontinued due to their feeling of discomfort and guilt when they made visits. The lack of family support and visits consequently triggered the Unsettled residents' feeling of isolation and loneliness.

> *They need family support, really…people coming to see them. 'Cause you get the feeling sometimes with the families that they are glad to get rid of the person. Might be they had a heavy job looking after them at home, may be, and they are glad to get them in here (Louise, 88).*

As was explained in Chapter 3, there was a question using a vignette, which asked interviewees what advice they would give to the researcher's grandmother who was preparing to move into a care home. The topics that came up most frequently in their accounts were information and prior knowledge of residential care and the home they were entering. It was

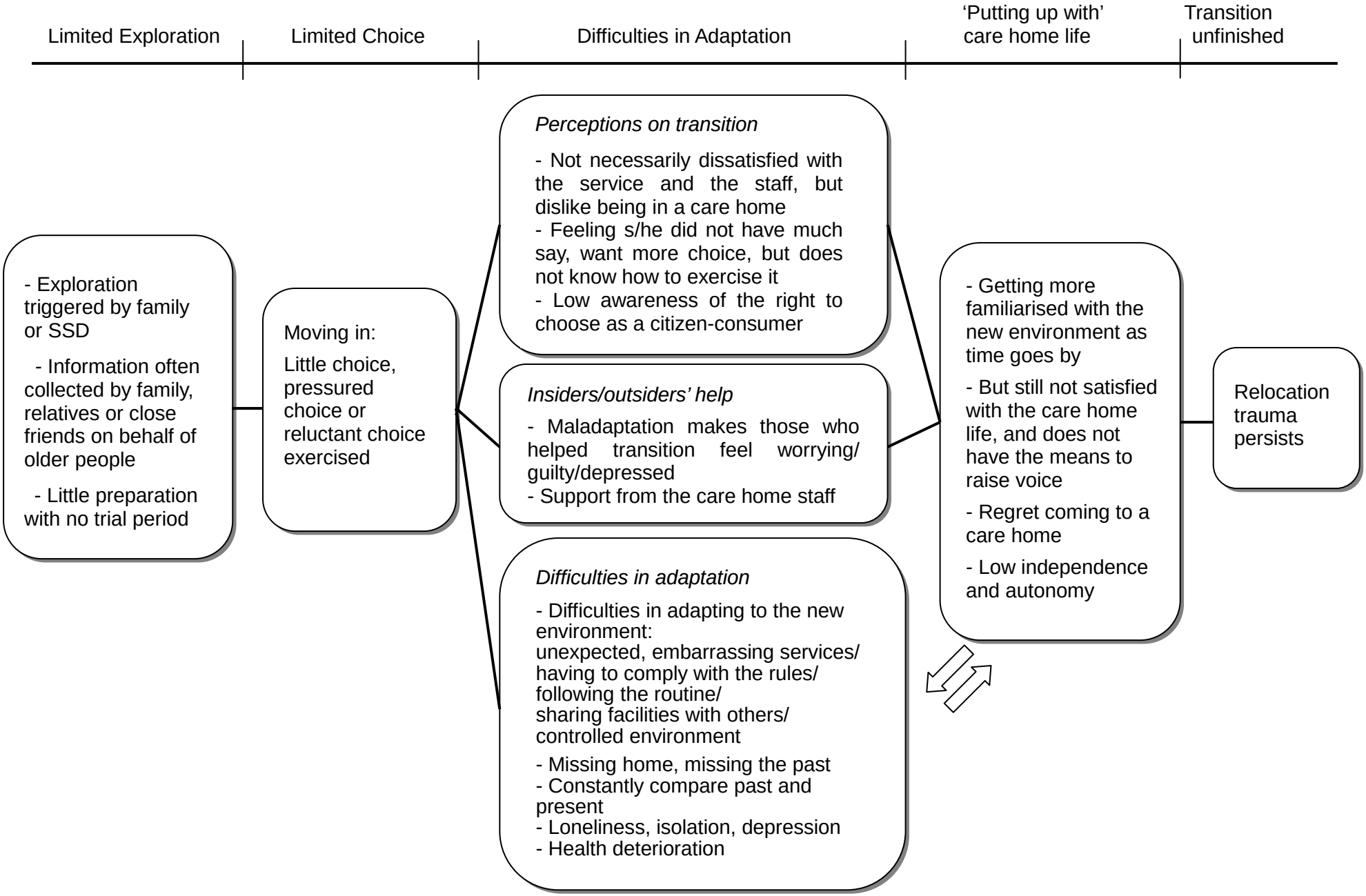
confirmed once again that having sufficient good quality information and obtaining knowledge of care home life was crucial for smoother transition.

> *If they know they are moving in, that's easier, really. If you can explain what it's like in here that they are going to do everything for you, they wash your clothes, bring them back and put them away for you... (Katie, 87)*
>
> *In the beginning if I had a bit of help from social services, it might have made a difference (Adrian, 72).*

The research findings hint that the Unsettled still did not know how to exercise choice at the time of the interview, even if they could go back to the past, whereas Conformists had at least a vague idea at least about who to contact or where to look for collecting information. It was partly because the Conformists' active use of peer support as they were able to obtain knowledge about choice in long-term care during their conversation with other residents.

For the Unsettled residents, it was difficult to come out of the transitional state. They saw themselves as still having troubles adapting – they thought that they were not adapted or, at best, 'struggling' to adapt. As a result, for all of the Unsettled, the transition remained uncompleted at the point of six months after the move and relocation trauma persisted, although the severity was decreased compared to early stages of the transition. Figure 5.9 illustrates how the Unsettled spent each stage of their care transition.

Figure 5.9. **The process of care transition and choice making in residential long-term care – The Unsettled** (author's own illustration)



Shelter Seekers

Shelter Seekers had unique needs that made them come into a care home. Their care transition was different in nature compared to the three other groups of Active Planners, Conformists and the Unsettled.

The initiation of the move

The term ‘Shelter Seekers’ does not only mean that they need the minimum physical environments that they can reside in, but also means that they need the secure living environments which can provide them with psychological stability. For Shelter Seekers, the reason for coming into a care home was often associated with family troubles or social problems that are too serious to be called personal problems, such as elder abuse or domestic violence. The problems they underwent were also closely related to the care they received in the community as abuse or violence was often committed by their family members who also played the role of an informal carer.

Unlike other groups, Shelter Seekers’ care transition was not triggered by health deterioration or difficulties in coping due to a low level of mobility. They were assessed as having ‘substantial’ or ‘critical’ needs due to their living in the environment which threatened their well-being. Almost all of them were exposed to multiple types of abuse, including verbal, physical, emotional or economic abuse (see Box 5.4 for the experience of a Shelter Seeker, who was affected by different types of abuse). Therefore, Shelter Seekers had better health status and were of a younger age than most residents from the three other groups. There was

no one older than 85 (the average age of the whole sample was 84.5), and the two youngest interviewees were also Shelter Seekers.

Shelter Seekers' exercise of choice

The move to a residential home was quick and mostly initiated and arranged by social workers, following initial reports from close friends, neighbours and relatives of the Shelter Seekers on the abusive incidents they experienced. Shelter Seekers did not think about moving into a home and hardly explored available options themselves, due to their lack of understanding of long-term care system and their lack of time for exploration. Their needs were considered urgent and were prioritised by social workers. The time constraint was the main reason for not considering alternative accommodation options. Hence, there was lack of choice over the timing of the move and over the alternatives to residential care. However, these types of choices were not even desired by Shelter Seekers themselves who longed to escape from the hostile environments they were living in. Despite their lack of choice regarding the time of the move, Shelter Seekers' move into a care home involved their active choice (including the types of choice in the top and middle layer). They exercised choice over the use of residential care itself and also over a specific home to move in, to some extent.

> *It's to do with my granddaughter...the oldest one. She punched me and spit at the face. So the supervisor used to come and see me. She made me come here so I can have some more protection here. (Barbara, 83).*

Shelter Seekers, who had the fewest people around to help them in the care transition, were better informed than most of the Conformists and the Unsettled. It was precisely because the fact that they had the smallest number of people helping them, which made information about the care transition being shared directly between them and social workers. Nevertheless, most

of them were informed of a small number of care homes which were initially filtered by social workers (typically two homes that had a vacancy at the time of the consultation and were recognised by social workers as providing adequate services). Shelter Seekers were directly involved in choice making with little help from their informal network. They could not rely much on their informal network as the most intimate relationships – family relationships – had already deteriorated at the time of the move. With the desire to escape from the painful reality, Shelter Seekers also had a strong will and motivation to exercise choice to move into a home:

> *[At that time] I definitely did say that my wellbeing was more important than a bit of possessions even though some were precious (Patricia, 84).*
>
> *I think it's sort of...you know, realising that it was necessary for me to have help around. My well-being is much more important than trying to manage, isn't it? (Charlotte, 70)*

They did not have a chance to explore other care options, but they believed that living in a home was the right option for them in terms of the level of protection and the types of services they received.

Box 5.4. The case of Shelter Seekers – Charlotte's experience

Charlotte used to live in a small flat with her husband, but she started to live with her daughter shortly after her husband died. It was her daughter's suggestion for them to live together, who used to have a partner, but had experienced separation a few months before Charlotte moved in. Charlotte felt rather insecure about living alone and she was walking less and less, so she agreed to move into her daughter's place.

Charlotte had some savings (although she could not recall the exact amount), but, not long after the move, her daughter insisted that she would take care of them. Charlotte did not hear anything about the savings, from then. Although her daughter was not involved in full time employment, she was out most of the time and Charlotte seldom had the chance to talk to her, while living in the same house.

One day, her daughter started yelling at her about small mistakes she had made (spilling some

water on the table) and Charlotte was terrified. Since then, these incidents had been repeated and she had started to experience other verbal, emotional and physical abuse. Her daughter always talked to her in an aggressive manner and, sometimes, ate meals alone when she came back in the evening, leaving nothing for her. Charlotte once had to take pills regularly for virus infection and her daughter did not even tell her where to find the pills on her way out, although Charlotte was sure that her daughter should have kept the pills somewhere. Charlotte recalled that when she went to see her GP, her daughter never showed her aggressiveness. Charlotte's needs were often neglected. She was left alone at home, even at times when she was not feeling well. Charlotte confessed that she used to have difficulties in getting to sleep, especially on the days when she experienced some form of harassment (especially shouting, which made Charlotte almost feel threatened).

She was also suffering from depression and sometimes she cried and asked her daughter why she was doing this to her. Charlotte was not in a wheelchair, but found it difficult to go out alone due to mobility issues. Her daughter hardly took her out and Charlotte had to stay in the house, even if she wanted to go out. This misery lasted for over a year. It was her niece (whom Charlotte had not seen for a while) who found out about this when visiting Charlotte and reported to the Social Services to see whether Charlotte could live somewhere else. A social worker came to see Charlotte a few days later and discussed with Charlotte about the residential care option. While going through the assessments, it was found that there was only a little money in her account. Her daughter said that she did not know anything about her savings and Charlotte had been receiving financial support from the local authority to pay for her care.

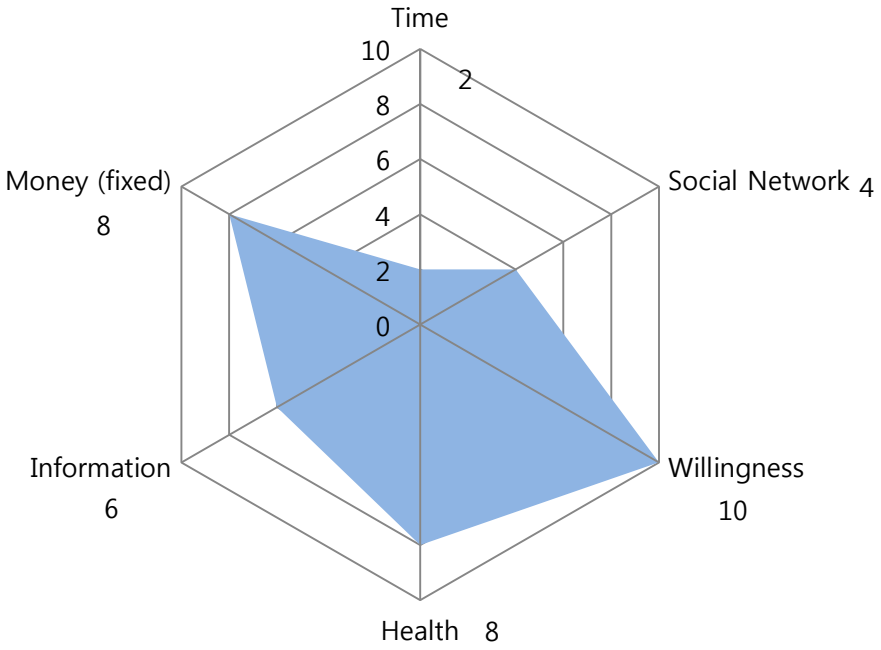
The social worker helped Charlotte considerably with filling in the application form. Charlotte heard the names of a couple of care homes and their services from a different social worker who was in charge of the practical arrangements for her move. She did not want to stay in her daughter's house and did not feel that she had the time to make an appointment and arrange a visit to a care home. Charlotte said that it was not a difficult decision, though - one reason for that was that there were only two choices (practically, as she did not know any other homes in that area) and another reason was because she thought that any place would be better than the place she was living in.

She did not have to wait long and it was clear that the social workers prioritised her needs. She had never lived with that many people in her life, but she felt safe and secure in the home. She was satisfied that she was able to take meals regularly and receive the necessary help she needed. The care home manager also arranged a counselling service for her for the first couple of months. Her health had improved overall since the move, although her mobility issues still remained. She said the traumatic memories would 'never go away' completely, but they did not prevent her maintaining her confidence and her sense of self anymore.

Figure 5.10 illustrates the level of resources that were available to Shelter Seekers at the time of the move. They lacked resources they needed for proper timed exploration, namely, time and social network, despite having better health than most other residents. However, despite having the short time to make relevant choices, they strongly expressed preferences towards

moving into a home that can meet their need. They thought that their choice was based on credible information from experts who knew well about the system (social workers).

Figure 5.10. Level of resources for exercising choice – Shelter Seekers (averaged)



Source: Author's own illustration based on research findings

Shelter Seekers' adaptation

Whereas Active Planners were satisfied with the sense of continuity with the life they had before in terms of being an autonomous individual, Shelter Seekers were satisfied with their separation from the past, the time when they constantly suffered in their own home. They never regretted coming to a residential home, as they knew for certain that the benefits of living in a care home outweighed some emotional difficulties they encountered:

> *I love to be here. I have told everybody I am so happy. I don't have things to think. I am not worrying. Before that I did cry day and night, when I went to bed I was crying. I can't live with that man... My daughter came crying, and said, mom you have to go out of the house...and I did cry that night, day and night, I*

> *did cry, my dear....cry over night and night. She found this house and said mom, you can live here. Ok, I am going out, and I never went there. I am so happier here. Very [happy]. Before that I was very worried, every single night I was crying, crying, crying. I like to be here. There I was in the house, but the man was not a good man for me. I said to myself many times, I can't live like that. My daughter came here three times, I think. Families are here now. Everybody treats me like a family and I am so happy to be here, very, very happy (Claudia, 72).*

Another Shelter Seeker who was had hard time enduring abusive languages and behaviour was relieved after she came into a home:

> *I said to myself, you are better here than was there because I couldn't be happy there. You know, I wasn't happy there. And here I am... (Patricia, 84).*

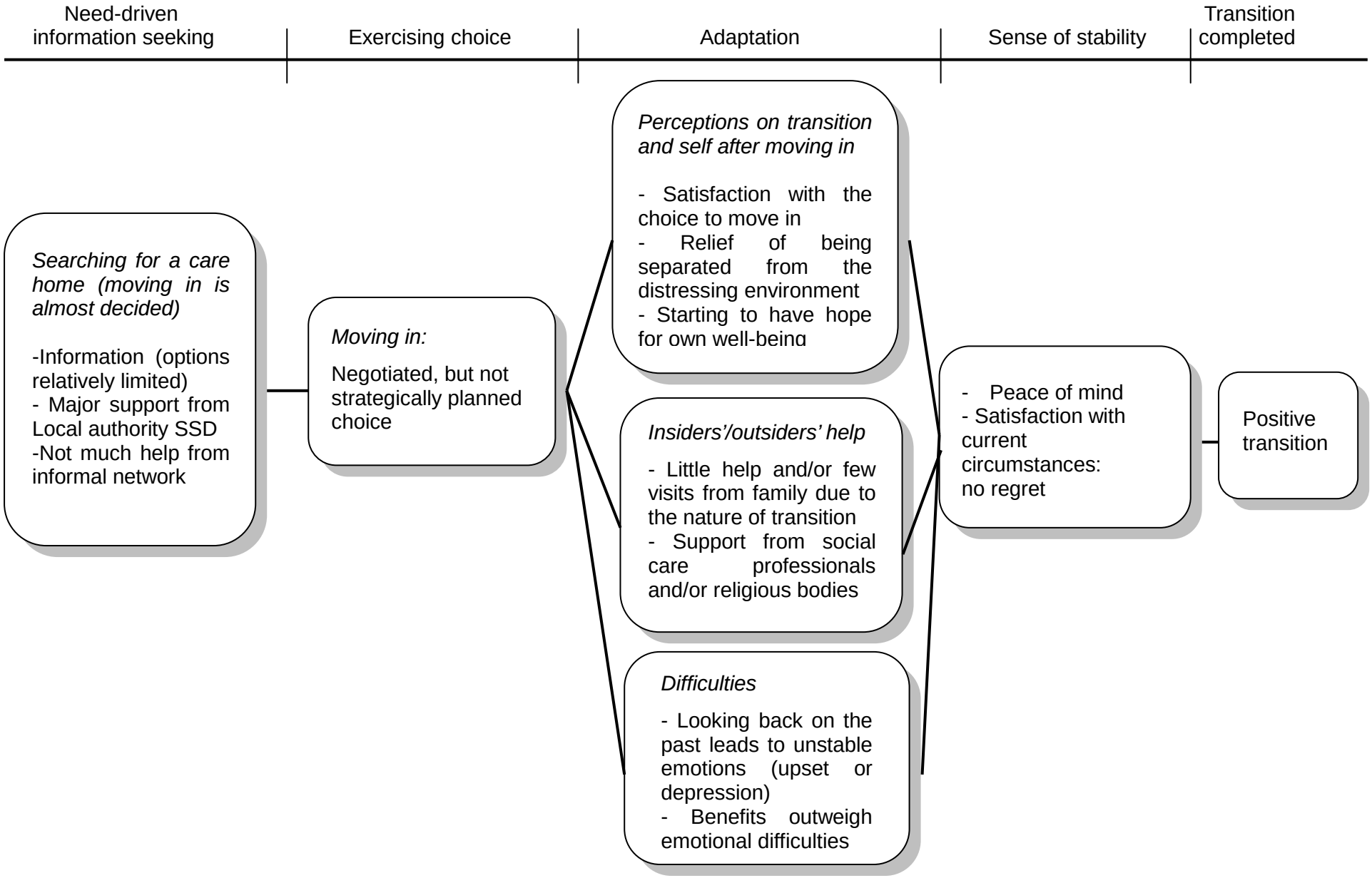
Due to the specific circumstances of Shelter Seekers and their previous relationship with their families, visits from families were not made often. However, Shelter Seekers were well aware of their circumstances and accepted the fact that they had fewer visitors than other residents. It did not affect their adaptation either. It was partly because there were other sources of support available including counselling service or aromatherapy sessions (which were arranged by the care home staff) and informal support from volunteers and peer residents.

> *She said, mom I can't come any time. I knew what it was. He doesn't want her to.... It was him [who] doesn't want her to see me. But I don't care about that because I am so happy here, everybody is so nice. In the beginning she came to see me but not now. She's my daughter...but it's better, because if she comes, and if he knows... He's a naughty man, a nasty man, and he frightens sometimes. I know she's frightened to come. I said to my daughter, don't worry about me, because I have a family. All of them are my family and I am happy to be here. Don't come to visit me, because I am happy. Everybody is happy with me and I am happy with them. I am not going there [where she lived] as well because of that man. It's the man who did that....it was the man who did that. Every [member of] my family said Claudia, you have to go out, because you can never be happy there. It's true. I am happy here (Claudia, 72).*

Shelter Seekers were the people who received the most help from local authority Social Services Departments and health care professionals. They were victims of family troubles

and social problems, but made a successful transition according to their will and started to live a new life in care homes. Shelter Seekers' experiences suggest once again that residential care can be a positive choice and that there is a role for care homes in securing older people's wellbeing (see Figure 5.11 for the summary of Shelter Seekers' experiences).

Figure 5.11. **The process of care transition and choice making in residential long-term care – Shelter Seekers** (author's own illustration)



Conclusions

Moving into a care home was a life changing experience for the older people who participated in this study. They experienced the care transition differently and their needs, exercise of choice, adaptation process, and perception of their experiences varied considerably, unlike the findings from other studies which often illustrated older people's passive and stressful move into a care home. The differences in their experiences and perceptions towards the care transition led to the formation of the four conceptual groups.

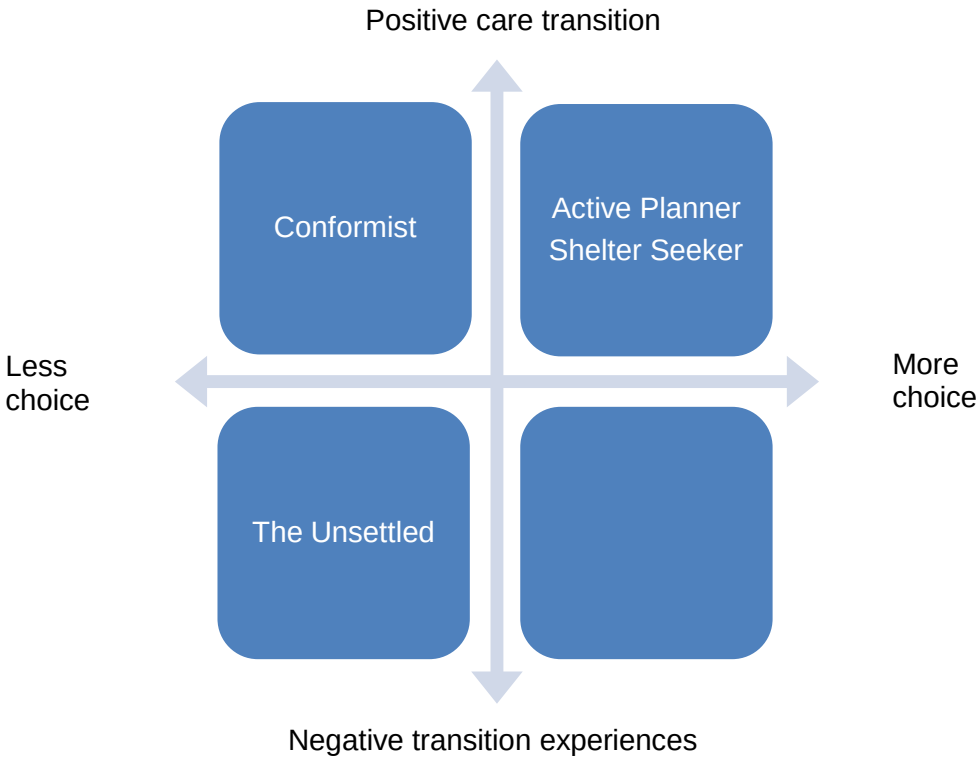
Active Planners were those who actively participated in the decision making process by exercising choice and adapted to the new environment quickly. They were satisfied with their care transition and their exercise of choice, with no experience of side effects or post-decision regret. Their experiences challenges the widespread belief in older people's indifference to choice and their passivity in using public services by showing that older people can be active consumers of long-term care who can initiate and take control of the process of their care transition. Shelter Seekers were a unique group of people who needed residential care due to their special circumstances that affected their physical and emotional well-being. They were not able to exercise choice in full, but the transition itself took place according to their strong preferences for residential care. The cases of Shelter Seekers and Active Planners showed that the transition to residential care can be accompanied by positive choices of older people. There was a gap between reality and the UK government's rhetoric of deinstitutionalisation, as some older people were genuinely seeking residential care as a way of meeting their needs and of enhancing their well-being.

In contrast, the experiences of the Unsettled highlight the consequences of their lack of choice in their care transition and suggest that there were systematic and administrative barriers to choice in residential care. The Unsettled had limited choice and information when moving into a care home and found it difficult to adapt to the new environment. They often had to compromise their right to choose due to local authority variations in the application of eligibility criteria, the level of funding and policies on cross-boundary moves. The stressful experiences of the Unsettled imply that the application of choice in public services cannot be expected to work as an invisible hand, as Le Grand (2007) argues, but should be accompanied by appropriate policy interventions to offer fairer opportunities for users and bring about the positive effects it was supposed to generate. Also, considering that these variations were caused by the long-standing problem relating to the lack of social care resources, there would have to be an important change within the system of funding social care in order to give service users real power to steer. Along with these interventions, as unanimously echoed by the interviewees, there is a need for a system that could support the provision of more accurate information in an easily readable, user-friendly format.

On the basis of the research findings, Figure 5.12 briefly summarises the relationship between the degree of choice exercised and the possibilities for positive transition. Older people's exercise of choice seems to affect positively their adaptation and their quality of life after transition. However, the experiences of Conformists also showed that a positive transition could take place without their exercise of choice. Among the Conformists, there were some older people who were not interested in exercising choice. Rather than encouraging everyone to exercise choice, there is a need to recognise systematically that not having a choice or delegating a decision can be a choice.

Despite the variations between individual groups' experiences, they shared a viewpoint that only limited scope of choice was ensured in policy and practice. The concept of choice is often interpreted only as a choice of provider in the relevant policy and the literature, but the interviewees valued the concept of choice as a means to getting involved in important events in their life (a more detailed exploration follows in Chapter 6). It is also conceived that a positive transition can be yielded by allowing users to make more fundamental, high level choices. Having explored older people's experiences using the concept of 'layers of choice', choices at the top layer, choice of alternatives and the choice of whether to move in, were not granted to many of the interviewees, although they considered to be the most important choices for them. It signifies that what mattered to older people was not only the type of choice that they exercised, but also the level at which the choice was ensured for them.

Figure 5.12. Exercise of choice and positive experiences of the care transition



Source: Author's own illustration based on research findings

Choice has not been fully promoted in residential care, but the extension of choice is under way with the introduction of Direct Payments in residential care and policies on the local authority provision of information and guidance (HMSO 2014). In order to enhance the user experience of choice, it would be important to realise that the working of choice cannot be complete with only the introduction of a new catchword to the old system, but should be accompanied by systematic changes including the lifting of geographical and administrative limits for the service provision. It will also be essential to allow them to be fully involved in different stages of care transition and expressing their thoughts and preferences during the transition period.

The discussion on older people's exercise of choice presented in this chapter leads us to question what choice means to older people and how it affected their experiences of care transition. The next chapter explores the meaning and the perceived effects of choice in residential care.

Chapter 6. The Meaning and the Effects of Choice

Following the discussion of the exercise of user choice during the care transition process in the last chapter, this chapter explores in depth the meaning and the effects of choice to older people in residential care. In order to identify the meaning and the effects of choice to the older people who were interviewed, this chapter looks at their perception of choice in residential care and their thoughts about their experiences of choice making. It was found that the older people exercised choice as a process of accepting dependence and gaining a renewed sense of independence. The exercise of choice, however, did not make them have consumerist identities. Choice offered enhanced autonomy and control, preparedness for residential care and an acceptable service quality to those who exercised it, but their choice did not necessarily lead to the use of better quality service or more efficient service than others in the current system of long-term care.

This chapter first looks into the meaning of choice for older people and discusses how their exercise of choice was related to their identity in the consumerist society. It then appraises the effects of choice in residential care based on their experiences.

Older people's experiences of choice in residential long-term care[19]

In order to understand what choice meant to older people and how it affected their experiences, the forty-eight older people's stories were analysed, with a focus on their

[19] In academic debates, the phrase 'choice in A' (with A denoting a name of a specific public service) is often used to refer to the application of choice in the specific service area. User choice in public services is normally exercised before the use of a specific service (as it relates to choosing which service to use in what way) and thus 'the interviewees' exercise of choice during their care transition' equates to 'their choice in residential long-term care'. Therefore, in this chapter, 'choice in residential care' is used interchangeably with 'choice during the care transition process'.

perception of choice in residential care gained from their own experiences of care transition. As the focus of this chapter is on older people's experiences of choice, relevant findings are often presented in connection with the cases of Active Planners and Shelter-Seekers, i.e. those who were able to exercise choice and to talk about the actual experiences of choice in residential care. The experiences of Conformists and the Unsettled were also explored, but only to the extent of what they thought choice meant to them and how the deprivation of choice affected their experiences of care transition.

The meaning of choice: Acceptance of dependence and a renewed sense of independence

The analysis of older people's transition experiences found that there was a clear meaning attached to their exercise of choice – namely, acceptance of dependence and gaining of a renewed sense of independence. The meaning of choice to older people has two theoretical implications. Firstly, older people's exercise of choice originated from a positive acceptance of their dependence and this led to a renewed sense of independence in the care home. This finding contradicts the structured dependency theory (Townsend 1981) that has been at the centre of critical gerontology and shows that residential care can play a role in forming a new sense of independence, not reinforcing older people's dependence, as has been claimed in the literature. Secondly, these experiences of choice in residential care imply that older people's needs were different from those of some other groups, whose goal of using social care is often related to the concept of independent living (Glendinning 2009). This questions the widespread assumption about the similarity between the needs of older people and some other user groups, especially those with disabilities.

Older people's exercise of choice started from the point when they accepted their dependence. In contrast, choice is often associated with the concept of independence in policy and the literature (e.g. The 2005 Green Paper *Independence and Well-being and Choice*). Before exercising any choice, older people themselves recognised their own needs and the dependence arising from them, on top of the needs assessment by professionals. This finding conforms to what was found by Roberts *et al* (1991), that seeking information on residential homes was related to a loss of independence. Moreover, the acceptance of dependence was a positive process for older people who were interviewed for this research, whereas the notion of 'dependence' is frequently interpreted negatively in many theories of old age, including the structured dependency theory.

Active Planners recognised their care needs relatively quickly. They often initiated the care transition themselves and exercised choice earlier than others. Their acceptance of dependence gave them a motivation to explore the residential care option, as illustrated in the following quotation:

> *I thought I would have to be somewhere where I was cooked for and assisted…for instance, I can wash myself, but not my back, you see. It's a bit awkward, isn't it? So I knew from the beginning I had to have help with that kind of thing (Joanna, 87).*

Following the acceptance of dependence, what older people valued most was their well-being. For Active Planners, choice was made in relation to their well-being, in whatever way they thought their well-being could be maximised. One Active Planner was aware of other long-term care options as well, such as assisted living, but said that she thought residential care was more appropriate, considering her care needs and well-being – 'I suppose I can have more independence there [other types of housing with care] but this suits me' (Sue, 86).

Six Conformists who transferred their right to trusted others, and a small number of Conformists who made a partially negotiated decision, also realised their own needs and dependence before taking such actions. Conformists were rather reluctant about the idea of living in a care home, but they accepted sooner or later their needs and the inevitable dependence following those needs. Their recognition and acceptance of the need for residential care was one of the biggest differences between their experiences and that of the Unsettled, as has been explained in Chapter 5.

There were six Unsettled residents who even refused to think about the care transition process itself, as was also found in Allen *et al* (1992). There was a conflict between individuals' assessment of their needs and that of the professional assessors, as pointed out in the *Independence, Well-being and Choice* Green Paper (DH 2005). There was no further exercise of choice for those Unsettled residents once their right to remain in the community was refused them.

For Shelter Seekers, their own well-being was the first and even the only thing they considered when they made the choice to move in. This was not surprising considering that they were living in a situation where their own well-being was seriously hampered. When she was asked whether she had enough independence in the care home, a Shelter Seeker said that 'Well, I have wonderful care, which is what matters. I don't want anything else' (Patricia, 74). Another Shelter Seeker, who was introduced in Chapter 5, firmly said that her wellbeing was more important than 'trying to manage' (Charlotte, 70).

It is noteworthy that older people's acceptance of their care needs and dependence preceded their exercise of choice, but it did not necessarily mean that they were losing independence

while living in a care home. In fact, some older people said that the acceptance of need and dependence provided them with a renewed sense of independence and control. The meaning of independence changed from managing alone in daily life to having a sense of independence in a more manageable environment while receiving necessary help and care.

> *They don't tell you what to do. I decide. I am still very independent (Rose, 68).*

What was meant by 'independence' was well-illustrated by what one Active Planner said:

> *I think they (new comers) will probably realise that obviously their freedom is restricted, clearly. But I have as much independence as my ability to cope physically with life [allows] (Steve, 82).*

A few Active Planners felt in a way that their sense of independence continued even after the move. This finding is consistent with Nussbaum (1991, cited in Biggs 1993) who found that residential care, the idea of a more manageable and contained space, has the potential to occasion increased control. Older people's interpretations of independence and control thus differed from younger people with disabilities. The experiences of the interviewees were in line with some of the positive traits of care homes argued for by OFT (2005), Victor (2005) and Johnson *et al* (2010). The renewed sense of independence and control that some Active Planners gained shows that there is a possibility that care homes can play a positive role in helping older people to balance their well-being and their sense of self.

It is remarkable to find that, after the acceptance of dependence, about half of the older people who were interviewed (Active Planners and Shelter Seekers) autonomously participated in the decision making process as agents, chose to use residential care themselves, and that these actions resulted in smooth adaptation and positive experiences of care transition. This

indicates that, despite the local authority differences which limited the degree and the extent of choice available, the experiences of care transition and of residential care itself can be transformed by older people's involvement. It also implies that the role of individuals at the micro level would be important for positive care experiences. The older people's genuine preference for residential care and their voluntary entrance challenge the arguments made by structured dependency theorists who assert that care homes are the last resort for older people who have suffered prejudice and discrimination in society (Townsend 1981). The interviewees' experiences also question Townsend's (1981) argument that residential care creates and reinforces the dependency of older people.

Townsend (1981, p. 22) points out that older people are often considered as 'grateful and passive recipients of services administered by an enlightened public authority', and that 'this can but reinforce their dependency both in their own eyes and that of the public'. Nevertheless, there was little consideration in his study that the same principle could be applied to the cases of those using residential care. Seeing residential care as the last resort and users of residential care as passive and dependent older people could lead to scepticism about older people's agency and autonomy. This would be partly related to the lack of recognition that people can continuously be active agents in their old age and partly linked to the prejudices against care homes and the services they offer. Townsend believed that residential care only performs negative functions and that all care homes should be closed and replaced by other types of accommodation. It should be noted, however, that older people who are living in care homes are not necessarily more passive (or less autonomous) than those in the community and that the bias against those in care homes can also strengthen and reproduce the prejudice against them, as Pickard (2008) suggests.

The experiences of older people in this study who exercised choice following their acceptance of dependence may possibly have been facilitated by the changes in the environment of residential care provision which took place in the last few decades. There have been substantial changes to the care home environment, which made it difficult for the structured dependency theory to explain the varied nature of the care transition experience and especially the cases of transition which involve positive experiences of residential care. Firstly, there have been notable improvements in care home services and their facilities, as was found by Johnson *et al* (2010) who revisited Townsend's project on residential homes. Unlike the large care homes which still had traits of Victorian workhouses, care homes have become smaller in size, offer single (sometimes en-suite) rooms to residents and provide services that could ensure more autonomy to older people (e.g. diets and activities). The inspection of care homes has become enhanced as well.

Secondly, the residential home population in the 21st century is very different from the one described by Townsend (1962). As discussed in Chapter 5, the eligibility criteria for publicly-funded residential care has become tighter. This refutes Townsend's (1981) findings that a high proportion of care home residents were relatively fit and did not have physical conditions that require residential care. As some social workers and care home managers confirmed, there is currently a blurred boundary between residential care and nursing care (Health Committee 2005) and older people who enter into a care home have greater needs compared to the 1950s-80s.

Thirdly, there have been important changes in the policy relating to the provision of social care. On the one hand, there has been an emphasis on care in the community and de-institutionalisation (Senior 1989), following the publication of findings on the abhorrent care

home environment in the 1960s. On the other hand, the importance of individual choices has been stressed in social policy and influenced the theory of public service provision [i.e. turning the service users' from 'pawns' to 'queens', as put forward by Le Grand (2003)] and the role of professionals in social work practice. The principle of choice started to receive more attention in the area of residential care (e.g. the introduction of Direct Payments in residential care).

Fourthly, there has been a marked change in the welfare mix for the last 50 years due to the private sector involvement in the provision of residential care. There has also been an increasing recognition in policy and the literature that public service users are customers with 'proxy money' (Clarke 2006, p. 438), rather than passive service recipients. The term 'customer' means a group of autonomous consumers pursuing their preferences, which differs considerably from the widespread image of older people and this leaves room for change in the perception of older people as passive welfare recipients.

The discussion on older people's acceptance of dependence and their gaining of a renewed sense of independence suggests that the theory of structured dependency may have limited relevance to the care transition experiences of older people living in contemporary Britain. However, it does not completely deny the validity of the theory itself. The experiences of some residents (namely, the Unsettled) were still in accord with the reports on traumatic experiences of residential care published in the previous decades.

The Unsettled did not wish to come into a care home and had their independence and human rights compromised in the process of making the forced transition to residential care, despite the possibility for continuing to live in the community by utilising other care options. The

stories of the Unsettled echo the ones disclosed in studies conducted by Townsend (1981, 2007) and Allen *et al* (1992). For them, a care home was indeed 'the last refuge' (Townsend 1962) and 'the cheap substitute for community services' (Townsend 1981, p. 14). Their life in the care home was miserable, as found in Thomson's study (1981, cited in Townsend 1981). For the Unsettled, care homes were the places that created undesired dependency by providing services that were unnecessarily intensive and inflexible. The experiences of the Unsettled are a reminder that there still exist practices in long-term care that neglect the basic rights of older people.

The different meanings of choice and independence for older people and for those with disabilities

Choice has been regarded as a core principle of policies promoting independence in social services since the publication of the *Modernising Social Services* White Paper (DH 1998) and has thus been promoted widely in social care services for various groups of users. Previous studies have, however, barely touched on the different needs of each service group. In the debates on the social model of disability and the wider citizenship approach, older people were often referred to as having similar needs to those of younger people (those under the age of 65) with disabilities (Morris 2006).

Nevertheless, the context of choice and autonomy was different for these two groups of service users. The older people who participated in the research exercised their choice when they accepted their needs and dependence, but, according to the literature, those with disabilities pursue choice in order to live more independently (Morris 2006). In residential care, older people's choice led to voluntary and planned care home entrance, whereas the

meaning of ‘choice’ for those with disabilities encompasses the struggle against forced care home entrance and the separation from their family and their community, as has been argued by Morris (2006).

The difference between how the concept of ‘choice’ is interpreted by these two groups becomes clearer if one thinks about the way of life led by older people and younger people with disabilities after the exercise of choice. One of the commonalities found between the forty-eight older people who were interviewed was that they were not aware of any financial arrangements regarding their care. This finding contrasts with the experiences of those with disabilities, who have fought for the right to arrange and manage their own care for themselves by managing their own budget while living in the community (Clarke 2007). This also indicates that service-specific aspects of individual services are important in the application of choice. The application of choice in residential care and community care would require different logic and mechanisms in the service delivery from those employed in other services.

Autonomy and control

Having explored the meaning of choice for older people, we turn to explore the perceived effects of choice recognised by older people. How did the exercise of choice influence older people’s experiences of care transition?

As discussed in Chapter 5, the interviewees in this research did not experience any adverse effects of choice and what those who exercised choice perceived as the ‘effects of choice’ could mostly be interpreted as benefits of choice. The most prominent benefit that was

attached to older people's exercise of choice was the enhancement of autonomy and control. The enhancement of autonomy was gained through involvement in decision making during the care transition process. For Active Planners, the involvement in decision making by exercising choice made them feel that they were still in control of their lives. Shelter Seekers valued the sense of autonomy that came from the feeling that they came out of an unprotected and threatening environment, according to their own will and choice. A Shelter Seeker described her involvement in decision making as an attempt to 'break the chain of suffering' (Patricia, 74), breaking the vicious circle of repeated abuse. The Unsettled, who felt that every decision about their move was made by others, reported feelings of helplessness. Choice was related to older people's sense of self, particularly the feeling of being in control and being an autonomous individual.

It was difficult to say that older people who exercised choice actually had full control over their care transition as they have to meet certain conditions and follow certain rules in order to be eligible for local authority funded residential care. Nevertheless, both Active Planners and Shelter Seekers thought it was important for them to have a sense of autonomy and control through their involvement during the care transition. What can be deduced here is that choice in long-term care gave the most fundamental benefit it can give to those who exercised it – satisfaction derived from the exercise of choice itself. As Schwartz (2004, p. 103) states, it seemed that one's 'most fundamental sense of well-being' crucially depended on exerting control over one's environment and recognising such exertion.

Interestingly, it was found that the sense of autonomy itself was valued by an overwhelming majority of older people across the four groups. More than four-fifths of the interviewees valued the concept of autonomy that comes from the exercise of choice, regardless of whether

they had any choice or not during the care transition. The feeling that they remained autonomous individuals was important even for Conformists and the Unsettled who moved into a care home against their will or who transferred their right to choose to others. Many interviewees who had little choice during their care transition wished to have a chance to exercise choice if they could go back to the past. One of the Unsettled said that she remembered vividly the day that she came into the care home where she was living:

> *Two close people came and picked me up one day and said 'come along, you are coming with us', and they brought me here. And that's all I remember. I had no choice (Clara, 92).*

Choice has an intrinsic value in itself

Active Planners and Shelter Seekers firmly believed that their exercise of choice yielded a heightened sense of autonomy and the feeling of being in control. However, it was difficult to see that the sense of autonomy and control that the older people gained came from having a 'genuine' choice in their residential care. Le Grand (2007) argues that choice contributes to the fulfilment of autonomy, which arises from the 'capacity to choose alternatives' (p. 43) that allows users to switch between different service providers. However, considering that Active Planners and Shelter Seekers were only able to choose a home that was located in their local area and explored only a maximum of five homes in most cases, it would be difficult to say that the enhancement of autonomy came from the availability of alternatives. In addition, older people had not thought of the possibility of moving into another home after the initial move and thought that the relocation to another care home could be stressful and would have some negative health effects. Hirschman's (1970) idea of 'exit' from the service remained as an unfeasible option for the older people who were interviewed.

Rather, the sense of autonomy that they gained was closer to the sociological interpretation of it, based on Giddens' (1991) idea of authoring a self-biography. It is a broader interpretation of choice and the fulfilment of the principle of autonomy and it remained important even after the move to a care home. In this context, the satisfaction comes directly from the expression of personal thoughts and preferences itself. This perspective explains well the experiences of Active Planners and Shelter Seekers. An Active Planner, while she was talking about her life in a care home, firmly said that:

> *You are not like an 11 years old. You have your own thoughts and ideas. Someone can advise me to do something that I don't believe in, but I won't do it. 'Cause I have my own private opinion (Claire, 80).*

It was found that having the sense of autonomy and control helped Active Planners and Shelter Seekers to have greater satisfaction with their move to a care home, compared to Conformists and the Unsettled. This finding was in accord with Perry 6's (2002) argument that enhanced choice leads to greater user satisfaction and well-being. It was also found that Active Planners and Shelter Seekers were also more satisfied with their life in a care home as well as with their move itself, implying that having the sense of self affected older people's life even after the move. It seemed that, to a certain extent, choice has the power to make people content with their decision simply by exercising it, although it was found that there were several other elements that also contributed to older people's satisfaction with living in a care home – the most notable ones include the perceived quality of services, peer support and informal care.

The choices they made during the care transition were some of the most important decisions in their life and, therefore, the involvement of older people (Active Planners and Shelter Seekers) was meaningful in itself. Older people referred to their past experiences of making

decisions (e.g. the ones over their jobs and marriage) and interpreted their exercise of choice in the care transition in the same context. This finding is consistent with the contention that, for many people, choice has an intrinsic value in itself (OFT 2005, Dowding and John 2007). It is often said that people do not want choice, but good quality public services (see Needham 2007), but an overwhelming majority of the older people who took part in the research were proponents of choice and valued the sense of autonomy and control, with those who were least involved in choice making wishing they could have had more choice if they could go back to the past and those who were actively involved in decision making being satisfied with their exercise of choice.

The scope of choice

The older people who participated in this study strongly felt that it was important to have choice in public services, including health care, education and social care. However, the interviews with older people revealed that their understanding of choice was different from that employed in the relevant policy and the literature. Whereas the concept of 'choice' in the policy and the literature often denotes the choice of a provider that induces competition between providers, older people's understanding of choice was wider and more fundamental. Rather than simply having a choice of provider, they valued their involvement in important events in their life by expressing their preferences. They thought they 'exercised choice' when they had this fundamental sense of autonomy secured. A similar view was put forward by the House of Commons Public Administration Select Committee (2005), which reported on the Direct Payment users' valuing the feeling of being in control of their lives and recognised choice of provider as one of the many types of user choice.

The belief in people's desire to have more choice has always been the rationale for introducing choice in public services (see Clarke *et al* 2007; Le Grand 2007; Needham 2007). However, the older people's interpretation of choice was different from that used in the policy and this implies the need to understand the concept of choice in a wider context from the policy design. After all, the traumatic experiences of the Unsettled also stemmed from the limited scope of the choices allowed to them, which prevented them from having a sense of autonomy.

Preparedness

Being and feeling prepared for living in a care home was another important benefit that was attached to older people's exercise of choice. During the care transition, preparation for care home life was made possible through the active exploration of different care homes and through information gathering. Active Planners, who were able to exercise choice during the care transition, felt that they gained both practical benefits (smooth adaptation) and psychological benefits (being psychologically prepared for the move) that enabled them to prepare for the move and for the care home life during the transition period. This would be a service specific benefit that can only be experienced by users of residential care. The benefits were not gained as a result of choice making, but were earned during the course of the exercise of choice, by gathering of hands-on information, sharing their thoughts and concerns, planning for their life in the care home, and giving a proper farewell to their pets, possessions and the place they lived.

First, Active Planners' taking of trial options enabled them to familiarise themselves with the atmosphere, layout and features of the care homes they considered moving into. An Active

Planner who had a month's trial period stressed the role of trial options in adapting by saying that 'understanding the home is very much important' (Brian, 71). They felt they had a clear advantage in adapting to the new living environment and they tended to be more lively and optimistic in a care home than those who did not have a chance to take a trial option. This was the most practical benefit of exercising choice during the care transition, as found in the story of another Active Planner:

> *There's nothing I didn't expect. I'd like to advise people to come and have a look around and be prepared to adapt and also, yes, with people you've got to be prepared to be friends with everybody. You have to get used to the very different time of life (Mary, 81).*

Most other Active Planners also explained how their experiences of trial options played a decisive role in their actual choice making. Besides getting information on the meal times, bed times, available services and facilities and other rules of care homes, Active Planners were even able to estimate roughly their daily contact time with the staff and whether the home was under-staffed or not within a week or two of their trial period. With a lack of prior exploration, it is not surprising that the Unsettled kept saying 'I didn't know what to expect' or talked about 'embarrassing services'. The differences in adapting between Active Planners and the Unsettled were amplified by the fact that Active Planners tended to explore more options, for longer periods of time.

More fundamentally, taking trial options also acted as a way of testing whether one can cope with the communal living and sharing facilities. The most difficult thing that Conformists and the Unsettled found was related to the nature of communal living.. Slightly less than half of the Active Planners had a trial period and they said they questioned themselves at least once whether the care home environment would suit them. Some Active Planners recalled their past experiences of communal living, for instance, as a nurse or a member of the army, and

they were able to imagine themselves living in a care home quite easily. An Active Planner said she looked back on her past experience as a nurse when she first came for a short stay:

> *I used to live and work in hospitals for many years and it was something similar. You have your room and you go to work and here you don't have to go out on your own for work but here you go for lunch and for things in the sitting room and then come into your room. (Vivian, 76).*

Conversation with the existing residents also helped Active Planners make up their mind. Eventually, those Active Planners were able to build confidence in their decision. In this context, one of the possible reasons for the absence of Unsettled Active Planners could be their ending up making a choice to remain in the community instead of moving into a care home.

Second, Active Planners had a chance to consult with others about the move, which not only helped them to collect information but also helped them to be psychologically and emotionally prepared for the move. It was also found that Active Planners spent more time talking to people around them about the move than older people in the three other groups. On average, there were 2.4 more people (3.8 people) involved in Active Planners' care transition compared to the three other groups. Active Planners discussed their move with various people, including their family, neighbours, friends, church members, and formal colleagues. Through conversation with someone close to them, Active Planners had a chance to unleash their anxiety or their worries about the move. Active Planners said 'it was truly a relief' (Mary, 81) that there was someone close to them who listened to them and reassured them about the choice they were going to make. This was contrary to the experiences of the Unsettled and Shelter Seekers who felt they could not have any say during the care transition or who thought there was no one they could talk to.

The people Active Planners talked to also included those who had some knowledge and indirect or direct experiences of residential care. In other words, Active Planners were able to meet those who could give practical advice to them and understand their position as a service user and a potential resident.

Next, Active Planners were able to plan their life after the move to a care home and to learn the way to maintain continuity in the care home. The preparation for the care home life was possible through learning the features of care homes and through conversation with other residents during the exploration.

There were certain things that Active Planners wanted to do in a care home and they varied from knitting to reading:

> *I read a lot, because when I was working, I had no time to read. [I was] So tired at the end of the day. I brought a lot of books with me. Now I can sit and read as much as I like (Rose, 68).*

An Active Planner asked her daughter who visits her regularly to iron the pieces she had finished knitting. She said she let her daughter know her favourite shop for buying knitting materials before she moved so that her daughter could help her to continue knitting, just as she had done before the move:

> *I've done all these. I've done the three daughters' and now I do these little ones for the grandchildren. I love doing them. My daughter has been a great help, she takes them every weekend and comes back with them all nicely ironed (Elizabeth, 80).*

A few Active Planners made a list of the things they needed in order to maintain their sense of continuity and to do the things they would like to do after the move. The sense of continuity was even pursued in teas of their favourite brands and the CDs or the DVDs they were

collecting. ‘That small thing makes a lot of difference’, said Elisabeth, an Active Planner. The role of previous networks was important in securing older people’s sense of continuity. For example, one Active Planner, who had been a member of the Church of England for a long time, was collecting CDs that contained recordings of cathedral choirs. He listened to the CDs every day and sometimes asked others to bring him new CDs that came out when other members of the church visited him.

Not surprisingly, the degree of boredom experienced by Active Planners and the other three groups was inherently different. The boredom experienced by Active Planners was often described as the remaining time even after they did the things they had planned to do or wanted to do in the care home. The other three groups expressed the idea that they were at a loss what to do from the first. This is well shown in what was said by a Conformist:

> *What can we do, really? I suppose that is one of the big problems, you know, we don’t know what to do with ourselves (Jill, 87).*

Active Planners on average took more personal belongings that were meaningful to them. As the care transition was not a hurried and unplanned one, they were able to choose carefully the personal belongings they would like to take with them and they made an enquiry to the care home they were moving into about whether certain big items (especially furniture) could be carried with them. These personal belongings, such as chests of drawers, chairs and tea tables gave Active Planners a greater sense of continuity with the past.

Lastly, most Active Planners had some time to say farewell to the place where they lived, to their pets and to the things they were familiar with. Although it was often not possible for them to choose a date to move in due to vacancy matters, they had a longer period of exploration and thus had the time to look around the house and sort things out before the

move. Most of them were not home-owners[20] (as the value of their capital was below £23,500 and thus they had been receiving local authority help to pay for their care), but a majority of them were living in the same flat (or house) for many years, often for decades. It was thus important for them to have their own 'ritual' (Vivian, 76) to say goodbye to the place.

Taking some clothes and photos to a care home was regarded as essential by the all the interviewees, but Active Planners spent more time than the other three groups sorting things out one by one. They had a chance to bid farewell to things that were of great sentimental value to them. In doing so, some of them donated their household goods to charity organisations they had been supporting. Tableware, ornaments, accessories, books and clothes were the most common among the donated items. Some valuable items, such as necklaces and bracelets, were also given to their family, relatives and friends who helped them during the care transition.

For those who had pets before the move, one of the most important things for them was to find a new home for their pets. The proportion of those who lived alone was high among the sample (and, in fact, among the whole population of care home residents across the UK) and they often raised pets as company. Care home policies on pets varied, as a couple of care homes allowed residents to take cats with them, but not dogs, but taking pets was not allowed in the majority of the ten care homes that the researcher visited. As pets were regarded as part of their family, Active Planners who had pets said they were particularly concerned about finding them a new home and they said that they were very prudent in doing so. It gave them 'peace of mind' (Sue, 86) that they had found a good home for their pets.

[20] Exceptional cases: some interviewees lived with their partner in the community and moved into a care home alone

After the sorting out of their personal belongings and finding a new home for their pets, those Active Planners were better able to realise that they were really moving into a care home. There was a look backwards on their past life as well. There was a psychological departure from their old home and those Active Planners were more prepared emotionally for the move.

Shelter Seekers and preparation

So far, the association between choice and being prepared for the move into a care home has only been demonstrated by the Active Planners' experiences, without mentioning the 'Shelter Seekers' who also had some choice, indeed, more choice than Conformists or the Unsettled, during the transition. This was because Shelter Seekers were only partly prepared for the move. Shelter Seekers were better prepared to live in a care home than were Conformists or the Unsettled, but there was not enough time for them to explore and be thoroughly prepared for the move. The nature of the decision was urgent and swift and the information on care homes was acquired only by the social workers who contacted them. The information they had was thus limited to the necessary administrative procedures and the practical part of living in a care home, mainly the description of the services provided in care homes. Considering that, for the other three groups, the discussion on the care home entrance mostly started within the family, Shelter Seekers with family problems did not have the chance to exchange their thoughts or to share their own feelings and emotions with other people before the move. In fact, it would be more accurate to say that the discussion and the sharing of feelings were not as important for the Shelter Seekers as for the three other groups. The decision to move in was made as part of the continuum of desperate attempts to escape from the reality they faced. Thoughts of possible maladaptation in a care home were a luxury for these Shelter Seekers.

Acceptable service quality

The effects of choice in public services have often been explained in terms of the promotion of quality, efficiency and responsiveness, as well as the enhancement of autonomy (which was dealt with in the previous section) and of equity (which has been much debated) (Le Grand 2007; Greve 2010; Clarke *et al* 2007). The potential of choice in bringing about improvements in service quality in a more responsive and an efficient way has also been a major driving force behind choice-related reforms. Did the exercise of choice lead to the interviewees' receipt of better quality, more efficient or more responsive services?

It was striking to find that there was little sign of older people who exercised choice necessarily ending up with a provider who could meet their specific needs better (responsiveness), who were committed to innovation, who provided better quality or cost-effective care service, compared to those who had little or no choice. Older people who were interviewed for this research often mentioned that they looked for 'acceptable' service quality, instead of 'good' or 'better' quality of care, and hardly related the aim of choice making to finding better quality homes.

Despite their being satisfied with their choice, their exercise of choice did not necessarily result in higher quality or more efficient care (as externally judged by the Care Quality Commission). Active Planners were more likely than the rest of the interviewees to end up in a home which was judged by the CQC to provide excellent quality care; and most Active Planners moved into a home which provided good or excellent quality care. Nevertheless, some Active Planners ended up living in a care home which provided lower quality services (judged by the CQC as providing adequate quality care) than the average at prices which were

similar to or higher than the average weekly charge for the interviewees. Furthermore, some Active Planners ended up in a home which belonged to a service category that was not related to their needs (e.g. older people with physical disability ending up in a home for those with sensory impairment) and did not receive care that was more responsive to their needs than those who did not exercise choice. In other words, some Conformists and some of the Unsettled lived in care homes which provided better quality services at a cheaper price than the homes chosen by a few of the Active Planners.

There were four main reasons why some Active Planners, the choosers, merely ended up in a home of an acceptable standard, but still remaining satisfied with their choice. The four reasons will be explored in turn.

Process outcomes

First, it was often the case that the interviewees, including Active Planners, did not know what to look for in order to find a good quality care home. To put it another way, what they thought important was different from the criteria examined by the CQC. Almost all the elements they looked for were what have been named 'process outcomes'. It is about the process, about 'how it is done' rather than 'what is done'. Glendinning *et al* (2006) found that the process outcomes were so important for older people that they undermined the impact of other important outcomes relating to their well-being. What other Active Planners, and those who helped their care transition, often looked at was the cleanliness of the home they visited and the kindness that the staff showed during their visit, which could only be a one-off experience and might not be significantly relevant to the quality of the care provided in the

home. This finding implies that service users' expectations of the service may differ from those of professionals, academics or policy makers.

In fact, while the researcher was visiting one of the care homes in borough A, the manager of the care home told the staff to pay particular attention to the cleaning that day and asked them to put some ornaments in the lobby as there was a visitor coming to see the home soon. As Debra (83) put it,

> *What struck me was they were kind and the place was clean.*

The cleanliness of a care home was also the most frequently mentioned element that was looked for by the family, relatives, friends or neighbours who carried out the information collection for Conformists and the Unsettled. A daughter who helped her mother to move into a care home said that the care home she looked at seemed to be 'quite a nice place' (Jenny, 47), and the reasoning behind that was the cleanliness of the home.

As almost all the interviewees had to choose a care home within the same borough as where they lived, they looked for a home that they had seen before while walking down the street or driving by. In other words, many older people, even those who had a chance to exercise choice, often did not look for elements that would directly affect the quality of services provided in a care home. This finding conforms to the studies by Allen *et al* (1992) and Fotaki *et al* (2005), which showed that, in using residential care, older people often did not know what to look at and paid attention to the exterior of the care homes during their visit rather than the elements that would directly affect the services they would receive in the homes.

In the UK, the only reference that contains measured values of the quality of care home services is the CQC inspection rating (previously star-rating)[21] system. There are also inspection reports available for individual homes which allow service users a detailed comparison of different care homes. Nevertheless, the awareness of CQC star-rating and inspection reports was low among the interviewees across the four groups, as was found in the study by Fotaki *et al* (2005). Some Active Planners were aware of the CQC rating and reports, but did not know where to find the relevant information, as, in many cases, it could only be found online. The problems with the way that information on care homes is distributed to older people will be discussed further below.

It was discovered that a couple of Active Planners ended up living in a care home which rated 1-star (denoting a care home that provides adequate quality care) and a further three Active Planners ended up in a 2-star home (with good quality care). Those who chose to live in a 1-star or 2-star homes were not necessarily paying less than those who lived in 3-star homes. This means that the exercise of choice did not necessarily lead to the use of more efficient (value for money) service or cost-reduction. One would not expect all Active Planners to live in a 3-star care home (with excellent quality care), but 1-star is lower than the average (2-star) of the all care homes which participated in the research.

When choosing a care home, there was also a lack of attention paid to individuals' specific needs. For example, some Active Planners said that attending Sunday services was important

[21] At the time of the interviews, the CQC star-rating system was in use to measure the quality of care provided in residential and nursing homes across the UK. The number of stars means: 0 star = poor, 1 star = adequate, 2 stars = good, 3 stars = excellent. The star-rating system was discontinued and the CQC consulted on the planned changes in their rating system between April-June 2014. There is now a new inspection rating system in place, which looks at five inspection areas about the quality of care (whether the care is provided in the manner that is safe, effective, caring, well-led and responsive to residents' needs). The new inspection ratings are awarded on a four-point scale: outstanding, good, requires improvement or inadequate.

to them, but they moved into a home where the need for religious support (e.g. prayer room, visiting priests) could not be fulfilled. They said that they did not particularly look for homes which provided religious support and thought the quality of the home they chose was acceptable or good enough for them. It was found that there was a focus on the exterior of a care home as discussed above, for instance, the size of the garden.

Also, it was often the case that Active Planners chose a care home which did not necessarily offer specialised care for their care needs. Care homes in the UK have registered care categories depending on the type of specialised care they offer to older people. For instance, some care homes provided specialised care for those with hearing difficulties or visual impairment, some care homes specialised in dementia and mental illness, and some care homes specialised in caring for older people who have general difficulties with coping in daily life. Most Active Planners, not to mention Conformists, the Unsettled and Shelter Seekers, were not aware of the category of the care home they were living in and did not consider the speciality of the care home when they made their choice of a home.

Low expectations of the quality of care

The second reason concerned the interviewees' expectations about residential care prior to the move. Most Active Planners did not particularly look for a care home of superior quality because their initial expectations about the quality of residential care were low. Even those Active Planners who ended up living in 1-star care home were able to be satisfied for the same reason. Older people's accounts hinted that their expectations about the service influenced their acceptance of the actual service quality. Considering this, older people's having low expectations can be interpreted as 'institutionalised thinking' based on an ageist

perspective (Bowers *et al* 2009), which sees old age as a period of decline and loss and legitimates low quality service for older people. Older people's experiences of having low expectations about the services they were entitled to or accepting less favourable services could be found in many other studies (see Glendinning *et al* 2008; Age Concern and BIHR 2009; CPA 2009).

The interviewees' low expectations were also influenced by the media, which reported some of the worst cases of mistreatment which happened in care homes. Their negative perception of residential care was also formed by conversations with other people of a similar age while they were living in the community. There were some older people, particularly those who had visited their family, friends or relatives who were living in a care home, who had some idea of what it was truly like to live in a care home. However, most of the interviewees had a vague fear of living in a care home, as found by the Joseph Rowntree Foundation (2004). This is clearly shown in what Chris (75) said. He said he was satisfied with the care home he was living in, but he had a negative perception of residential care:

> *I think, on the whole, care homes are horrible.*

The Active Planners' remarks on the negative image of care homes also carried overtones that the care homes they were living in were different from others. An Active Planner who was living in a care home which was rated 1-star in the last CQC inspection said that:

> *There are homes closing because of ill treatment and I've heard awful stories about some of the homes. But this is not a typical care home, you see, not that typical. I think I was very lucky (Rose, 68).*

The negative perceptions of care homes helped them to justify their choice and those who made a choice were relieved that they were living in a care home which was providing

reasonable services from their viewpoint. Nevertheless, among the interviewees in other groups, the vague unspoken fear of mistreatment existed in their minds, at least during the early stage of the transition when they did not know much about individual care homes.

Likewise, Shelter Seekers did not expect to live in a care home that provided services of a high standard. However, the context of Shelter Seekers' having low expectations was different from the others. Shelter Seekers thought that moving into any care home would be better for their security and well-being than staying in their own home.

The lack of local residential places and financial limits

The third reason why the choosers ended up living in a home that provides 'acceptable' quality care (but still feel satisfied) relates to financial considerations and the lack of local residential places. An Active Planner talked about why she did not particularly look for a good quality home as below:

> *I think most people who have decided to come into a care home are so pleased to get into one, you know, they don't mind at all [which home they were moving into]. It's very difficult to find a place. (Joanna, 87).*

In some cases, Active Planners looked for elements that would affect the quality of the services provided in a care home, but they had to disregard these elements at the decision making stage due to practical considerations relating to their needs. In those cases, better quality care homes were not necessarily better homes in terms of meeting their needs. The story of an Active Planner who ended up living in a 1-star home is introduced below. In her case, the provision of local authority-funded residential care was based on the types of services available at the time of the move and her complex needs were not taken into account.

An Active Planner, Jennifer, who had previously lived in an area where there was a lack of residential places, recalled that she had to choose a home based on only one criterion. She was living in a care home that was rated 1-star. She told the researcher that she chose the home not because it provided particularly better care and services than other homes. She carefully planned the move and looked into three different care homes. There were two other homes that she had some information on, but the weekly fees of the two homes were too high and could not be covered fully by the local authority. While she was visiting the home she lived in with her daughter, she thought it was a home of an acceptable standard. Jennifer was in a wheelchair and she only moved into the home where she lived because it was the only home where there was a ground-floor room available. She was fully prepared to live in a care home and therefore she adapted fast to the new living environment and was satisfied with her life in a care home in general. However, she found that the degree to which the facilities were shared between residents was higher in the home she had chosen, compared to the two other homes she had visited during the exploration period. There was only one toilet facility per floor in the care home where she lived, as it was an old building, while some of the other homes she visited had two or more toilets on the floor on both sides of the corridor, with some even having en-suite rooms. Jennifer found that the cost of care was not any cheaper than the care homes with better facilities. She could not remember the difference between the weekly charges, but the weekly charge for her care was more expensive than the other care homes she looked at, although she was not paying the fee herself, as the care fee was fully paid by the local authority. She felt that her choice was limited and important elements that might affect the quality of care, other than the availability of a ground-floor room, had to be disregarded when she was making a choice. She thought that, as there were so few vacancies, it would have been better if she had been allowed to move into a care home in another London borough in which her daughter lived.

There were some other cases where older people had to make a compromise since they could not find a care home that fulfilled all the conditions that they thought important. As found in the study by Phillips and Davies (1990), most of the Active Planners, like the others who took part in the study, preferred small care homes, which could accommodate about 20-25 people. Nonetheless, several Active Planners ended up in a big care home with more than 40 (in one case, more than 120) residential places. These Active Planners had to decide where they were going to put their priorities. For example, an Active Planner who chose to live in a home with 65 other residents said that she chose privacy over a more family-like small care home:

> *I thought that this was the nicest one, as I could have a room to myself. In some of the places [I researched], they have two or three people to share a room but it doesn't work out very well, really… (Joanna, 87)*

Those Active Planners thought that they had made the best choice that was possible and said that they were satisfied with their choice. The elements that were believed to affect the quality of care (e.g. the CQC rating) were not always considered more important than the others in their own criteria. After all, the feeling of satisfaction was the subjective experience.

Limited access to information

Lastly, the way that relevant information was provided deterred older people from accessing good quality information on care homes. Most of the data which can inform older people's choices in residential care can primarily be - or only be - accessed through the internet, which older people were often found not to be familiar with.

Among the information that can be accessed via the internet is care home directories, CQC ratings, inspection reports and local authority policies and administrative procedures

regarding care home entrance. Some Active Planners said that they knew about the CQC but had not had a chance to read any inspection reports as they did not know how to find them. Almost all the interviewees preferred, and were more familiar with obtaining information, from hardcopies rather than from the web. Even their family, relatives and neighbours who helped the move to a care home did not know how to search for individual reports on the CQC website. A few Active Planners looked for hard copies, but they could not get hold of any printed copy of the inspection reports on the care homes they were interested in. A member of the CQC staff who was interviewed confirmed that there was no hard copy available except those displayed in care homes. According to the CQC regulations, a hard copy of their inspection report has to be displayed inside individual care homes (at a spot where they can easily be found) for the information of visitors. Nonetheless, there were several homes which participated in the research where there was no report displayed. The CQC staff member who was interviewed also said that more and more reports and information leaflets were uploaded online only and hardcopies were not readily available.

In the case of hard copies of local authority booklets on residential care, older people can formally request a hard copy, but few interviewees knew that they could contact the Social Services Department and ask them for a hard copy, a special copy with large letters or an audio guide on local authority funded residential care.

There are various online care home directories that are available and they provide a summary of each care home in the UK by region (e.g. carehome.co.uk), including the weekly fee, number of residents, registered care categories, specialisation, CQC star-rating, contact details and a web link to the recent inspection report. As most of the older people who participated in this research were not aware of the existence of the website itself and were not familiar with

using computers, online care home directories were not used by older people as a means to access information on care homes. Active Planners ended up looking for care homes that they had seen before, care homes recommended by others, or care homes that distributed advertising booklets. It was found during the visits to care homes that homes that were big and were part of a large chain of private care homes were good at providing booklets with colourful photos. Small homes, independently-run homes or local authority homes did not tend to distribute them. The role of the extra information provided by individual care homes was important for Active Planners, as they often decided to make a visit to a particular home after reading a booklet about the home. Having information on a particular home made them feel that they knew more about the home and this affected their choice of a home. A number of Active Planners emphasised the need to have good quality information made easily accessible.

Choice and identity: A chooser, but still a user

Consumption is often seen as closely related to one's identity formation, not just a way of fulfilling needs (Gabriel and Lang 2006). There has been a vigorous discussion on citizens' becoming consumers through the application of choice in public services (see Baldock and Ungerson 1994, 1996; Baldock 2003; Scourfield 2007; Clarke 2007; Clarke *et al* 2007; Simmons *et al* 2009). It was debated whether and how the move from a more collective provision of social care towards the one emphasising individual choice (Baldock and Evers 1991) affected the notion of citizenship and users' perception of their identity (i.e. whether they define themselves as choice-exercising consumers) (Clarke 2007). In order to capture the changing expectations of users' experiences and of their attitudes and the behaviour, the term 'citizen-consumer' has been introduced (Needham 2003; Clarke *et al* 2007).

Social care is the area where both the users and relevant professionals (frontline staff) have welcomed the prospect of more choice and believed in choice as a way of improving the service the most (Clarke *et al* 2007). The concept of choice was often discussed in the context of consumerism and the link between social care and consumerism has often been made in the literature. Yet it was found that even the 'choosers' in the research sample, Active Planners and Shelter Seekers, primarily recognised themselves as users of public services. For the older people who participated in this research, having choice did not mean becoming a consumer or a customer, as found in the study by Clarke *et al* (2007). As Baldock and Ungerson (1996) found, it was not the case that users' values and expectations about the use of care change at the same speed as the policy change. In order to bridge the gap between policy and the actual user experience, there seems to be a need to understand the context of users' exercise of choice in order to better accommodate their needs.

Looking into the interviewees' experiences in detail, Shelter Seekers had a unique reason to believe that their foremost identity was a public service user. Their transition to residential care was often initiated and arranged by social workers who had the clear intention to protect them from hostile environments which were threatening their well-being. Shelter Seekers clearly made a choice themselves to move into a specific care home, but they felt that they were receiving public services; services which were offered by the local authority.

Active Planners also identified themselves primarily as public service users, just as did Conformists or the Unsettled who had limited choice during the care transition. Their identity as public service users mainly came from the way their residential care was financed and their perception of the 'right to welfare' gained during their working life. These Active Planners linked their experiences with the 'rights of citizenship', as did a respondent in Clarke *et al*

(2007, p. 129). Some Active Planners, who worked throughout their lives, took the view that they had earned the right to receive residential care by paying tax and National Insurance contributions, despite the fact that publicly-funded residential care is provided on the basis of both their means and their care needs, regardless of their employment history:

> *When you have paid in all your life, you're entitled to it. I say to people, 'it's not a gift, it's something you worked for. That's why we got deducted wages. It comes out of your National Insurance.' (Sue, 86)*

This view was close to 'welfarist' approaches identified by Baldock and Ungerson (1996), which were centred around the ideas of citizenship and welfare rights, although the Active Planners did not explicitly identify themselves as 'citizens' as Clarke *et al* (2007) found. Some may think that the concept of citizenship is at odds with the concept of choice, but, for most of the interviewees of this research, choice was not understood as part of the market mechanism.

For Active Planners, the fact that the cost towards their residential care was paid mostly or fully by the local authorities based on the financial and needs assessment made them feel that they were using public services, although they were living in a privately-run residential home. Moreover, the state benefits they used to receive were discontinued and the amount they used to receive was diverted to cover part of the fees for their residential care. These include both social security benefits (e.g. Housing Benefit, Disability Living Allowance, Income Support, Pension Credit) and social insurance benefits (e.g. the Basic State Pension). This made them feel that the services and state benefits they received were being replaced by residential care.

There were even some Active Planners who linked the public service ethos to their care, raising concerns about key characteristics of public services being undermined (see Baldock

2003 for discussion on ‘the declining publicness of public services’). Some Active Planners believed that care homes, as they thought they provided public services, should not prioritise profit over the quality of services. An Active Planner pointed to the lack of care home staff in the home she was living in. She said that she heard from her son that the reason for the lack of staff was related to financial considerations and said that care homes ‘should not simply make money for themselves’ (Elizabeth, 80).

Active Planners and Shelter Seekers, as well as Conformists and the Unsettled, did not know much about the detailed financial arrangements for their own care and about the contract between the local authority and the care home they were living in. They said they had never received any report about the financial arrangements over their care and that all the money they had before they moved in, although the amount was small, was managed by their family (mainly their daughters) and their relatives. Despite the sense of autonomy they gained through making choices during the care transition, the lack of information on these financial arrangements sometimes made them feel that they did not have ‘the power to do the steering’ (Debra, 83).

Active Planners tended to recognise the traits of being a chooser better than Shelter Seekers and thus they more strongly considered themselves to be choosers. However, the meaning of having choice was about individuals’ having the freedom to plan and exercise choice over important matters in their life, according to their perceptions and preferences. Again, this implies that the concept of choice needs to be interpreted in a broader context to reflect users’ needs and expectations. Many Active Planners also found the term ‘consumer’ or ‘customer’ unfamiliar when they are used in relation to public services. At best, they interpreted the term ‘consumer’ in the broader sense of consuming good and services and, as was argued by

Clarke *et al* (2007, p. 138), the term 'consumer' failed to represent 'popular and organisational imaginations':

> *What do you mean by that? I mean, I live here, well looked after, it's a kind of using services, isn't it? Is that what you mean? (Claire, 80)*

Over three quarter of the older people interviewed thought that when there is any serious problem with the services in the care home, the first port of call for seeking help would be their family or the social workers who helped them during their care transition (particularly in case of Shelter Seekers), rather than making a complaint directly to the staff or the manager of the care home or moving elsewhere. There was a gap between the interviewees' experiences and the attitude and behaviour that is expected of users as consumers and customers of care.

The views of care home managers and social workers

Interestingly enough, the identity of the older people who moved into a residential home was interpreted differently by the other actors who were involved in the care transition. The older people who were interviewed, whether or not they had any choice, identified themselves as residents. 'A resident' was also the identity that was the second most prominent one among Active Planners and Shelter Seekers. This contrasts with some care home managers' recognition of their residents as customers. Four of the seven care home managers who were interviewed, particularly those who were in charge of privately-owned care homes or homes which were part of a large chain of care homes, directly referred to their residents as customers. They were well aware of the fact that, in publicly-funded residential care, money follows the resident, just as in the case of self-funders (although the amount of weekly fee was lower for local authority residents than for self-funders). It was remarkable that providers in the private sector were the first to see public service users as having a consumerist identity.

Considering that older people are often seen as being in the process of decline on the basis of a medical model, the care home managers' view of older people as customers was a fresh recognition.

Meanwhile, the social workers in the Social Services Departments who were interviewed had a different view. They recognised all care home residents as users and recipients of public services rather than as consumers or choosers, as Clarke *et al* (2007) also found. Despite the emphasis on choice in residential care policies, the identity of older people using local authority funded residential care still remained unchanged.

Among the social workers interviewed, there was also a reluctance to accept and/or adapt to consumerist approaches regarding the service provision, as reported in other studies (Clarke *et al* 2007; Scourfield 2007). All but one of the social workers interviewed said that choice in residential care is only an ideal and a mere 'policy gesture' (Lisa, Borough A) due to budget constraints and the lack of residential places in London. The social workers who were interviewed stressed that the budget for residential care had become tighter in recent years. There is another burden on their shoulders due to the introduction of the new requirement to reduce the spending on residential care in order to make sure that no more than 40% of the adult social care budget is spent on residential care (CSCI 2009 cited in Land and Himmelweit 2010). They also said that in some parts of London where the running cost and the cost of land are high, the number of homes was small and the number of beds was never sufficient to match the number of people needing residential care.

The separation of funding and provision of social services meant that social workers are supposed to act as enablers and facilitators who support users' choice. However, they thought

that older people often lacked information and that the social workers' help and guidance during the process of care transition was essential. They thought that the application of the choice policy made it difficult for them to give advice to older people who had seemingly made a 'wrong' choice to move into a care home that provided low quality services. Expressions that implied the passivity of service users were often used by the social workers, such as care home 'placement' or 'recipients'.

As mentioned in Chapter 5, it was found that some boroughs made a block contract with some care homes (homes that provided 'decent' care in their view) and included these homes when they informed people of a few (usually between 2-3) available options. A majority of the block contract homes received a three-star rating from the CQC on their last inspection. In that way, the local authorities were able to save some money by paying deducted flat-rate care fees (block-contract rate) and were able to ensure that older people in their boroughs received reasonably good quality care. Unless older people were Active Planners themselves or had an active family member who explored many different care homes, there was a high chance of older people choosing to move into one of the few homes suggested by social workers. Slightly over a quarter of the forty-eight interviewees were living in a block contract home. Social workers admitted that block contracting could limit user choice, but thought that it was a good way of providing a safe option (which was 'filtered' by local authorities) for older people.

Conclusions

The interviews with older people in this study revealed the present state of the working of choice in residential care for older people. The needs of older people who participated in this

study were different from other groups of service users and this affected their exercise of choice. Their experiences of choice illustrated some of the fundamental benefits of having choice and positive traits of residential care, but did not show signs of the expected effects of choice discussed in the relevant policy and the literature. Older people's understanding and utilisation of choice was based on their belief in their right to choose as a public service user and a citizen, rather than as a consumer or a customer, and this highlights that there might be a gap between policy and residential care users' expectations.

Older people's experiences of care transition challenged some important arguments put forward by structured dependency theorists, which has provided a key perspective of critical gerontology. Many older people who were interviewed for this research showed that the acceptance of dependence could take place in a positive manner, which led to their exercise of choice. Furthermore, the receipt of residential care helped them to regain a sense of independence, which they lost as their needs increased, in a more manageable environment. As has been discussed in the previous chapters, older people's experiences suggests that care homes can be places that enhance their sense of well-being and this adds to the literature on the positive roles of a care home (Victor 2005; Johnson *et al* 2009; OFT 2005). While it is difficult to deny that social processes such as the imposition of early retirement and the legitimation of low income in old age have brought the decline of financial position of older people, it is doubtful whether residential care should also be recognised necessarily as an element that contributes to the creation and the enforcement of dependency in older people.

Older people often related their exercise of choice to positive experiences of adaptation and of the care home life. Contrary to Hunter's (2009) argument that choice is a middle class obsession, findings from the research suggest that choice is a symbol of autonomy and

control that all the interviewees desired and longed for. Regardless of the level of choice that they exercised, the interviewees expressed a desire and a will to exercise choice in residential care that was strong enough to challenge the argument emphasising older people's passivity and dislike for choice in public services.

However, it was found that the sense of autonomy that older people experienced did not come from having any real alternative service options, as Le Grand (2007) argued, since practical alternatives to residential care were hardly available and were not even considered by many interviewees. The enhanced sense of autonomy originated from the fundamental sense of well-being and satisfaction coming from having the right to choose itself, as Schwartz (2004) suggests. The sense of autonomy that older people gained could also be understood in the wider context of Giddens' (1991) idea of 'authoring a self-biography'.

Similarly, older people recognised themselves as a service user or a citizen and did not particularly link their experiences of choice making to consumerist identities, as found in the study by Clarke *et al* (2007). Local authority officials played the role of gatekeepers and the older people who participated in this research were clearly aware of the fact that their care was funded by the local authority. The state benefits that they used to receive in the past were automatically transferred to fund their residential care and were paid directly to the care homes from the local authority. Hence, some of the interviewees simply thought that there was a change in the services they received from the government and did not think about the concept of choice very much. The current system did not make the users feel like consumers. The social workers who participated in this study also stressed the practical difficulties in pursuing the choice policy and the confusion and the complication involved in defining their role and that of service users in social care. However, some care home managers of private

homes recognised publicly-funded residents primarily as customers. While it could be a way to recognise the potential for older people's being active and autonomous users, it could also make one consider the impact of consumerism on citizenship and public service ethos.

Another important benefit of choice was that it enabled older people to prepare for the move into a residential home and for the care home life after the move. Older people gained the sense of 'preparedness' through collecting hands-on information about individual homes, sharing their feelings and thoughts with other people around them, and giving a farewell to their pets, possessions and the place they lived.

Nevertheless, the interviewees felt that they did not gain other benefits of choice which were dealt with in the literature, including efficiency, responsiveness and quality improvement in relation to service provision (Le Grand 2007; OFT 2005). It was found that older people's exercise of choice did not necessarily result in their receiving better quality, more cost-effective or more responsive service. Those who exercised choice found a care home which they thought provided a reasonable quality care and verified their initial choice by taking trial options (e.g. visits or temporary stays). However, it was difficult to say that they made the best possible choice out of their resources in terms of meeting their needs effectively and efficiently.

There were several reasons for choosers' (Active Planners) not gaining the expected benefits of choice. Older people had low expectations of the services they were entitled to and even those who ended up in low-rated homes found it satisfying overall to live in the home they had chosen. Their low expectations could have been created and fuelled by the media and the perspectives that legitimate less favourable treatment of older people. Some older people had

to compromise on some important elements that could affect the quality of care due to the lack of vacancies and financial limits set by the local authority. Often, the elements that older people valued were easily changeable and were not directly related to the quality of service. The interviewees were not properly informed of what to look for and this draws attention to the importance of information provision for users. Their experiences suggested that they made their choice using their own criteria and that what was considered important for constituting good care in policy and practice might not bring them the sense of satisfaction.

Having explored the meaning and the effects of choice in residential care, it seems that, the application of choice in residential care was significantly affected by limitations in policy and practice which made it difficult to bring about the expected benefits of choice. The users' needs and their interpretation of choice were different from the ones the relevant policy entails. In order to empower users and provide person-centred services, it would have to be ensured that the user experience of choice in residential care is used to inform future policy decisions.

Chapter 7. Choice and a Positive Care Transition

Choice has been referred to in the literature as an important element that helps older people ease the impact of care transition and contributes to their positive transition experience. Yet, there are few studies on how choice works to help shape positive care transition experiences.

Moving on from the discussion of the meaning and the impact of choice discussed in Chapter 6, this chapter examines the role of choice in older people's care transition experiences. It identifies elements that shape positive transition experiences and explores the scope for a positive care transition. Whether the older people experienced a 'positive transition' and whether they 'adapted' successfully were self-reported by older people. It then discusses the role of choice in facilitating a positive transition[22] by examining how the concept of choice is related to the elements of a positive care transition.

The elements of a positive care transition

In order to discuss the role of choice in a positive transition, this chapter begins with the exploration of elements that constituted a positive care transition. There have been attempts to identify elements that helped older people to experience less stressful move into a care home. There are two studies (Nolan *et al* 1996 and Chenitz 1983) which explored elements that influenced older people's perception of, and adjustment to, care home life. Although the studies only looked at part of the period of care transition (the adjustment stage) and did not explore how the elements impact upon older people's experiences, the elements identified by

[22] As was explained in Chapter 1, 'positive transition' is defined as care transition that takes place in a way that reflects older people's desired choices, facilitates their adaptation to the new environment and enables them to maintain their sense of self and of autonomy.

the studies still provide some importance grounds for the working of choice in residential care. Chenitz (1983) identified four key elements that affected older people's perception of the move - desirability, legitimation, centrality and reversibility. Nolan *et al* (1996)'s study found continuity along with three of the four elements identified by Chenitz (1983) – desirability, legitimation and reversibility.

In this research, the analysis of the interview data found five elements which constituted a (self-reported) positive care transition (see Table 7.1). The elements included the voluntariness of transition, the exercise of informed choice, the recognition of continuity with the past, the potential for justification and the existence of active informal support.

Table 7.1. The elements that shaped a positive care transition

Element	
Voluntariness	Whether the move to a residential care home was something older people themselves desired (e.g. older people's agreement to the move or their initiation of it)
Informed choice	Whether the transition was properly informed and allowed opportunity to older people to explore available options and prepare for the move physically and emotionally
Continuity	Whether there was perceived continuity between the care home life and the life before moving into a care home
Justification	Whether the care transition could be justified by older people themselves in any way (e.g. older people's self-recognition of the need, perception of the move as necessary and inevitable)
Informal support	Whether there was informal support from the peer residents, volunteers' support or support from family, relatives and friends by visiting older people, advocating their needs, and doing a favour for them

Source: Author's own elaboration based on research findings.

Voluntariness is about whether older people had a desire and will to move into a care home and whether their desire was reflected in the move. *Informed choice* means the extent to

which older people were able to make decisions based on sufficient and appropriate information. *Continuity* is related to older people's maintaining the sense of continuity of life (continuity with the past) after moving into a care home. *Justification* denotes the extent to which older people can justify to themselves their move into the care home. *Informal support* encompasses support from volunteers and other residents living in the same home, and support from family, friends and relatives. The five elements played an important role in helping older people to experience a positive care transition.

There are similarities between the elements found in this study and the ones found by Chenitz and Nolan *et al* – one of the elements is named the same (i.e. continuity) and the interpretation of some other elements (e.g. justification or voluntariness) shared some similarities compared to the ones found in their studies. However, there were some important differences between the elements found in this study and the ones found in other studies and some of the elements found in this study (e.g. informal support) were entirely new. The differences might well come from the source of data used in each study. This study found the elements of a positive transition to residential care based on the accounts of older people, by placing the service users at the centre of the transition process. In contrast, the other studies figured out relevant elements indirectly by reviewing the literature (Nolan *et al* 1996) or by reflecting other actors' views onto the analysis as well as the older people's (Chenitz 1983). In addition, the elements found by Chenitz and Nolan *et al* were associated with the *nursing home* environment, not to the *residential home* environment, and were not related to the whole process of the care transition. It is discussed below in detail how each of the five elements contributes to older people's experiences of positive care transition and how they differ from the elements of a positive transition found in other studies.

Voluntariness

Voluntariness was about reflecting older people's desire to initiate the care transition and was related to the matter of whether the move into a care home was made according to, or against, their wish. The element of voluntariness was also partly linked to the concept of 'desirability' identified by Chenitz (1983) and Nolan *et al* (1996), which encompassed the perceived desirability and the subsequent older people's participation in making the move. However, it differs from the concept of desirability in that it embraces older people's desire for the move formed by their positive acceptance of need, whereas the move triggered by necessity, whether the need was accepted by older people or not, was excluded in the cases demonstrating desirability found by Chenitz (1983) and Nolan *et al* (1996).

The most obvious example that showed older people's voluntariness regarding their move into a care home would be their self-initiation of the move, following the self-recognition of their needs (Active Planners). A rather passive form of voluntariness could be found in cases where older people agreed to move in, following the acceptance of their needs (e.g. Conformists). Lack of voluntariness was most clearly shown in cases where older people had to move in against their wish (the cases of the Unsettled).

The degree of voluntariness older people experienced affected them throughout the period of care transition, particularly during the adaptation period. The lack of voluntariness in the move made older people less satisfied with the move and with the new living environment.

Different degrees of voluntariness were involved in the move of the four conceptual groups. Active Planners' move involved the highest degree of voluntariness and many Active

Planners provoked the care transition themselves. They enjoyed the highest level of satisfaction overall and had the least traumatic memory of moving into a home.

Shelter Seekers were another group of people who wished to come into a care home as much as Active Planners. Their move clearly involved a high degree of voluntariness, and, their level of satisfaction with living in a care home was high. There was a unique source of Shelter Seekers' satisfaction with the care home life, which came mostly from distancing themselves from the threats of physical/mental violence and insecurity. In other words, their satisfaction came from the elimination of the root cause that made them volunteer to move into the care home in the first place.

Conformists hardly initiated the transition to residential care themselves, but the final decision to come into a care home reflected their agreement to move into a home. Their adaptation took longer than Active Planners, but they were largely satisfied with the care home life.

The emotional turmoil caused by the lack of voluntariness was most visible among the Unsettled, who moved into a care home against their wish. Some of the Unsettled said that they suffered from feelings of depression after they made an undesired move into a home.

Informed choice

Choice means a lot to older people using the local authority-funded residential care, as discussed in Chapter 6, challenging Hunter's (2009) argument that choice is a middle class obsession. However, the analysis of the interview data hinted that informed choice played a

far more important role in facilitating a positive care transition than choice made without sufficient reliable information. It was found that choice (the exercise of the right to choose) gave older people the feeling of enhanced autonomy and sense of self, but informed choice offered them some practical benefits as well. The availability of reliable information was essential in making informed choices, as put forward by many scholars (Le Grand 2007; Greve 2010; Lent and Arend 2004) and the Wagner Report (HMSO 1988*a*) also emphasised the importance of informed choice.

Active Planners and Shelter Seekers said that they did not regret the decision to move into a specific care home. It showed that Schwartz's (2004) argument on buyers' remorse, the post-decision regret, was not applicable for the cases studied for this research. There were two possible reasons for the absence of buyers' remorse. First, those who exercised active choice were genuinely satisfied with their choice. In fact, most of the Active Planners and Shelter Seekers had clear practical reasons why they believed that they made the right choice and in what ways they benefitted from the move. Second, as explored in Chapter 6, it could be the case that older people valued having choice as a way of involving in making decisions about important life changes. Their accounts hinted that the importance older people attached to choosing a care home would be qualitatively different from the one involved in choosing a chocolate bar, tea, a jar of biscuits (Gu *et al* 2013) or jam (Iyengar and Lepper 2000), which were used in other studies to prove adverse effects of having too much choice.

It was found that those who had more comprehensive, good quality information tended to answer clearly that they would make the same choices again over their care arrangements as well as having no regrets about the move itself. Among the four groups, Active Planners were those who enjoyed the highest degree of informed choice and obtained more comprehensive

information on care homes than the three other groups. They used their personal network and trial options to collect relevant information and the information they collected from multiple sources helped them making choices more confidently. Active Planners' having confidence in their choices left them no room for hesitation to answer that they would make the same choices again, if they were placed in the same situation where they had to make choices over their move. The types of choices they referred to included most of the seven types of choice outlined in the analytical framework, including choice over whether to move in, when to move in and where to move in.

Unlike Active Planners, the utilisation of personal networks was not part of Shelter Seekers' information collection behaviour. Damaged or broken family relationships were usually the root cause of the problems Shelter Seekers suffered and the only reliable source of information for them was the social worker who found and/or contacted them. Shelter Seekers inevitably received screened information from social workers and the amount and the types of information given to Shelter Seekers varied between individuals. There were variations between boroughs in the amount and the types of information that Shelter Seekers could access as social workers played a role of the major information provider in addition to the role of a gate-keeper for the use of publicly-funded residential care.

The Conformists and the Unsettled lacked informed choice which in turn could have caused a lack of understanding of the care home life. Conformists spent time that was significantly longer than Active Planners to adapt to the care home life. All of the Conformists were affected by the lack of appropriate information. They did not suffer from having anxiety and worries as was the case of the Unsettled, partly because about half of the Conformists

voluntarily refused to exercise choice and partly because their move was at least agreed by Conformists themselves following their recognition of the need.

The care transition experiences of the Unsettled showed that the lack of informed choice affected them in a critical way in terms of adapting to the new living environments. On the one hand, the lack of choice itself made the Unsettled have dwindled sense of self and may have accounted for their lack of confidence and willingness to adapt to the care home life. Their experiences of having their choice rejected or neglected appeared to affect negatively their state of mind and their sense of self. On the other hand, the lack of information appeared to be related to their lack of understanding of residential care and caused practical difficulties in adapting to the care home environment. Thus, one of the things that were frequently talked about by the Unsettled was that they did not know much about a) the care home they were moving into, b) what to expect in the care home and c) the whole care transition process and arrangements.

Continuity

Having continuity of life was important in older people's perception of the care home life. Some older people who were interviewed for this research tended to judge the successfulness of their adaptation to the care home environment based on the degree of continuity they sensed during their care home life, by comparing their life in the care home and their life before coming into the care home.

Whether one was able to have the sense of continuity of life also affected their impression of the whole care transition process. Those who were able to maintain the sense of continuity in

key aspects of their life were confident that their care transition was made in a way that allowed them sufficient time for preparation and tended to think that living in a care home was a good and effective way of receiving the extra help they needed in order to continue to live their life in a meaningful way. The concept of continuity found in this research conforms to the notions of 'biographical continuity' and the 'continuity of self', which were put forward by Giddens (1991). The importance of having the sense of continuity has been also mentioned in other studies, including the studies by Nolan *et al* (1996), Allen *et al* (1992) and Reed and MacMillan (1994, cited in Nolan *et al* 1996).

This study found two types of continuity of life which were revealed in the interviewees' accounts: continuity regarding ways of life (how they live their life) and continuity regarding aspects of life (how they maintained certain important aspects of their life in the care home). Table 7.2 outlines the two types of continuity of life older people experienced and how each type of the continuity was maintained.

The interviewees felt that there was continuity in their way of living when they were able to maintain their sense of autonomy and their personal life styles in daily life. Regarding the continuity associated with ways of living, it was only Active Planners who had the continuity. Many of them were living alone before they moved into a care home and they were used to living an autonomous lifestyle. Their involvement in decision making process made them feel that they were still living a life in their own way. This type of continuity shared some similarities with the concept of 'centrality' put forward by Chenitz (1983), which stresses the importance of maintaining a sense of independence, autonomy and control in adjusting to the new care environment. However, the continuity of life found in this study did not entail the

sense of independence, as discussed in Chapter 6. There was no 'continuity' in terms of maintaining the same sense of independence they had in the past.

Table 7.2. Types of continuity of life older people experienced

Continuity of life	**Maintenance of continuity**
Continuity regarding ways of life	Maintaining autonomy in life Maintaining personal life style (e.g. continuing to live an active life or to enjoy spending time alone most of the time)
Continuity regarding aspects of life	Continuing to have the same hobbies Continuing to go to religious services Continuing to enjoy one's favourite food Continuing to collect books/CDs Maintaining good family relationships Maintaining personal network

Source: Author's own elaboration based on research findings.

Some of the interviewees were also content that their life style could be maintained in the care home. There were some Active Planners who enjoyed talking to other people and enjoyed going to activities sessions, but there were also some other Active Planners who preferred to spend time alone, knitting, reading books or listening to music. They valued their life not being significantly disturbed by care home routines. Most Active Planners thought that their personal characteristics were reflected in their life, as illustrated in the quotation below:

> *I am not really social. I meet people at lunch and that sort of thing. But everybody is different, aren't they? I don't play bridge, I don't play, you know, I'd much prefer to be in here, reading, and that sort of thing. You do what you like, you see? (Chris, 75)*

Conformists' experiences of continuity were different as a great majority of them showed behaviours of active adaptation. Many Conformists said that their aim in going to activities

sessions was not necessarily related to personal interest in the sessions but was about getting used to the care home life, meeting new people and adapting to the new environment. It was difficult to say that their adaptation strategy reflected their way of living.

Continuity of life regarding aspects of life was gained through older people's maintaining the same hobbies, regularly going to religious services as they did before the care transition, enjoying their favourite food (e.g. favourite type of tea or biscuits), and maintaining good relationships with those who belonged to their personal network. Active Planners were able to have the highest degree of continuity regarding different key aspects of life, as they had more time to prepare for the move and plan for their life in the care home. Many Active Planners brought the materials they needed to continue their hobbies. In this sense, bringing some important personal belongings also helped them to maintain the sense of continuity of life, as Cram and Paton (1993) found. Most of the older people interviewed considered it important to engage in hobbies continuously, confirming the finding by Gabriel and Bowling (2004) that engaging in hobbies was a crucial dimension of quality of life of older people.

Active Planners also received help from their family, relatives and friends in pursuing their continuity of life. There were even a couple of Active Planners who were able to attend Sunday services that took place in the church they used to attend. Their family and members of the church were coming to a care home in turn and helping them moving on a wheelchair. In other words, the sense of continuity was something that made Active Planners saying things such as:

> *I had a very similar private life before I came here. (Mary, 81)*

The type of continuity that Conformists had was mostly related to their aspects of life. Many Conformists were receiving informal support from their family, relatives and friends and maintained good relationships with them. There were even some Conformists whose relationship with their family was strengthened as a result of the move, particularly those who were regularly looked after by their family members and who experienced some crisis in caring. The experiences of both the Active Planners and the Conformists challenge the assumption made by disengagement theorists (see Cumming and Henry 1961) that old age is a distinct phase of life and that it is accompanied by needs and wishes which are necessarily different from the ones related to earlier stages of life.

Shelter Seekers and the Unsettled hardly had any continuity of their life. As most of the Unsettled were not content with their move nor admitted the need for residential care, they often did not have enough willingness to assimilate with the new living environment. Interviews with care home managers confirmed that some of the family members of the Unsettled residents found it difficult to see them being unhappy in the care home and seldom made visits to a care home. For Shelter Seekers, it was natural not to have any continuity of their life. Having no continuity in life was the source of Shelter Seekers' well-being.

Justification

Another important element that facilitated older people's positive care transition was the potential for justification of their move. It was found that there had to be a just cause for their move in order to help older people see their care transition as a positive one. Whether someone was able to justify their use of residential care was important for his/her emotional

stability and peace of mind after the move to a care home and, subsequently, for his/her attitude to the care home life and willingness to adapt.

The concept of justification resembles the concept of 'legitimation' which was captured by Chenitz and Nolan *et al* (1996) in that it relates to the process of finding a plausible reason for the move. Nevertheless, the process of justification was related to older people's exploring reasons for their care transition themselves, whereas legitimation was often sought from older people's family members and doctors who recommended the transition.

Each conceptual group justified their care transition experiences differently with the exception of the Unsettled who were unable to justify their move in any way. Table 7.3 summarises the four conceptual groups' scope for justification found in the stories of the interviewees.

Active Planners found it easier than the three other groups to justify their move to a residential home. They were able to enumerate the largest number of reasons among the four groups for their believing that their move was just.

The first and foremost reason that provided justification for Active Planners' move was their recognition of the need for extra care and security and the subsequent self-initiation of their move. Active Planners' exploration and their preparation for the care home life also helped them justify their use of residential care, making sure that they were living in a way that their continuity was maintained, in the environment that they expected and had information about. There was not a single Active Planner who made a direct connection between their exercise of choice and their justification behaviour (e.g. one's making justifications for the move

purely because it was his/her choice to move in). Almost all the Active Planners who were interviewed listed some practical reasons why they believed that their move to a care home was the right thing to do. Hence, there was no account which could imply cognitive dissonance (Festinger 1957) found in the stories of Active Planners, although there was a possibility that Active Planners' satisfaction with their exercise of choice and with the actual options they chose left a greater room for justification.

Table 7.3. Scope for justification for individual conceptual groups

Conceptual groups	Scope for justification
Active Planners	Recognition of the need for residential care, Self-initiated care transition, Continuity of life, Acceptable/good quality care home facilities and services (as expected)
Conformists	Recognition of the need for residential care, Seeing the move as inevitable, Acceptable/good quality care home facilities and services, Family members/informal carers' feeling relieved as a result of the move
Shelter Seekers	Enhanced sense of well-being and security
The Unsettled	Being unable to justify their move to themselves (Move made without choice against their wish, no continuity with their past life, discontinued family support)

Source: Author's own elaboration based on research findings.

For Shelter Seekers, the most important thing they considered when they thought about the move was their physical and mental well-being. Moving into a care home made them feel secure and protected and the feeling of being well cared for gave them the confidence that their move was just.

Conformists were likely to make justifications on the basis of others' feelings and satisfaction and/or their seeing the move as inevitable. Their justification behaviour originated largely from how others around them (especially those who helped them before and during the care transition) felt about the move. As is shown in the verbatim quotations below, some Conformists said that their family, relatives or friends were feeling relieved after their move into a care home, as they knew that there would always be someone available for help in care homes:

> *My brother, Ron, he was worried and he said to me, you can't go on like this. How would you feel about moving into a care home? I didn't really care where I lived. So he went round with my social worker, he went round to different places to look at them. I trusted him to get somewhere where I would be ok and he thought that I would be alright here. So the next thing I know was…they brought me in here. … It's good to know that he's not worrying anymore (Helen, 86).*

> *My sister was very good but she lived at quite a distance and her husband had her sons [when she came to look after me]. She used to come to my place once a week and she did the best she possibly could. She is relieved that I am here and properly cared for (Margaret, 87).*

A few Conformists also said that they were happy about the move as it gave their informal carers the opportunity to overcome the health and emotional effects of caring. The fact that their former informal carers were living a better life, spending more time with their children and not worrying too much about them helped them justify their move. The experience of the Conformists differed from findings from some other studies found that the quality of older people's move into a care home affected their family and carers (see Dellasega and Nolan 1997).

Older people's recognition of their needs and their perception of the move as an inevitable option also played an important role in their justification behaviour. As is illustrated in the

verbatim quotation below, some older people said that they started to think differently when certain health conditions made it difficult for them to manage alone:

> *As I did say, never in a million years would I think that I'd ended up in a care home. But, then, I had no idea I would have in the end five back operations (Howard, 86).*

There were also some Conformists who found the quality of care home facilities and services acceptable or better than they expected, despite the fact that they moved into a care home without having enough information of the home. This unexpected satisfaction partly contributed to their thinking that it was right or just to move into a care home.

The only group of people who failed to justify their transition to residential care were the Unsettled. They moved into a care home without choice and the acceptance of their needs and sensed no continuity between their life in the care home and their life in the past. As most of the Unsettled wanted to continue to live in the community, they did not find the care home environment particularly beneficial for their sense of well-being. Some of them also said that family support discontinued after they moved into the home and it appeared that this left little room for justification.

Informal support

Informal support older people received from non-professionals during their use of residential care played an important role in fostering a positive care transition. There were three main types of informal support available for the interviewees: support from other residents living in the same home, support from family, friends and relatives and support from volunteers (see

Table 7.4). The three types of informal support provided different help and benefits to older people and helped them adapt to the care home environment.

Table 7.4. Types of informal support and their strengths and weaknesses

Types of support ***Groups which experienced the support***	**Support provided**	**Strength**	**Weakness**
Support from family, friends, relatives (blood-tie/personal network-based) ***Active Planners, Conformists***	Personal favour, being an advocate and mainstay when problems occur	Sense of belonging, psychological support, helps maintain continuity of life	Frequent support not available, limited to special occasions
Peer support (proximity-based) ***Conformists, Active Planners***	Meal/teatime company, introducing the care home facilities and services, tips, conversational partner	Practical support, everyday support, reduced loneliness	Not enough to fulfil emotional needs, not intimate enough to share personal feelings and stories
Volunteers' support (based on good will) ***All Groups***	Outings, coffee time, regular visits, being a companion, small concerts, etc.	Greater feeling of community, liveliness, sense of wider community	One-off support or support discontinued after limited period of time.

Source: Author's own elaboration based on research findings.

The first type of informal support was provided by family, relatives, friends, neighbours or other intimate members in older people's personal network. This type of support was therefore provided on the basis of blood-ties or the existing personal network which was established before the move and had matured over time. The role of informal family care has been portrayed in the literature as something that is greatly valued by older people and stays important to them even after the move to a care home. Although the importance of family

support has been emphasised in several studies (Cooney *et al* 2009; Clark 1995; Dellasega and Nolan 1997), it has not been referred to as an element of a positive transition. Findings from this research suggest that informal support was an important element that constitutes a positive transition and visits from family members, relatives and friends were greatly welcomed by many interviewees, especially Active Planners and Conformists who experienced this type of support.

In older people's stories of care transition, family support and support from intimate others (usually relatives or long-time friends) remained important throughout the transition process. The help from family, relatives and friends started from pre- transition period. More than three quarters of the interviewees were informally receiving some kind of help with their care from their family, relatives, friends and neighbours. They were often involved in initiating the care transition and/or initial consultation with social workers during the early period of the care transition. They also helped older people with collecting information, exploring individual care homes and making choices.

Once the move took place, the types of support from those in older people's personal network became more diverse. The researcher identified four types of informal support provided by their family, relative and friends: making visits, doing personal favours, inviting older people for special occasions, and being their advocates.

Support from family, friends or relatives was mostly used by Active Planners and Conformists who maintained good relationships with those in their personal network. Nevertheless, almost all the interviewees, with an exception of Shelter Seekers who were not in the situation to expect family support, were looking forward to seeing their guests and to

talking to them. In particular, older people were delighted to see their grandchildren and enjoyed talking about them during the interviews. Visits from old friends were as much awaited by older people as visits from their family, despite the fact that the role of intimate others around older people, was not dealt with much in the literature.

Some Active Planners and Conformists were looking forward to going back home for their birthday or Christmas. What they referred to as 'home' was not their flat/house they used to live in, but their children's, relatives' or grandchildren's place. Nevertheless, having somewhere to go to on special occasions made them feel that they could celebrate the occasions properly and regain the sense of community that had been weakened since the move to a care home.

> *I am going home for Christmas. I am going to my grand-daughters. It would be nice for Christmas. I am looking forward to it (Jennifer, 88).*

However, besides spending time and celebrating special occasions together, there were some important practical benefits of having support from those who were in older people's personal network. It was found that older people who were interviewed in this research valued the relationship that had built over years and many were thus very hesitant to call other residents 'friends'. They also found it easier to ask a favour from those who they had known for a long time, rather than asking a peer resident. The interviewees found that the greatest advantage of receiving support from family, relatives or close friends was that the personal network had been built on trust over a long time and that the interviewees' most intimate parts or unique personal characteristics could easily be understood by those in their personal network. The interviewees were able to maintain the same hobbies, attend Sunday

services, have their favourite food or personal items delivered or have their clothes mended, thanks to the support from their family, friends and relatives.

There was also a unique role played by family members, close friends or relatives – being an advocate for older people when problems or inconveniences occurred to them. Family members, relatives or close friends were in charge of speaking to care home manager or staff about details of specific health conditions that needed particular attention, inconveniences that older people experienced while living in the care home or any other matters relating to the running of the care home from weekly diet to the expansion of facilities. Interviews with care home managers and staff confirmed that most care homes had some form of regular meetings which involved older people's family or relatives and they were often called 'friends of N' (N being the name of the care home). Hirschman (1970) suggests 'voice' (represented by the act of making complaints) as one of the two mechanisms to react to dissatisfying service, along with 'exit'. The findings suggest that user voice in residential care is indirectly exercised through their family members, relatives or close friends. This will be dealt with in more detail in the next section.

There were some other important actors in the provision of informal support, which have hardly been studied in the literature. In particular, the role of other residents living in the same care home and volunteers in helping newcomers' adaptation has rarely been illuminated.

For about half of the interviewees, support provided by other residents was as important as support from their family, relatives or friends. The importance of peer support started to be recognised in recent policy documents (DH 2012), although it is often discussed in the context of community care. Conformists found peer support particularly useful. Peer support

was provided on the ground of proximity-based relationships, the depth of which was relatively shallow compared to family relationships or intimate friendships that had been built over years. The type of support provided by the peers ranged from being meal time or tea time company to the provision of tips for care home life. The interviewees said that they shared views on care home services or on particular staff/carers with other residents who moved in before they came, although they were sometimes not able to share stories that they found to be too personal. This type of support gave them some invaluable practical benefits and helped them to reduce the feeling of loneliness.

The third and the last type of support that was valued by the interviewees was support from volunteers. Support from volunteers was something that was equally used and valued across the four conceptual groups, whereas peer support or family support was mostly offered to Active Planners and Conformists. The types of help provided by volunteers varied between homes. In some homes, volunteers from a music school organised and played for a series of concerts for care home residents. In some other homes, volunteers organised regular weekly outings and took the residents to a nearby cafeteria or a restaurant and spent time together. School children were also involved in volunteering and some schools encouraged their pupils to visit care homes on a regular basis and to be company for the residents. The interviewees tended to encounter young volunteers, with most of them being teenage school children or in their twenties or thirties. While living in a care home with others from the same or similar generation gave the interviewees the sense of homogeneity, visits from volunteers of a younger generation made them feel that they were still connected to the wider society outside the care home boundary. Older people particularly valued the liveliness of the volunteers and the feeling of greater community they gained from the time they spent with the volunteers. For the same reason, the most awaited visitors for older people were their grandchildren. The

researcher's visit was also warmly welcomed and many residents, even those who did not fall into the sampled category, volunteered to offer their stories.

Scope for a positive care transition

Having explored the five elements of a positive transition, we now turn to examine the scope for a positive care transition. This section appraises the role of each element in making a positive care transition and discusses how the five elements were related to each other.

Each of the five elements explored above played an important role in forming older people's positive care transition experiences, affecting various dimensions of older people's care home life and adaptation (see Table 7.5). Voluntariness of the move gave older people greater satisfaction with the care transition and helped them adapt relatively easily in a shorter period of time than those who experienced an undesired move. Informed choice offered the interviewees the potential for continuity of life and enhanced autonomy and the sense of self. Continuity facilitated older people's smooth adaptation and helped them to have a positive perception of the move and of the concept of residential care and the care home. Older people who were able to justify their move to a care home tended to be more satisfied with the care home life, adapt easily and have a positive view of the care transition as a whole. Informal support from family, relatives, friends, peers and volunteers was also important in older people's positive transition experiences, as it was the source of various practical and emotional support for older people.

While the involvement of individual elements yielded different benefits, the lack of the elements caused something in common – older people's experiences of difficulties in

adapting. In other words, all of the five elements facilitated older people's adapting to the new living environment in different ways, helping older people's completing the last stage of the care transition.

Table 7.5. The role of the five elements in making a positive transition

Involvement of the element	Elements	Lack of the element
Satisfaction, shorter and easier adaptation	**Voluntariness**	Dissatisfaction, depression, difficulties in adapting
Autonomy, sense of self, high potential for continuity of life	**Informed choice**	Lack of knowledge of care homes, lack of confidence and willingness to adapt
Easier adaptation, positive view of the care transition and of the use of residential care	**Continuity**	For Shelter Seekers: no continuity was desired/natural, For other groups: difficulties in adapting, negative view of the care transition
Satisfaction, easier adaptation and positive view of the care transition	**Justification**	Difficulties in adapting, lack of willingness to adapt
Useful information, help with maintaining continuity of life, advocating, sense of community, daily support, family occasions, outings	**Informal support**	Lack of psychological and practical support, feeling of isolation, difficulties in adapting

Source: Author's own elaboration based on research findings.

All of the five elements worked differently towards older people's positive transition experiences, but not all the elements were needed to shape a positive transition. Moreover, each group experienced individual elements to a different degree (see Table 7.6). Three of the four conceptual groups experienced a positive transition, but only Active Planners' experiences were related to all of the five elements. The care transition experiences of Conformists and Shelter Seekers were different from that of Active Planners and lacked two or more elements of a positive transition. Conformists' positive transition experiences relied

on informal support and their justification of the move and Shelter Seekers' positive experiences were formed of their exercise of choice and the voluntariness and justification of the move.

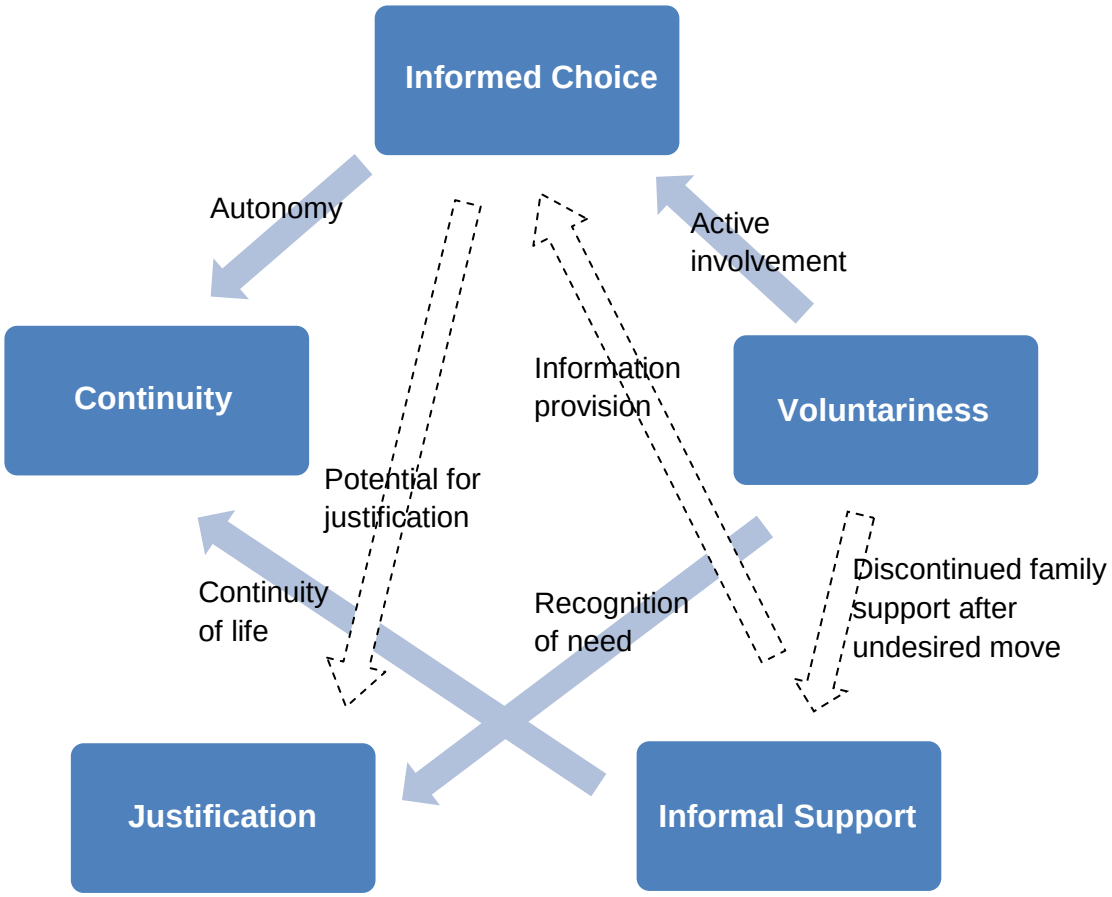
Table 7.6. Individual groups' experiences of the five elements of a positive care transition

	Informed Choice	**Voluntariness**	**Continuity**	**Justification**	**Informal Support**
Active Planners	High	High	High	High	High
Conformists	Low	Medium-Low	Medium-Low	Medium-High	High
The Unsettled	Low	Low	Low	Low	Low
Shelter Seekers	Medium-High	High	No continuity	High	Medium-Low

Source: Author's own elaboration based on research findings.

It was evident from the findings that the lack of some elements did not lead to a traumatic transition, but it was notable that the five elements were inter-linked and that the absence of one element can affect the working of other elements (see Figure 7.1). In particular, informed choice was related to all other elements. On the one hand, informed choice directly affected older people's feeling of continuity of life through giving the sense of autonomy and provided potential for older people's justification of the move. On the other hand, informed choice was indirectly affected by the provision of informal support as older people often obtained information on care transition from those in their personal network. In cases of Active Planners and Shelter Seekers, the voluntariness of their move also led to their making informed choices over the care transition through active involvement.

Figure 7.1. The interaction between the five elements of a positive care transition[23]



Source: Author's own illustration based on research findings.

Older people's feeling of continuity of life in residential care was influenced by informed choice and informal support, with each of them providing continuity regarding ways of life and aspects of life respectively. Older people who participated in this research were able to justify their move, mainly because there was an element of 'voluntariness' in their move gained from their recognition of the need for intensive care. Informed choice provided the potential for justification, since those who exercised active choice and experienced a positive transition found it easier than the others to believe that their move was legitimate. The

[23] The direction of the arrows represents the direction of interaction. Filled arrows denote that there is a direct interaction between any two elements. Dotted-line arrows stand for indirect interaction between any two elements.

element of voluntariness was the basis for the older people's exercise of informed choice and their justification of the care transition itself. Informal support provided grounds for older people's having continuity of life, but the lack of voluntariness led to conflicts between older people and those who initiated or helped their transition and resulted in the cessation of informal family support.

The inter-connectedness of the five elements suggests that all five need to be considered in policy and practice in order to promote a positive transition.

Choice and a positive care transition

Informed choice was one of the elements that formed older people's positive transition experiences, but how important was choice in shaping a positive transition? In order to examine the role of choice in a positive care transition, this section attempts to answer the following four questions: Q1) can there be a positive transition without choice and how important was the role of choice in a positive care transition?; Q2) how important was the concept of 'choice' for older people in their use of residential care?; Q3) how was the concept of 'choice' related to the five elements of a positive care transition?; Q4) how important were choice-related elements during each stage of the care transition (namely, initiation of the move, exploration/choice making and adaptation)?

The importance of choice in a positive care transition

The answer to the first part of Question 1 may seem obvious if one thinks about the experiences of the Conformists. As can be seen from Table 7.6, the existence of Conformists

implies that positive transitions can happen without choice-related elements, through relatively strong informal support and the justification of the move originating from their own recognition of the care need. The case of the Conformists also hinted that 'informed choice' may not be a precondition for a positive transition, especially for those who were not keen to exercise active choice themselves.

However, the interviewees' experiences suggest that choice was important, perhaps more important than the four other elements, in the formation of a positive care transition and that it was important even for the Conformists who transferred their right to choose to others. The older people only experienced a positive transition when they a) exercised choice themselves, or b) voluntarily gave up exercising choice, or c) managed to justify their lack of choice regarding their care transition.

First, older people's exercise of choice led to positive transition experiences. Choice might not be a prerequisite for a positive care transition, but when there was choice, there was a positive transition (e.g. the cases of Active Planners and Shelter Seekers). Second, some older people's voluntary delegation of their right to choose could be interpreted as the result of their exercise of choice and this led to positive transition experiences as well. Third, the rest of the Conformists, who experienced positive care transition without choice, had the means to justify their having a low degree of informed choice during the transition. They recognised and accepted the need for residential care and this formed the basis of their justification of the move, which was the key element in their positive care transition experiences. Therefore, to be precise, it was difficult to say that the Conformists' care transition was possible without any consideration of choice.

The importance of choice becomes more evident when one thinks about the fundamental cause of a traumatic care transition. The Unsettled residents' care transition lacked all the five elements, but the most fundamental reason for their being unsettled and distressed was their lack of choice. The experiences of the Unsettled suggest that choice can be a key to the solution for those experiencing difficulties during the care transition.

The importance of choice for older people

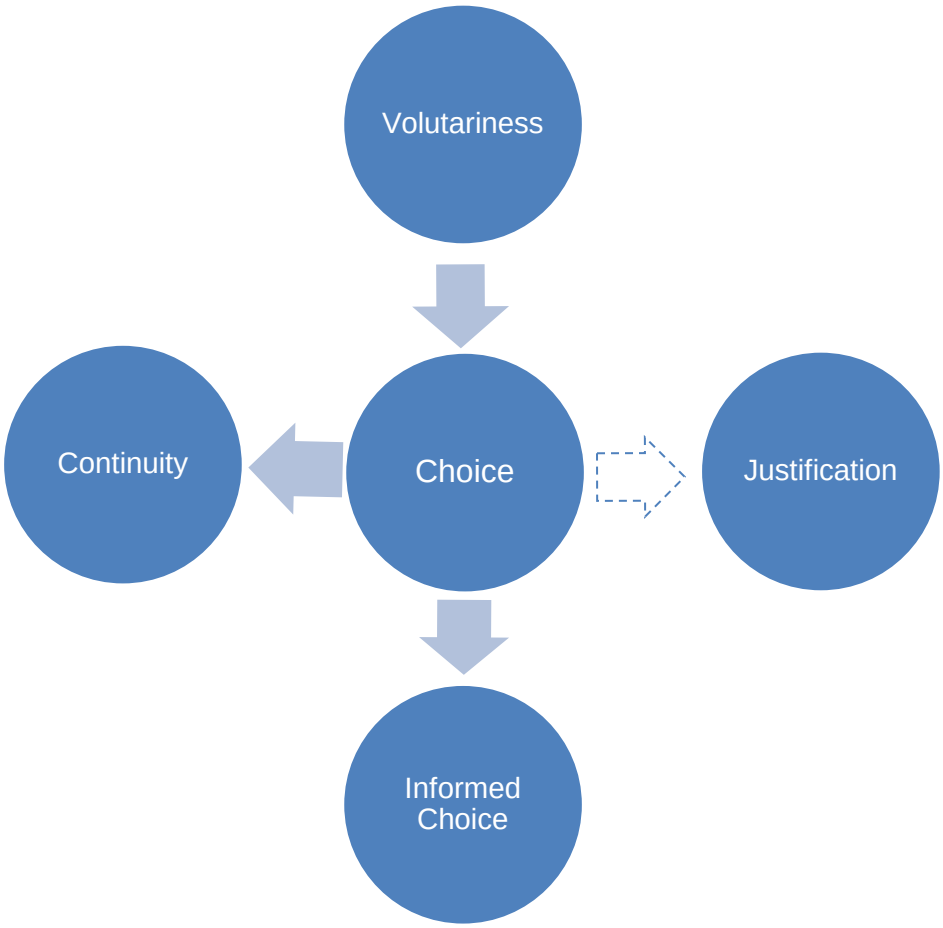
The second question is related to the interviewees' desire to have choice and the expected benefits of choice for those experiencing the care transition process that lack choice. Having choice during the care transition was considered important for almost all the interviewees and a great majority of them wished that they had more choice over their care arrangements. It was also assumed that the involvement of choice during the care transition can facilitate a smoother transition even for those who experienced a positive transition without choice. Not to mention the Unsettled, the addition of choice to the Conformists' experiences of care transition would enable them to reduce the period of adaptation by alleviating difficulties in adaptation caused by their lack of preparation for the care home life.

Choice and the five elements of a positive care transition

In order to answer the third question, it was explored how choice worked to promote the elements of a positive care transition or, conversely, how these elements affected older people's exercise of choice. Older people's experiences showed that the concept of 'choice' was directly or indirectly related to four of the five elements of a positive transition (see

Figure 7.2). Among the five elements, three were directly related to the exercise of choice – informed choice, voluntariness and continuity.

Figure 7.2. The dynamics between choice and the four other elements of a positive care transition[24] (author's own illustration based on research findings)



Informed choice was directly related to the exercise of choice, as it denoted the extent to which the move was properly informed and allowed an opportunity for older people to explore the available options and to prepare for the move. Voluntariness, the extent to which the move was desired by the older people, was also related to choice because it provided grounds for the exercise of choice. The sense of continuity was also affected by choice,

[24] The direction of the arrows represents the direction of interaction. Filled arrows denote that there is a direct interaction between any two elements. Dotted-line arrows stand for indirect interaction between any two elements.

because maintaining control and the sense of autonomy was important for their perceived continuity of life. Besides these three elements, choice can also influence justification. It was found that greater satisfaction often led to a greater potential for justification of one's move.

Choice and voice: the role of choice-related elements in each stage of the transition

The answer to the fourth question involves the exploration of the relative importance of choice over other elements or concepts relating to older people's experiences. Considering how each element of a positive transition worked at different stages of the transition, it becomes clear that there was another important concept that was closely related to older people's experiences of adaptation – namely 'voice' (i.e. making a complaint inside the home, often by their family, relatives and friends). In fact, choice and voice were both identified as the means to enhance users' control in their use of health and social care in the 2006 White Paper *Our Health, Our Care, Our Say* (DH 2006). Older people's experiences implied that the voice mechanism almost replaced the choice mechanism once they had moved into a care home. This leads us to the discussion on the complex dynamics of the relation between choice and voice. This section deals with the choice mechanism as a means to express users' preferences and discontents, and how older people's experiences were related to the three concepts put forward by Albert Hirschman (1970) – exit, voice and loyalty.

Hirschman (1970) suggests that individuals have two ways of reacting to dissatisfaction about services (other than doing nothing) – they can 'exit' the relationship (e.g. switching to another provider by exercising choice) or they can express a 'voice' for service improvement (e.g. by making a complaint). Individuals' having 'loyalty' to a service provider can increase the chance for the exercise of 'voice' rather than 'exit (choice)', according to his theory. His

framework has been used in many studies on the application of choice in public services (see, for example, Greener 2009).

Older people's experiences of care transition showed that choice-related elements and informal support played a particularly important role at each stage of the transition. Choice-related elements (voluntariness, justification, informed choice and continuity, as identified in the previous section) played a major role in forming positive experiences throughout the transition, but informal support played an equally important role once older people's move into a home had taken place. The most practical help that older people received during the adaptation period was related to the specific role played by their family, relatives and friends – their becoming 'voice' of the older people. Choice, as a means to express older people's preferences, was replaced by voice after their move into a care home. The discussion on choice and voice thus begins at this point.

Table 7.7 summarises which elements of a positive transition played a major role at each stage of the transition, based on the accounts of those older people who experienced a positive transition. At the initiation stage, it was important whether individuals desired the move (*voluntariness*) and whether they could recognise their care need and justify their move (*justification*). These two elements of voluntariness and justification formed the basis of exercising '*informed choice*', which was the most important element during the stage of exploration and choice making. During the adaptation period, the sense of *continuity* and *informal support* from the older people's family, friends, peer residents and volunteers played a major role in forming positive transition experiences. At the adaptation stage, informal support, especially the advocacy provided by the older people's relatives and friends, replaced choice and became the means of putting the older people's preferences into practice.

Table 7.7. The role of the five elements of a positive transition at each stage of the transition

Stages of transition	Elements played a major role
Initiation	Voluntariness, Justification
Exploration/Choice Making	Informed Choice
Adaptation	Informal Support, Continuity

In order to explore the role of choice and voice throughout the process of the care transition, it would be necessary to recapitulate the nature of choice first. It was clear from the interviewees' accounts that choice made a fundamental difference to their whole transition experiences, but choice in residential care is often irreversible, as discussed in Chapter 5. Applying Hirschman's framework, there was forced loyalty to the service provider created by older people's inability to exit the user-provider relationship. The only way to reflect users' opinions on the service delivery in the absence of exit was by raising their voice, as Hirschman's (1970) argues.

Nevertheless, the type of voice that older people used was different from the one that was assumed in the theory. Dowding *et al* (2000) and Dowding and John (2008, 2011) classified voice into two types, individual voice and collective voice. However, the type of voice used by the interviewees did not fall into either of these. As was discussed in the previous section on informal support, older people used what could be described as a 'delegated voice', the type of voice that was also found in the study by Van de Bovenkamp *et al* (2012).

As some Conformists transferred their right to choose to trusted others, any complaints or suggestions for service improvement were passed onto care home managers by those who were close to the older people. Yet, there was an important difference between the delegated choice and the delegated voice. The delegated voice was used by most of the interviewees,

while the delegated choice was only preferred by a small number of interviewees. Older people preferred not to raise their own voice, fearing that they might experience disadvantages in their use of a service. Instead, their relatives and friends individually raised any concerns for them to care home managers or collectively voiced their concerns with other residents' families and relatives at regular meetings in the homes. This finding is consistent with the research evidence reporting older people's reluctance to speak out their concerns (Bowers *et al* 2009) or their feeling of power imbalance in residential care (Granville *et al* 2014). Despite the indirectness of the involvement, the advocacy from relatives and friends benefitted the older people considerably during the adaptation period. The help from relatives and friends with tackling practical difficulties inside the home explains why informal support, especially support from family and friends, contributed more than choice in shaping older people's positive transition experiences during the adaptation period.

While the delegated voice helped the older people to adapt to the care home environment, it also has three potential pitfalls in reflecting older people's ideas to the actual service delivery. First, the exercise of delegated/surrogate voice means that there is no room to exercise choice after the move, even for older people who lived autonomously and exercised active choice (namely, the Active Planners). Second, this type of voice is not an available option for everyone and it carries a danger that some residents' voices are not heard by those providing services. The delegated voice could not be a useful means to make a complaint for some of the Unsettled who experienced the cessation of informal family support after the move. Third, a surrogate voice cannot guarantee that older people's views are prioritised over the views of the deputies and that they might not be passed onto the care home staff in the way the older people desired. In fact, older people's relatives and family members who were interviewed for the research said that they often made suggestions to care home managers based on the

older people's thoughts and ideas, but they also admitted that they added what they thought was the best option for the older people. These drawbacks show the need to offer users greater autonomy through the extension of choice in care homes and to introduce policies that help users to voice their opinions on the services they are using. The combination of these two measures will help those who cannot utilise delegated voice as a means to express preferences or complaints and ensure that older people no longer experience the feeling that they will face disadvantages in the pursuit of their preferences.

To sum up, informed choice was not an essential element of a positive transition, but choice played an important role in the positive transition experiences of older people. There was a consideration of choice even for those who experienced a positive care transition without it. Choice has more potential than the four other elements to make a real difference to older people's care transition by promoting improvements in their transition experiences. It was also valued and considered important for older people across all the four conceptual groups. In other words, it would be possible, but very difficult, to have a positive care transition without considerations of choice. There was, however, little room for exercising choice after older people's move into a care home and the importance of informal support started to increase from the adaptation stage in the absence of choice. This finding shows the importance of the informal family support even after the move into a care home and, at the same time, indicates a lack of formal support for those living in care homes. As was mentioned in Chapter 5, these pieces of evidence suggest that there is a need for an element of choice inside residential homes as well as a need for ensuring that individuals' voices are heard regarding the provision of services.

Conclusions

The analysis of the interview data identified five elements that shaped older people's positive care transition experiences; voluntariness, informed choice, continuity, justification and informal support. Some of the elements shared similarities with the findings by Chenitz (1983) and Nolan *et al* (1996), but also displayed important differences based on older people's lived experiences. The findings of this research demonstrated the importance of choice and information for older people in their care transition and stressed the role of family support, which was also identified in the literature (Cooney *et al* 2009, Clark 1995). This research also suggests new evidence that support from peer residents and volunteers helped older people with their adaptation to the care home environment.

The existence of the five elements of the positive transition, however, did not mean that the involvement of all of the five elements was essential for a positive transition. It was also found that not all the elements were desired by the interviewees themselves. The findings from this research, however, did imply that choice had a special importance in shaping older people's positive transition experiences and the importance of choice was assumed to be greater than the four other elements of a positive transition. It was found that a positive care transition would usually involve some consideration of choice and that the emphasis on 'positive choice' in Wagner Report (HMSO 1988*a*) still had a valid point. Older people who were interviewed genuinely desired and searched for choice in the use of residential care, hinting at the rise of consumerist culture in reflexive modernity (Beck 1992; Giddens 1994). Their satisfaction with the choice they made was based on the perceived benefits of using residential care which resulted from their exercise of choice. This leaves little room for cognitive dissonance (Festinger 1957) or buyers' remorse (Schwartz 2004). The enhancement

of choice and appropriate changes to the application of choice in residential care were also believed to have the potential to transform the distressed experiences of the Unsettled.

The concept of choice was also related to four of the five elements of a positive transition and choice-related factors played an important role throughout the whole process of the care transition. However, there was another concept that played an equally important role at the adaptation stage – namely, 'voice'. The voice of older people's family, relatives and friends replaced the function of choice during the period of adaptation by helping older people to express their opinion through their deputies. While market provision of residential care has become a norm in recent decades, older people's experiences showed that informal support from family, relatives and friends continued and still played an important role even after older people's move into a care home. However, the delegated voice option carries several pitfalls and there were some people who had no one around them to help raise the voice. The 2006 White Paper *Our Health, Our Care, Our Say* (DH 2006) emphasised offering people more control in using health and social care services by a variety of means, namely, more choice, more voice and more responsibility. The promotion of user voice has been insufficient, while more choice and the responsibility following the choice have received considerable attention in relevant academic and policy debates. In a situation where the 'exit' from the service is almost impossible, it would be crucial to secure opportunities to raise voice for older people in the way they desire, without worrying about potential disadvantages that they might face. At the same time, there is also a need to ensure low-level choices (i.e. practical choices over the use of service) in the care home.

The case of Shelter Seekers, together with other cases of a positive transition, showed again that care homes can be a place for enhanced well-being and comfort for older people needing extra help and protection in daily life, as argued in the Wagner Report (HMSO 1988*a*). The

research evidence suggests that the positive role of the care home should be recognised and that genuine choice in long-term care should be secured for older people.

Chapter 8. Conclusions

This thesis has explored older people's experiences of the transition from community care to residential care and discussed the nature and the role of choice in the transition. The research involved 48 semi-structured interviews with local authority-funded residents who moved into a residential home for the first time. This chapter brings together the findings by revisiting the research questions and drawing on the theoretical and policy implications of the research.

The concept of 'choice' is important in this research for two reasons. First, as several studies have stressed, having choice is important for individual service users in facilitating positive transition experiences. The concept of choice is becoming ever more important, considering that the transition is a life-changing experience. Second, the concept of choice is at the centre of the contrasting policy agendas of deinstitutionalisation and consumerism in public services.

The findings of this research reveal the dynamics behind the care transition experiences and their implications for theory, for policy and practice and for further research. This chapter first explores the four research questions in turn and presents answers to the questions by drawing on the relevant findings. Then, it is discussed how this research contributes to the literature. Next, there is a consideration of the scope for further research, followed by implications of the research findings for policy and practice.

Key findings

This thesis has addressed the following four research questions:

1. What are older people's lived experiences of the transition from community care to residential care in England?
2. How, if at all, do older people exercise choice in their transition to residential long-term care?
3. What are the meaning and the perceived effects of choice in residential care?
4. What is the role of choice in shaping a positive care transition?

Each research question is answered in turn in the rest of the section based on the research findings.

Q1. Older people's experiences of the transition from community care to residential care

Unlike the literature which has stressed the passivity of older people during the move into a care home, this research has found that older people's care transition experiences significantly differed between individuals throughout the care transition process, in terms of *their needs*, *their exercise of choice* and *their adaptation to care home lif*e.

Regarding *the needs of older people*, they had various needs which triggered their transition to residential care. In most cases, the move into a residential home was triggered by health deterioration and difficulties in coping in daily life, but in a few cases, the transition was initiated due to a circumstances that seriously threatens their well-being, including domestic violence, elder abuse and neglect, or conflicts with the primary informal carer. About two-thirds of the

older people who were interviewed (31 of them) had their transition initiated by someone close to them, but 17 older people initiated their transition themselves based on their self-perceived needs. This finding contrasted with the literature stressing the cases of passive and reluctant move to care homes. It was also notable that even the 31 interviewees whose transition was initiated by someone else had considerably different experiences, in terms of their exercise of choice and their adaptation.

Older people's *exercise of choice* was related to their recognition of the need for residential care and their willingness to explore available options and exercise choice. However, self-recognition of the care need did not always result in the exercise of choice and there were some older people who preferred to have a surrogate decision-maker. The extent of choice older people had varied between individuals, but they all felt that there was a lack of information and alternatives to residential care. This made them think that there was insufficient support for choice in residential care. This calls for the need for the better provision of information in user-friendly format. Older people's exercise of choice was influenced by many different factors, but differences in local authority funding, policy and practice affected their experiences the most. Besides, older people's education helped them in forming their prior knowledge of the long-term care system and their occupational history, family structure and personal network affected the quality and the amount of the information they collected. However, contrary to the findings from other studies, this research found that older people's age and their diagnosed health status did not play a decisive role in terms of their involvement, as has been argued by Vaillant (2002).

After the move, older people's experiences of *adaptation* varied significantly, depending on their acceptance of the need for residential care, their exercise of choice and knowledge of residential care and the degree of help they received from relatives and friends, peer residents and volunteers. Although to a different degree, older people who were interviewed all underwent substantial changes in virtually all aspects of their life, including environmental, emotional, physical and relational changes. Older people thought that the use of residential care can have several advantages when compared to community care; especially in terms of low staff turnover, safety and protection, reduced loneliness and housework. Yet, they found it difficult to cope with the routine, the way of communal living and superficial relations inside the home.

Based on the differences in older people's experiences, this research has identified four broad types of residential care users. Active Planners formed the largest group and their positive experiences of care transition, along with that of Shelter Seekers, suggested a great potential for an active and positive transition. However, there were a significant minority of older people who had their choice denied and experienced a stressful transition. There were also many older people who were happy to accept others' recommendations regarding their care and were still satisfied in the care home.

In order to aid understanding of the key findings, Table 8.1 summarises how the four groups' care transition was initiated. The cases of Active Planners provided encouraging evidence which can overcome the long-standing prejudice against older people's being active in the use of public services. Different from Active Planners, the cases of Conformists showed that a positive transition was possible without any active exercise of choice. Although they exercised little

choice, they accepted their need for extra care and this was the major difference between them and the Unsettled. Their positive experiences were gained through active adaptation by accepting their care needs and using peer support. Some Conformists decided not to exercise choice and delegated their right to choose to others around them. This finding challenged the assumption rooted in policy documents on user choice that people want to make choices themselves regarding their use of public services, as argued in other studies (Dowding 1992; Barnes and Prior 1995; Baldock 1997; Boyle 2013).

The stories of the third group, the Unsettled, were rather appalling in terms of the extent of the choice and the rights they were able to exercise throughout the process of care transition. A considerable minority of the interviewees entered a care home without accepting the need for residential care and became Unsettled residents. Their transition experiences were traumatic and stressful, as described in other studies on older people's care home entrance. The causes of an undesired and forced move into a care home included the disallowance of inter-borough moves, the denial of older people's right to refuse residential care and insufficient local authority funding for social care and the resultant impracticality of providing long hours of community care. The cases of these Unsettled showed that older people's experiences of being denied choice had a lasting impact[25] on their life in the care homes, affecting their adaptation, their emotional and health status and their willingness to live autonomously. Their experiences of local variations also seemed to strengthen the widespread public perception that there is a persistent 'postcode lottery' regarding the provision of public services.

[25] The researcher used the term 'lasting' impact as the interviews with older people were conducted after they had spent between 6-12 months in the care home they were living in.

Table 8.1. The four groups' initiation of care transition

Conceptual groups	The reason for the initiation of care transition
Active Planners	Acceptance of need for residential care (self-perceived)
Conformists	Acceptance of need (detected by others) and others' recommendation
The Unsettled	Purely others' recommendation (found it difficult to accept the need)
Shelter Seekers	Acceptance of need (detected by others) and social workers' recommendation

Source: Author's own elaboration of the key findings (extracted from Chapter 4).

The discovery of Shelter Seekers is significant in that it contributes to the literature by presenting new evidence that can inform policy and practice by reporting a group of older people with unique needs. There would have to be some consideration of Shelter Seekers in drawing up a blueprint for the long-term care system in the UK. The experience of Shelter Seekers illustrates the need for improvements in safeguarding practice and for recognition of these extra needs that older people may come to encounter in their later life.

Q2. Older people's exercise of choice during the process of care transition

The type and the level of the choice that older people exercised were examined using analytical frameworks developed by the researcher. The four groups of interviewees showed considerable differences in their exercise of choice during the period of care transition. Not surprisingly, Active Planners were those who exercised choice most extensively, followed by Shelter Seekers. There were few types of choice available to Conformists and the Unsettled. The four groups not only showed differences in terms of the types of choice they exercised, but also in terms of the main body of those who exercised choice (see Table 8.2). Active Planners and Shelter Seekers exercised choice themselves, whereas Conformists and the Unsettled did not. In the case of the

Unsettled, with the addition of administrative limitations that did not allow them to remain in the community, the relevant choices were often made between their family members and social workers.

Table 8.2. The main bodies who exercised choice during the period of care transition

Conceptual groups	Whose choice was valued?
Active Planners	Active Planners themselves
Conformists	Others (mainly their family members and relatives)
The Unsettled	Others (mainly family members, relatives and social workers)
Shelter Seekers	Shelter Seekers themselves

Source: Author's own elaboration of the key findings (extracted from Chapter 5).

Among the seven types of choice that were studied, the choice of which personal belongings to take into a home was the one which was most frequently exercised. The second most frequently exercised choice was the choice of a home, followed by the choice of trial options before the actual move. Both types of choice were related to the exploration of the specifics of the service (residential care). The choice of whether to move in, which was related to a decision over the actual use of service, was only available for Active Planners and Shelter Seekers. Many older people experienced difficulties in finding a residential place due to the lack of vacancies and were not in a position to choose the timing of the move. Finally, the two least exercised choices were the choice of alternatives to residential care and the choice of care arrangements during the transition. There was a lack of real alternatives to residential care (e.g. extracare housing) and a lack of bridging care and transitional support services for older people.

The lack of each type of choice negatively affected the interviewees' care transition experience, as can be seen from Table 8.3. In particular, the lack of choice of whether to move in caused forced entry and this was directly linked to older people's becoming Unsettled residents. Similarly, being denied the choice of a residential home also triggered an undesired move.

Table 8.3. The seven types of choice and the impact of the lack of choice

Type of choice	Lack of choice
Choice of a residential home	Undesired move, discontinuation of informal support
Choice of when to move in	Lack of time for exploration and preparation
Choice of whether to move in	Forced entry – unable to justify the move and become Unsettled residents
Choice of alternatives to residential care	Difficulties in adapting to communal living, lack of understanding of the long-term care system
Choice of personal belongings to take in	Lack of continuity and sense of self
Choice of trial options	Lack of preparation for, and understanding of, care home life – maladaptation
Choice of care arrangements during the care transition	Lack of proper bridging care – difficulties in adapting to the intensive care provision in residential homes

Source: Author's own elaboration of the key findings (extracted from Chapter 5).

The researcher developed the concept of 'layers of choice' and systemised the seven different types of choice depending on the level at which each type of choice operated and the order in which each choice was made. The seven types of choice used in this research were classified into three categories of choice over the use of service, choice over the specifics of service and choice of additional services. The findings of the research shows that the choice which was made most often by older people was the one at the bottom level – choices relating to additional aspects of service, which was made after making high-level choices such as whether to move in. In general, the types of choice which older people had difficulties in exercising were those on the top layer

and were related to the use of the service itself. The interviewees found it difficult to exercise choice as the level of the choices went up, regardless of the conceptual group that the interviewees belonged to. What older people valued about having choice was their having a sense of control over their life and the lack of choice over the use of residential care gave them the feeling of losing control over their lives. A positive care transition for the Unsettled would only be made possible if they could understand the long-term care system and make high-level choices over the use of service itself, as well as low-level choices.

Q3. The meaning and the impact of choice

For older people who were interviewed in this research, choice meant an acceptance of dependence, which led to a renewed sense of independence following their move into a care home. Older people's acceptance of dependence preceded their exercise of choice and it was of this that their will to exercise choice came from accepting their need for extra care and help and the inevitable dependence it created. Nonetheless, older people's acceptance of their dependence did not mean their losing their independence. Older people often found their sense of independence was renewed while they were living in a more manageable environment of a care home. This signifies two things that challenge widespread beliefs about the nature of dependency in old age and of residential care: that the concept of dependence can be accepted positively by older people themselves and that residential care environment can offer enhanced sense of independence, rather than reinforcing the dependency of older people.

The older people's experiences of choice was unique and they involve effects of choice that were different from what have been described as the conventional benefits of choice (see Table 8.4).

Table 8.4. The impact of choice on older people using residential care

The impact of choice	
Autonomy and control	The feelings of enhanced sense of autonomy and control coming from the exercise of choice itself
Preparedness	Choice enabled people to learn about residential care and individual care homes during the exploration stage and being prepared for a care home life
Acceptable service quality	Choice was related to find a home of an acceptable standard; older people's exercise of choice did not lead to better quality, cheaper or more responsive service (based on the CQC rating)
A service user mindset	Consumerist identities did not present in the accounts of older people interviewed; older people recognised themselves as public service users with the right to choose

Source: Author's own elaboration based on the key findings (extracted from Chapter 6).

The discussion on the impact of choice starts with its relationship with the sense of autonomy and control. Is choice a luxury or an undoubted right for users of residential care? Le Grand (2007) has argued that choice policy gives the right to choose, which has been only available to middle class people, to those who have been marginalised in the society. In contrast, Hunter (2009) asserts that choice is simply a middle class obsession. Some also argue that most citizens do not want choice and just want good public services (see Needham 2007). With regard to the question above, the findings from this research support Le Grand's (2007) argument. The interviewees longed for choice not only in residential care, but also in the use of public services in general. Choice was desired by those who did not have any chance to exercise it as well as those who actively exercised it. For older people who were interviewed in this research, having choice was itself meaningful in that it gave them an enhanced sense of autonomy and control.

However, the feeling of autonomy and control did not come from being an autonomous consumer with real alternatives, as in the argument of Le Grand (2007). Older people did not have real alternatives to residential care, and, as with some other public services, the often non-retractable nature of choice in residential care did not allow them to switch between providers. Rather, as Schwartz (2004) or Perry 6 (2002) put it, their sense of autonomy and control was related to the fundamental sense of well-being and satisfaction which came from the exercise of choice itself. While choice in residential care has been merely referred to as choice of a provider in policy and practice, older people's interpretation of choice was wider than this, the one related to Giddens' (1991) idea of people 'authoring a self-biography'.

Second, choice also gave older people the sense of preparedness for a care home life. The exercise of choice entailed the exploration of different care homes and this exploration encompassed collecting information, having conversations with their family, friends and relatives, making visits to homes and spending a trial period in homes. Those who exercised such choice actively, namely Active Planners, were able to learn about the care home environment during the exploration stage and they felt that they were prepared for living in a home.

Third, older people's experiences showed that their exercise of choice was related to finding a home of acceptable service quality, not necessarily the one of better service quality. A comparison of individual cases found that the Active Planners, who exercised choice most actively, did not necessarily end up in a care home which was better rated by the CQC than the homes their peers moved into. Nor did it mean that the homes they chose charged lower weekly fees for similar quality service or provided specialised services for their needs. The benefits of

choice which have been conventionally argued for in the literature, including cost-effective, responsive and better quality service, were not fully enjoyed by those who exercised choice. There were both systematic and administrative reasons and the reasons relating to individuals' values and their perceptions of residential care. The former concerns the lack of vacancies in homes combined with the infeasibility of inter-borough moves, variations between local governments in the supply of residential care and the amount of funding available to service users. The latter can be interpreted in terms of older people's low expectations of residential care and their tendency to value what were called 'process outcomes' (Glendinning *et al* 2006), 'outcomes of maintenance' (Qureshi *et al* 1998) and other factors which were not necessarily related to the quality of care.

Lastly, it seemed that older people's exercise of choice did not lead to the change of their identity as a public service user. For older people who participated in this research, having choice meant having a service user mindset, not a customer mindset. The interviewees were clearly aware that the funding for their care was made available to them through the local authority assessment of needs and means. Some of them even emphasised the importance of public service ethos in the service provision. Despite the burgeoning discussion on citizens becoming consumers or customers, this finding strengthens the argument of Clarke *et al* (2007) that public service users are not familiar with the consumerist approach. Also, as discussed above, there was a gap between older people's understanding of choice in public services and the concept of choice receiving attention in academic and policy debates. This illustrates the need to understand users' expectations and perceptions before designing and implementing further reforms in long-term care.

Q4. The role of choice in positive care transition

What is the role of choice in facilitating a positive transition? Is the exercise of choice a precondition for it? In order to study the influence of choice on older people's experiences, this research first identified five key elements which shaped positive care transition experiences: *voluntariness, informed choice, continuity, justification and informal support* (see Table 8.5).

Table 8.5. The five elements of a positive care transition

Elements	
Voluntariness (of the move)	Was the move desired by older people themselves?
Informed choice	Was the choice properly informed?
Continuity (of life)	Did older people have a sense of continuity of life after moving into a residential home?
Justification (self-justification of the move)	Was the move something older people were able to accept and justify to themselves?
Informal support (volunteers' support, support from family and friends, peer support)	Was there sufficient informal support from family and friends, volunteers and peer residents during the care transition?

Source: Author's own elaboration based on the research findings (extracted from Chapter 7).

Voluntariness was related to the matter of whether the care transition was something that older people desired. The voluntariness of the move encompasses both an active form of voluntariness, the self-initiation of the care transition, and a less active expression of voluntariness, the acceptance of the need for the care transition. The recognition of the less active form of voluntariness was the major difference from the findings of Chenitz (1983) and Nolan *et al* (1996). *Informed choice* was related to the question of whether older people had sufficient information to exercise choice. *Continuity* was concerned with older people's having the sense of continuity after their move into a care home and *justification* was about their finding an

acceptable reason for their care transition. *Informal support* encompassed three different types of support from volunteers, their peer residents and their family and friends. The importance of informal support, particularly the support they received from volunteers and peer residents, has not been illuminated in the literature, but it was important for older people's adaptation to life in the care homes.

Not all these elements were needed for a positive transition, but the role of choice seemed to be important. Four of the five elements of a positive care transition were related to the concept of choice. Where there was choice, there was a positive care transition. The cases of the Conformists showed that it was possible to experience a positive transition without the exercise of choice, but a positive care transition often involved some consideration of choice, even if the consideration was about acceptable reasons for their lack of choice. The findings hinted at older people's genuine desire for choice within the context of reflexive modernity, as Beck (1992) and Giddens (1994) have argued. Older people's experiences of care transition suggested little possibility for cognitive dissonance (Festinger 1957) or buyers' remorse (Schwartz 2004).

Older people's account showed that choice and choice-related elements played an important role in forming positive transition experiences, but, when it comes to the adaptation stage, another element equally contributed to older people's smooth adaptation – namely, informal support. In particular, informal support from relatives and friends offered them the means to express their opinion on service through surrogate voice. There was a lack of choice regarding the service use once older people moved into a home and the irreversible nature of choice in residential care made older people to use voice mechanism, as Hirschman (1970) puts forward. Their fear of potential retaliatory action by care home staff, however, precipitated them to use delegated voice.

This implies the need to secure ways to raise user voice in residential care, especially for those who cannot utilise the delegated voice option and to ensure low-level choices for older people.

Contributions to the literature

The contributions of the research to the literature are discussed in relation to the three policy areas that are most closely related to the context of this research (i.e. the three topics written in the solid line hexagons in Figure 1.1): *choice in public services*, *older people as public service users*, and *ageing in place and de-institutionalisation*.

Choice in public services

Older people's experiences of choice in residential care

This research contributes to the literature in five ways in terms of providing evidence on the user experience of choice in residential care. It does so by offering new evidence on older people's care transition and their exercise of choice, by developing a taxonomy and identifying older people's varying needs and experiences, by recognising the move from community care to residential care as a process, by unveiling the nature of choice in residential care and by demonstrating cases of positive transition.

First, the foremost original contribution of this research is the identification of the way that older people exercised their choice during the process of care transition, the working mechanisms

behind it and the implications of choice. Clarke *et al* (2007) found that social care was the area where both users and frontline professionals showed the strongest preference towards choice. However, how choice is applied, and how it is used in residential care in reality, have not been studied. The findings from this research add to the literature by providing new evidence on the working of choice in residential long-term care and user experiences.

Second, this research identified four conceptual groups among the interviewees, who experienced the care transition process differently in terms of the need, the exercise of choice and adaptation. The development of a taxonomy involving service users and the concept of consumerism is not unique to this study, as there is a well-known taxonomy of stroke patients that was developed by Baldock and Ungerson (1994, 1996). However, this study makes a unique contribution to the literature by developing the first taxonomy of users of residential long-term care that has significant theoretical implications. It was found that older people had varying needs and experienced the transition differently throughout the transition process.

Third, this research recognises the move from community care to residential care as a process and employed the term ‘care transition’ as it can encompass the whole process. The use of the term ‘care transition’ was intended to accommodate the radical nature of the changes older people might encounter during the move from community care to residential care, while encompassing an unbiased view on the topic studied to ensure the research captures the potential variation in older people’s expectations and experiences. Terms such as ‘admission’, ‘move’ or ‘placement’ have been used in the literature (see, for example, Brearley *et al* 1980; Philips 1992) and among the frontline professionals, but they tend to treat the change of care settings as a

one-off event rather than a process and put an emphasis on older people's passivity in the use of public services. The unbiased approach employed in this research led to the researcher's finding a number of cases of positive transition, which often involved older people's exercise of choice. This is explained in the next point.

Another point relating to the contributions of the research is its providing aid for the understanding of the nature of choice in residential care. The nature of choice that could be deduced from older people's accounts was irreversible. The literature suggests that this would also be the case in other public services, such as education, but it means that there is often no option for what Hirschman (1970) termed 'exit' for users of residential care. It also stresses the importance of making a good choice in the first place.

Fifth, contrary to the prevalent research evidence which indicates negative experiences of the care transition, a great majority of the older people who were interviewed in this research experienced a positive care transition and the feelings of satisfaction. For 37 of the 48 older people who participated in this research, the move to residential care was a search for the help that was necessary for them to maintain their quality of life. Moreover, many of those who experienced a positive transition exercised choice during the process of the transition, demonstrating the potential for older people's being active users of public services. In particular, Active Planners' experiences resembled that of self-funders in that it involved their active planning and exercise of choice. The number of older people who exercised choice and experienced a positive transition accounted for about half of the interviewees (23 interviewees).

Choice, voice and a positive care transition

One of the important theoretical implications this research has is about the potential for a positive care transition. This research not only shows actual cases of a positive transition, which have rarely been found in other studies, but also attempts to explain the role of choice in shaping positive transition through in-depth exploration of the elements constituting a positive care transition.

This research identified five elements which constituted a positive care transition and demonstrated the importance of choice by showing that four of the five elements were related to the concept of choice. The findings of this research confirmed the importance of older people's involvement and their exercise of choice, which have been emphasised in the literature (see Chenitz 1983; Allen *et al* 1992; Nolan *et al* 1996; Kellaher 2000). The cases of some Conformists who decided not to get involved in the decision-making process and happily accepted the choice others made for them showed that making no choice can be a 'choice' for some older people, as found in some other studies (Boyle 2013), and that it can still lead to positive transition experiences. This means that choice may not be the most valuable principle to some users of residential care, as argued by Dowding (1992) and Barnes and Prior (1995), and implies that there might be a gap between policy and users' expectations and preparedness regarding the exercise of choice (Baldock 1997).

This research found that the one element which was not related to the concept of choice, informal support, played an important role throughout the transition process and became more

important once older people moved into a care home. The enforced loyalty of older people, precipitated by their lack of choice in care homes, led to their use of voice mechanisms, but in an indirect way through the use of surrogates. This finding is consistent with older people's unwillingness to raise their voice found by Bowers *et al* (2009). It also confirms Hirschman's (1970) theory on the working of exit, voice and loyalty. It also signifies that older people's preferences would be better reflected in the delivery of service if both choice and voice can be secured in care homes.

The meaning of choice: the human rights framework and the structured dependence of the elderly

Another important contribution of the research concerns finding the meaning of choice for users of residential care. Older people who were interviewed in this research attached their own meaning to the exercise of choice that was different from other groups of service users.

The introduction of choice in public services has often been linked with the concept of independence. The pursuit of independence was the aim of introducing Direct Payments for younger disabled people (HMSO 1996, Morris 2006) and extending choice in social care (see 2005 Green Paper *Independence, Well-being and Choice*). Older people who were interviewed in this research also valued the sense of autonomy and control arising from their exercise of choice and this was related to accessing human rights (i.e. valuing the fact that they can be involved in making important decisions in their life), as younger disabled people (Morris 2006).

However, the exercise of choice was understood by the older people as the process of accepting dependence and gaining a renewed sense of independence. It was not related to maintaining the same sense of independence that they had before their move into the home, but was related to having the sense of control in a more manageable environment while accepting extra help. This contrasts with the idea of independent living which has been put forward by disabled people.

Structured dependency theorists (Townsend 1981; Walker 1981; Phillipson 1982) put forward that old age is often associated with less favourable economic position due to structural early retirement and low income and this creates unnecessary and undesirable dependency of older people. In particular, Townsend (1981) argues that residential care is the last resort for older people who have suffered all the structural problems. Residential care, in his view, only recreates and reinforces the dependency of older people. Nonetheless, older people's experiences illustrated that the concept of dependence can be a subject of positive acceptance, which took place in the process of leading up to the active search for the help that they needed. Also, their experiences of discovering new roles and independence in a more manageable environment showed that residential care can be a 'positive choice' (HMSO 1988*a*) and implied that there have been significant improvements in the residential care environment since the time Townsend's study took place (1962).

Choice and identity: consumerism and citizenship

It is commonly assumed that user choice in public services is exercised as a 'consumer' in the changing welfare mix, but this research found that older people using residential care exercised

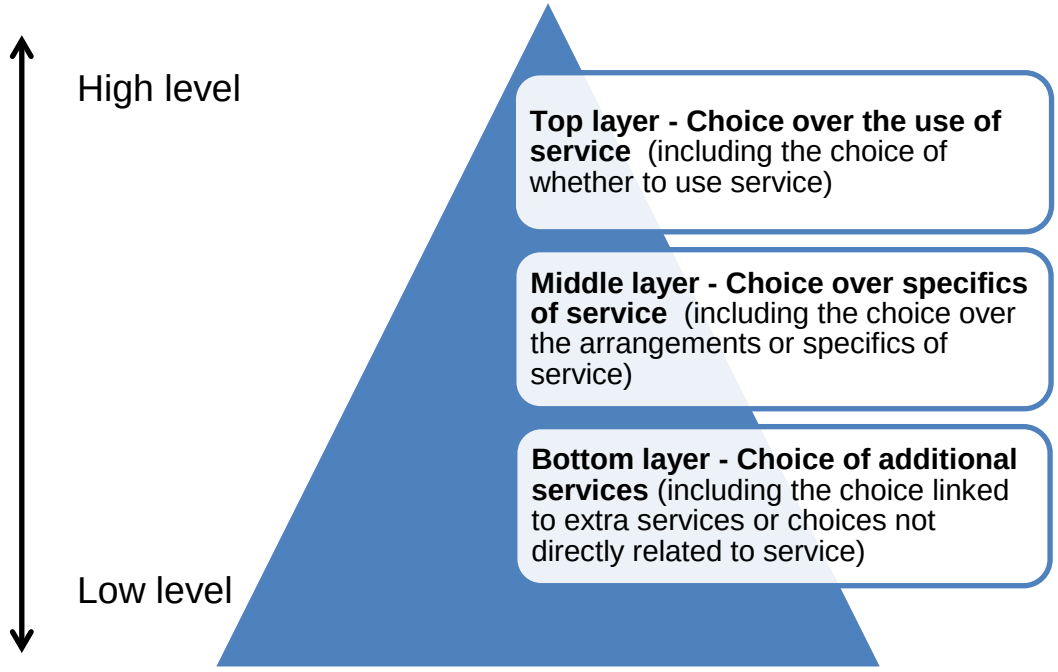
choice as a citizen and a public service user rather than a consumer or a customer. This echoes Clarke *et al* (2007)'s finding and suggests the possibility that there might be the lack of consideration of users' thoughts and expectations in the discussion of choice. Some older people even showed strong belief in the ethos of public services and the concern towards the private sectors' involvement in the provision of residential care. Their interpretation of choice was not related to consumerist approaches, but to a more fundamental sense of getting involved in important changes in their life. Social workers also maintained sceptical views on older people's turning into consumers or customers. Some care home managers, however, explicitly referred to local authority-funded residents as 'customers' and this, in a way, hinted a potential for older people's being seen and treated as consumers with choice and funding, just as self-funders.

Layers of choice

This research employed a self-developed concept of 'layers of choice' in order to explore the level and degree of choice that older people exercised. It was developed from the findings from the pilot interviews and was further refined throughout the main stage of the research. If Le Grand's conception of choice enables us to identify 'what' types of choice available to service users, the concept of 'layers of choice' makes it possible to discuss 'how' different types of choice is exercised. The concept of 'layers of choice' takes a step forward from Le Grand's (2007) idea of 'aspects of choice' in that it developed a hierarchy of different types of choice considering the level of choice and the order in which the choice is made. There are three layers of choice: the top layer concerns the choice to use the service itself; the middle layer concerns the choice of the specifics of the service; and the bottom layer is related to the choice of

additional services, as shown in Figure 8.1 (reproduced in Chapter 6). Findings from this research showed that service users often made choices in a particular order from the biggest choices (e.g. the choice over whether to use residential care) to the smallest ones (e.g. the choice of personal belongings was made after the other choices.

Figure 8.1. Layers of choice (applied to residential long-term care)



Source: Author's own illustration

The literature on choice has been largely concerned with the choice over specifics of service and there has been little consideration of the most fundamental choice, the choice over the use of service itself. The interviewees' experiences of the transition suggest that Hirschman's (1970) two mechanisms for dissatisfied service users, exit and voice, cannot be exercised easily in residential long-term care and that the fundamental choice of whether to move in or not has to be ensured for users of residential care. The concept of 'layers of choice' incorporates different levels of choice, being informed by the older people's lived experiences of care transition. This

concept would be applicable to other areas of public services, as it enables a researcher to study not only the types of choice that service users exercise, but also the question of the order in which each choice is exercised and to what level the choice is ensured for the users. Eventually, the 'layers of choice' can be used to explore how user choice influences the way in which a specific service is provided. It would be possible to see the degree of choice that service users have in each service and the types of choice that need to be strengthened.

Choice and competition in public services – an invisible hand?

The findings from this research provide grounds for extending user choice in residential care, but, at the same time, question the proper working of choice in this area. It would be difficult to tell from the findings of this research whether the participating service users gained the expected benefits of choice.

Older people's experiences of care transition also suggest that the introduction and the extension of choice in residential care seems to be especially appropriate among the public services. There was a strong desire towards having more choice in the use of service amongst the older people who were interviewed. This confirms the survey findings demonstrating support for choice by both users and professionals (Clarke *et al* 2007). Choice in residential care is the most typical and representative type of choice in public services, the one which resembles the Patient Choice initiative in the NHS the most (Fotaki *et al* 2005). Yet, users' collection and understanding of the relevant information is easier in residential care than it is in the health service. Moreover, practical trial options are available in residential care and can be repeatedly used, whereas there

are no ‘trial’ treatments in health care for ethical and practical reasons. Residential care is also the area where tailored services can be easily applied, when compared to other services such as education, where there is collective service provision in place.

However, the working of choice in residential care and the benefits it generates are rather questionable. Le Grand’s theory logically explains that the application of choice brings various benefits to service users, including an enhanced sense of autonomy and improvements in equity, quality, efficiency and responsiveness of service. Nevertheless, the interviewees who exercised choice were largely satisfied with their choice, but they were not necessarily in an advantageous position in terms of the quality (based on the CQC rating), responsiveness (based on the registered category that the care home belonged to) and efficiency (based on weekly charge) of the service they received, when compared with those who had little choice.

As is shown in Table 8.6, the interviewees’ experiences of choice differed from the benefits of choice asserted in the literature. Some of the conventional benefits were mildly experienced by older people due to their lack of relevant knowledge and information and some other benefits were offset by local authority variations in policy and practice. As explored above, older people also had unique needs which were different from other groups of service users and their concept of independence was also different from others. The notion of being a consumer also seemed to be distant from older people’s experiences and perceptions. Also, as Greve (2010) has argued, there seemed to be an imbalance between the amount and quality of information among the interviewees, drawing attention to the importance of, and the need for, systematic information provision. This suggests that the provision of advice and guidance, which has been largely

neglected in Le Grand's (2007) study, may benefit many older people who are experiencing the care transition.

Table 8.6. Comparison of the benefits of choice argued for in the literature and older people's actual experiences of choice

Expected benefits of choice	Actual experiences of older people
Enhancement of autonomy from having real alternatives - practical benefit	Enhancement of autonomy and control from the exercise of choice (having the right to choose) itself - psychological benefit
High quality services (quality improvement)	Acceptable quality services – having choice did not necessarily result in living in a better-rated home
Efficient service (cost-effectiveness)	Not necessarily cost-effective service – having choice did not result in paying a lower weekly charge for similar quality service
Independence	Acceptance of dependence and a renewed sense of independence
Becoming a consumer/customer	A chooser, but still a user
Innovative, responsive service	The chosen care homes were not necessarily the best homes to meet the needs of users
Equitable service (in terms of extending choice beyond middle class users)	Every user had the same right to exercise choice in theory, but variations between boroughs significantly affected the degree of choice that individuals were able to exercise

Source: Author's own elaboration based on the key research findings (extracted from Chapter 7).

The findings from this research suggest that choice and competition in public services is not an invisible hand that automatically brings a maximum benefit by balancing supply and demand and controlling the price, but a means to an end that needs proper government intervention to produce its expected benefits. The research findings also hint that in order for choice to work more equally and successfully for all service users, choice policy cannot work alone to achieve the relevant policy goals, but has to be a part of a well-designed policy package which incorporates consistent national guidelines and appropriate measures of information provision

and quality control. Introduction of choice without changing the means of service provision made it difficult for older people to exercise choice autonomously over different aspects of the use of residential care. Therefore, there have to be clear national guidelines over the eligibility criteria, the level of funding and inter-borough moves which would leave little room for substantial areal variations in policy and practice. In addition, there is a need for stronger inspectorate for social care, as quality control has more importance in the provision of public services led by choice and competition.

Local governments were having difficulties in meeting the demand for residential care within tightened budgets. With an addition of different interpretations of eligibility criteria, they found it difficult to support even users with substantial care needs, not to mention the provision of preventative services to those with mild and moderate needs. The difference in the level of funding available in each borough, together with the disallowance of inter-borough moves, meant that some of the interviewees underwent problems with a forced entry or an undesired move, and this affected their adaptation to the process and made them become Unsettled. The Unsettled also experienced a discontinuation of informal care due to the distance between them and their family members. The imperfect working of choice and competition was also detected in the accounts of social workers who informed the researcher of cases of mass relocation of residents due to a radical rise in the care home fees. The fact that the care home was able to raise the fees substantially implies that there was no real competition taking place between homes inside the local authority boundary, leaving some users with only a small number of options available. Overall, the evidence from this research shows cases of care transition made within an environment where there was a lack of policy guidelines and funding to support user choice. It

makes the researcher question the supposed working of an invisible hand in public service provision, at least in relation to residential care.

Older people as public service users and active ageing

Older people's active involvement in the use of public services

The advent of an ageing society and the social cost involved in this has put the idea of active ageing at the centre of the social policy debate. Nevertheless, older people have often been described as vulnerable users who do not have the means to exercise choice (Walker and Warren 1994). Several studies also reported on passivity in the receipt of services (Townsend 1962, Chenitz 1983). Their participation in the use of Direct Payments is also known to be low and older people have even been considered as a 'reverse critical case'[26] (Roberts and Chapman 2001). Older people's age and health status have been regarded as obstacles to their exercise of choice.

However, this research has found that most of the older people who were interviewed for this research were great proponents of choice and that a considerable number of them actively exercised choice. Moreover, older people's age and their diagnosed health status were found not to be the determinants of their exercise of choice. This finding implies that active ageing is possible through older people's active involvement in the process of transition and in the planning of their life in old age. This finding supports Vaillant's (2002) argument that

[26] A critical case denotes a group of people who react sensitively to social and political changes. The term 'critical case' was first used by Goldthorpe *et al* (1968) in *The Affluent Worker: Political Attitudes and Behaviour*.

self-perceived health was one of the most important elements in older people's sense of well-being.

Older people as peers, relatives and friends

Besides older people's involvement in the decision making during their care transition, older people also played an important role in helping other people to settle in in the care home. Older people who were interviewed from this research received informal support mostly from other people who were in old age themselves. The older people who were relatives and friends of the interviewees actively provided informal and family support. The availability and the utilisation of peer support, which has also been emphasised in recent policy documents (DH 2012), was the key to some older people's (especially Conformists') positive adaptation to the care home environment. This finding indicates that the scope for 'active ageing' should not be confined to those living in the community.

Ageism

Older people's experiences did not explicitly reveal incidences of ageism, but they suggested some evidence which could be understood in the context of ageist practice in social care. Older people who were interviewed in this research had low expectations of services provided in residential homes and were satisfied with care homes that were assessed by the CQC as providing low quality service. The cases of forced entry caused by insufficient funding for social

care for older people (see Humphries 2011 for discussion on the reduction of local authority spending on care for older people) could also be seen as a reflection of ageist approaches.

Extended life expectancy has not been viewed as a blessing to the society, but rather as a burden or a problem that could be addressed. Ageing populations have been used as a reason for welfare state retrenchment in the last few decades. The long-standing problem with the lack of social care resources and the ever-tightening eligibility criteria also imply that the current provision of social care might not be meeting older people's needs properly. Some older people's experiences mentioned above could be interpreted in a similar context, as they might hint that older people themselves were influenced by the perspective that places older people in a less favourable position in terms of their receipt of social care and other public services.

Ageing in place and the deinstitutionalisation debate

This research can also throw a new light on the ageing in place agenda and the deinstitutionalisation debate. This section is devoted to the reconsideration of the role of residential care and the role of informal sector (family) in the welfare mix.

The role of residential care

Evidence from the literature emphasised the hostile environment in care homes. Townsend (1962) even argued that care homes should be gradually replaced by other types of care facilities, which are smaller in size and contribute better to older people's well-being.

This research found a number of cases demonstrating positive traits of care homes. It disclosed cases of Shelter Seekers and showed that there is a unique role for homes regarding securing the safety and well-being of a specific group of older people. The merits of living in a care home were also testified by the interviewees in the three other groups as other interviewees also felt that they were safe in the care home and they found it convenient and satisfactory to have their meals provided. The low staff turnover in the care homes was one of the greatest merits of care homes for older people and they also valued the renewed sense of independence they could gain in the more controllable environment. As has been argued by some academics (Johnson *et al* 2010; OFT 2005; Biggs 1993; Nussbaum 1991), it seemed that there were positive roles for care homes.

The role of family in the welfare mix

The analysis of the interview data also suggests that informal care still remains important for older people living in residential homes as a complementary and supplementary service to residential care. The lack of availability of informal care itself was an assessment criterion for the local authority provision of residential care and it affected older people's move into a home. The importance of informal care continued throughout and after the period of care transition. The families and friends of the older people who participated in the research were often involved in the initiation of the care transition, the information collection and exploration, the making of choices (some were asked to make choices on behalf of older people) and providing informal support and advocacy after the move to a care home. Informal care played an important role in improving the quality of life after the care transition. This finding supports arguments made by

Clarke (1995) and Cooney *et al* (2009) that informal care continues to play an important role in promoting older people's well-being after they move into a care home. Whether the care is provided in the community or in residential homes, the role of informal care would remain important, although the availability of informal care may decrease in the future due to women's active participation in the labour market and changing family responsibilities. This implies that, despite the fact that there is a heavily privatised market of residential care, the informal sector still plays a significant role in promoting the well-being of older people.

Scope for further research

The findings of this research have implications for further research. In order to see the full picture of how choice works in residential care and to address the issue of equity in choice, it would be necessary to compare the experiences of private service users and public service users. It has been suggested in the literature that self-funding residents tend to exercise more choice and have more positive experiences of care transition than the local authority funded residents. By comparing the experiences of the two groups, it would also be possible to draw some useful implications for policy and practice as it will become clearer what can be done to improve the care transition experiences of publicly-funded residents.

The introduction of Direct Payments in residential care, which is scheduled to be implemented in April 2016, is likely to bring a considerable change in the degree of choice individual users can have. The comparison between those who opt for Direct Payments and those who do not will

enable the researcher to explore how older people make use of Direct Payments and how the expansion of choice changes user experience.

An in-depth study on choice and voice in residential care would also provide importance evidence to the literature. This research found some evidence on the working of voice in residential care, but the exploration was rather limited as it was not the focus of this research. At present, choice and voice are promoted simultaneously in British social policy and it would be worth investigating how older people utilise voice inside care homes and the dynamic between the two mechanisms.

It would also be worth studying the role and the limitation of both community care and residential care as there has been a blurring of the boundaries between different care sectors. Studying the care transition experiences of those who lack cognitive ability would also be important (e.g. those who are suffering from dementia) as it is more difficult for them to make their voices heard.

There has been an increasing supply of alternative types of housing with care, including extra care housing and very sheltered housing. The older people who participated in this research were not given many options regarding alternatives to residential care, but these options have increasingly been made available to older people in the last few years. The study of how older people exercise choice in long-term care (not only residential long-term care) and how the choice they made influenced their transition experiences and their quality of life would be able to inform policy and practice in a meaningful way.

Implications for policy and practice

The findings from this research have significant implications for policy and practice in the provision of local authority-funded residential care and in particular about how to facilitate older people's positive experiences of care transition. The research found that positive transition was possible within the current system of long-term care in England, but it also indicates that there were systematic and administrative limitations which made some older people compromise or deprived them of their right to choose.

The Unsettled residents' traumatic experiences of care transition suggest that there are a number of interventions that could improve their experiences. All of the Unsettled residents found it challenging to live in the residential care setting. Some Unsettled residents thought they could manage in the community with a little bit of extra help, but their thoughts were not reflected in the assessment. The introduction of the choice over whether to move into a home and the choice of alternatives to residential care would prevent a forced entry to care home and help them find a better care option for them. It would also be helpful to find ways to involve older people in the process of the needs assessment. The forced entry was the outcome of local authority financial considerations and this was related to the lack of social care resources and the consequent tightening of the eligibility criteria. Increasing funding for social care and the introduction of consistent eligibility criteria will improve the experiences of older people by addressing the postcode lottery over the provision of publicly-funded residential care.

Some of the Unsettled wanted to move to a home near to their relatives and friends, outside their local authority boundary, but had their choice rejected. The introduction of portable budgets would enable them to move near to their family and friends. A better co-operation between local authorities would be required for inter-local authority moves and regular reviews.

Conformist' experiences showed that positive transition can take place without active exercise of choice. This implies that choice would need to be ensured and enhanced in the context of enabling individuals to be engaged in making important decisions in their life, reflecting the human rights framework.

Shelter Seekers' transition to residential care was triggered by prolonged abuse or neglect that took place in the community. This highlights the need for improvements in the safeguarding practice so that this type of transition can be prevented by minimising older people's exposure to abuse or neglect.

All the four conceptual groups thought that there was a lack of information in an easily accessible format about individual homes and the process of the care transition. It is important to offer older people access to accurate information in an easily-readable format.

Some of the possible interventions suggested above are introduced by the Care Act 2014. They include the introduction of more consistent eligibility criteria and Direct Payments in residential care, better provision of information and improvements in safeguarding practice.

While the findings from this research support the introduction of these policies, it appears that there is a need for further policy interventions for improving older people's transition experiences. The Care Act introduces Direct Payments in residential care and this would help older people explore alternatives to residential care. However, since the payments are not in the form of portable budgets, it may not help older people to live near to their relatives and friends and maintain the close relationships with them. There is also a need to understand choice not simply as a choice of provider, but a fundamental right that can secure their autonomy and to recognise the two other layers of choice, namely, the choice over the use of service itself and the choice of additional services in policy and practice. Ensuring that older people's thoughts and opinions are heard during the process of local authority assessment is important in helping to prevent undesired transitions to residential care.

Concluding remarks

The findings from this research suggest that choice in residential long-term care has a considerable importance, since the choice made during the care transition transforms every aspect of the life of older people. Older people’s experiences of the transition from community care to residential care varied significantly, offering a strong rationale for the provision of personalised and tailored services in social care. The interviewees experienced the transition process differently in terms of their needs, the period of exploration, the degree of choice they exercised, their adaptation behaviour and the length of the adaptation period. The cases of Active Planners and Shelter Seekers suggest that there is a potential for positive roles for residential homes, which have been portrayed as inherently offering a hostile environment for older people.

Choice in residential long-term care was desired and was considered important by the service users who were interviewed for this research and was thus seen as a right that needs to be ensured more extensively. Choice played a crucial role, though it was not a precondition, for a positive care transition and older people wanted to have more choice in residential care, as has been found in the social care literature. It was clearly shown from the cases of Active Planners that, contrary to the overwhelming evidence on older people's passivity in the receipt of public services, older people can utilise their user choice in a way that would enhance their sense of well-being with appropriate help. The interviewees who could not exercise choice also longed for choice, challenging the argument against older people's activeness.

Nevertheless, the exercise of choice is still limited in residential care and the working of choice and competition seems to lack many of its functions. Not all the interviewees who wanted to exercise choice were allowed to do so. The analysis using the concept of 'layers of choice' shows that more people were involved in choice making if it was related to low level decisions and fewer people were involved in high level choice making. A substantial minority of older people, the 11 Unsettled residents, even experienced their choice as being denied or rejected and suffered the side effects for a long time. This research found some alarming cases of forced entry among the Unsettled, who were denied their legal right to refuse residential care. The cases of undesired moves were triggered by the limited application of choice, variations in policy and practice between different boroughs and the lack of budgets for social care on the whole. The Unsettled had to move without recognising their need for residential care or having the time and chance to accept the need. Financial and administrative considerations were prioritised while the needs and the rights of the older people remained largely neglected. This might well be a

nationwide problem, as the older people who were interviewed thought that the incidences of undesired transition were not rare. The cases of the Unsettled stress the fact that choice has to be given to users within a large frame of service provision so that the use of care itself, whether it is provided in the community or in care homes, has to be an active choice.

There is a blurring of the boundaries between different types of social care services, with the local authority eligibility criteria for both community care and residential care being tightened to include only those with substantial and critical needs. Inside the care home industry, there is a blurring of the boundary between residential care and nursing care. In these circumstances, the meaning of choice for service users would become more important. It would be possible to achieve the aim of personalised service provision in long-term care, but only if users can exercise choice in a way that meets their needs and improves their quality of life. There is a need to recognise the care transition as a process, not a one-off event, and to better understand older people's varying experiences of care transition. A positive care transition can be yielded by allowing users to make high level choices and introducing more consistent eligibility criteria across the UK, a stricter quality control and an accessible system for the provision of sufficient user information. Through these changes, it would be possible to better understand and reconsider the roles and limitations of residential care and to provide residential care which reflects their varying needs and preferences.

Appendix A. The Administration of Residential Long-Term Care

This appendix explores the provision of residential long-term care in England and the administrative procedures involved in the move to a residential home. It presents both a description of the relevant administrative procedures and an examination of the variations between local authority areas in the administration and the delivery of residential care. By doing so, it attempts to provide background information about the provision of local authority funded residential care which can aid the understanding of the research findings.

While the findings of this research are primarily drawn from older people's accounts of their care transition experiences, this appendix has been written exclusively on the basis of interviews with social workers working in the three London boroughs, Care Quality Commission (CQC) staff and the managers of the participating care homes.

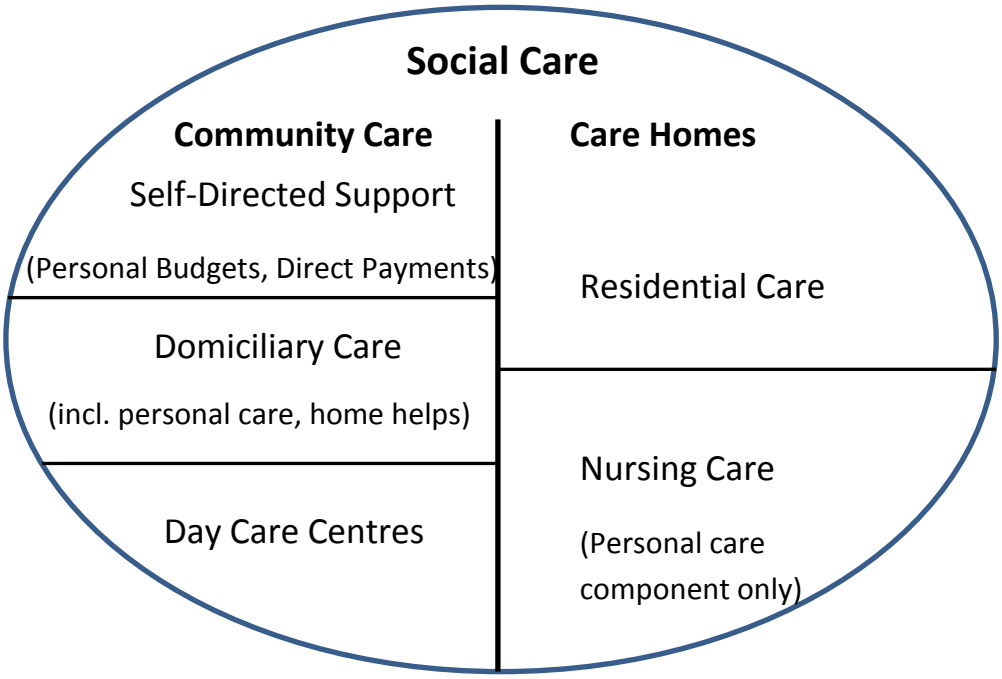
This appendix first explores different types of long-term care provided in the UK and how residential care is financed. Then, there is a detailed description of local authority funded residential care, including changes in the welfare mix in the provision of residential care, the eligibility criteria and the quality control mechanism. Last, there is a discussion of variations between local authority areas in the provision of residential care, which can be caused by disparate applications of administrative procedures.

The long-term care system in the UK and the financing of long-term care

In the UK, long-term care can be provided in three different settings: in the community, in residential homes and in nursing homes (see Figure A.1 for an illustration of the full picture

of the UK social care system). These three different types of care are called community care, residential care and nursing care, according to the environment where the care is provided.

Figure A.1. The provision of social care in the UK



Source: Author's own illustration.

The degree of care that is provided in the three settings also differs, with community care often involving personal care and domestic tasks, residential care entailing intensive personal care and nursing care involving even more intensive (often 24 hour) personal care and medical or specialist care. It is widely acknowledged that older people often move from the community to a residential home when their care needs increase and from a residential home to a nursing home when their needs become more intense, requiring medical attention (although this is not always the case). However, some older people with sudden and critical needs move directly from the community to a nursing home. In general, those moving into a nursing home are considerably more likely to suffer from dementia and to have a lower level of mobility compared to those going into a residential home. However, some care home

managers pointed out that the boundary between a residential home and a nursing home has been blurred in recent decades as the government's emphasis on community care has been matched with older people's preferences for community care over residential care.

In terms of financing, residential care and domiciliary care provided in the community can be funded by local authorities depending on individuals' care needs and their financial circumstances. Older people receiving nursing care can receive funding from the local authority and also from the NHS. The eligibility criteria for publicly-funded residential care are explained in detail in the next section. However, to a certain extent, the distinction between users with private funding and those with local authority funding is not clear, because private users can turn into publicly-funded users at any time if their financial circumstances change. For example, in residential care, a private resident (or the manager of the care home that the resident lives in) can request an assessment from the local authority once the resident's revenue starts to run out and when it falls below the eligibility threshold of £23,250 (2013/14 threshold). A social worker comes to assess the resident's needs and financial circumstances and makes appropriate care arrangements. As there is a limit to the amount of local authority funding for individual residents, some private residents have to move to a different care home which will provide residential care at a cheaper rate. As is mentioned in Chapter 2, it is estimated that around two-thirds of the care home population in the UK receive local authority funding for their care (Lievesley *et al* 2011).

The provision of local authority funded residential care

Under the National Assistance Act 1948, local authorities are liable for the provision of residential care to those who need residential care, if their capital falls below a certain financial limit. In cases where those with care needs refuse to go into a care home and wish to

remain in the community, local authorities are expected to respect their preference and ensure that they receive an adequate level of home care instead. Guidance on the arrangements for local authority funded residential care is set out in the 1992 Local Authority Circular (LAC) entitled 'National Assistance Act 1948 (Choice of Accommodation) Directions' and the 2000 Care Standards Act regulations (HMSO 2000).

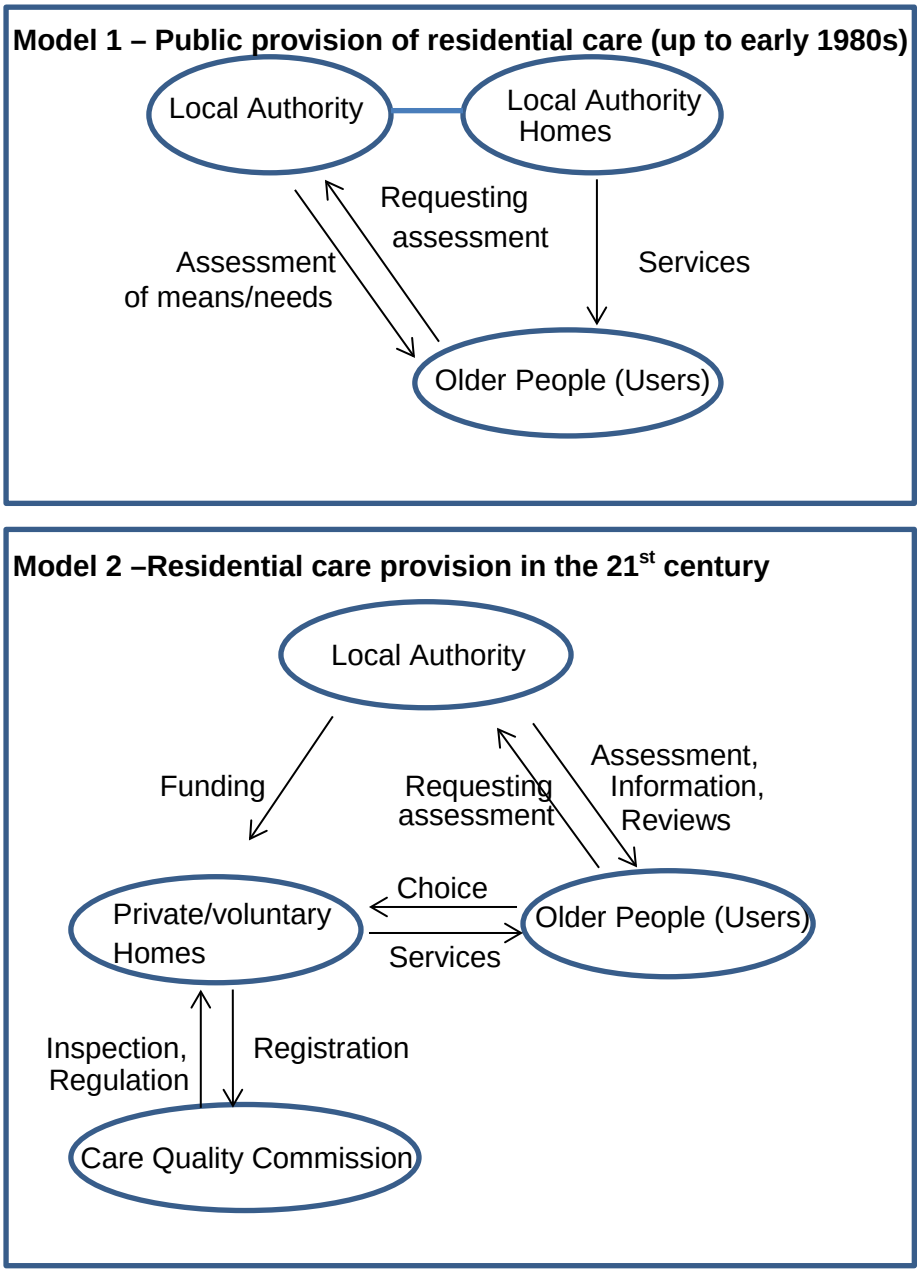
The changing welfare mix in residential care

The way that residential care is provided has changed considerably in the last half a century, and, accordingly, so has the role played by each actor in relation to the provision of residential care. As has been discussed in Chapter 2, the changes in the welfare mix were mainly triggered and accelerated by relevant changes in the legislation, notably changes in the Supplementary Benefits regulations and the 1990 National Health Service and Community Care Act, which encouraged the involvement of the private sector in care provision. Yet, the social workers who were interviewed for this research said that there were some problems with the sustainable running of local authority homes, too, as the cost of running them increased and local authority provision of residential care became unfeasible. There was a similar concern regarding local authority provision of home care and local authorities have ceased to provide personal care to users due to the high cost for retaining staff and making the service available 24/7.

Figure A.2 illustrates how the roles of local authorities, service users, care homes and the regulatory body have changed in relation to residential care in the last few decades. Model 1 illustrates the system of residential care provision before the early 1980s (before the changes in Supplementary Benefits regulations). It shows the dominance of the public sector in the

provision of residential care, as the local authority was responsible for providing, funding and regulating the service.

Figure A.2. Changes in the mixed economy of residential care



Source: Author's own illustration

There was a big change in the way of residential care provision since the 1983 Supplementary Benefits Act and the 1990 National Health Service and Community Care Act

(which was enacted in 1993) and the publication of the 1992 LAC on giving choice of accommodation to residential care users. As can be seen in Model 2, the current system of long term care assigns the role of an organiser to the local authorities, the role of a provider to residential homes (mostly owned by the private and independent sector) and the role of a regulator to the Care Quality Commission (CQC, 2009-present). The predecessors of the CQC which were in charge of controlling the quality of social care (which includes residential care) include Social Services Inspectorate (SSI, 1984-2003) and Commission for Social Care Inspection (CSCI, 2004-2009). There were many different bodies inspecting different areas of social care, but the UK has had a single unified system of social care inspection since the establishment of the CSCI in 2004.

Eligibility criteria and the administrative procedures of moving into a care home

The administrative procedures of residential home entrance involve eight stages (see Figure A.3). Following the notification of the need for residential care, there is an assessment of the applicant's needs. At the time of the interviews with social workers (2009), older people's needs are assessed using Fair Access to Care Services (FACS) guidelines (see Table 1 for the detailed guidelines) and they are classified into four groups: low, moderate, substantial and critical. In the three boroughs studied, only older people who fall into the substantial and critical needs categories are entitled to receive financial help from the local authorities with the cost of their formal residential or nursing care. If older people have substantial or critical needs, they are required to fill in the Details of Financial Circumstances form for financial assessment. If older people's financial circumstances meet the eligibility criteria of a lower

capital limit of £14,250 and an upper capital limit of £23,250[1], they are asked to sign a letter outlining the findings from this assessment as a sign of their agreement to it. If their capital is below £14,250, older people are no longer assessed for residential or nursing care charges, and if it is between £14,250 and £23,250, older people are required to make some contributions (£1 per week for every £250 over £14,250), and the rest of the care fee is paid by the local authorities.

Older people's receipt of both social security and social insurance benefits (including the state pensions) were counted as their income and the benefits were also used to pay for their care. Older people's family members can also make a contribution (optional), which is called a top-up, if older people choose a care home which charges more than the level of the available local authority funding. However, interviews with the family and the relatives of older people suggested that they were given little information about this top-up policy, albeit most of them did not think that they could afford to pay for the top-up fee. It was confirmed during the interviews with social workers that there were relatively a small number of older people across the three boroughs whose care was covered by the top-up payment. Service users' ending up in block contract homes also affected the low proportion of residents whose care is covered by the top-up fees. The researcher made an enquiry to individual care homes and obtained top-up fee related information on 37 of the 48 interviewees (8 of 10 participating residential homes provided the data). It was found that 29 of the 37 residents were not covered by the top-up fees[2].

[1] The upper and lower capital limits are rising by £250 every financial year. The same upper/lower financial limits are applied to the provision of local authority funded domiciliary care.
[2] The interviewees themselves were hardly aware of the financial agreements made between their local authority and the care home they were living in. The researcher had to ask care home managers or staff to confirm the details of the financial agreements, but the details about some interviewees were not clear.

Care homes apply different weekly charges for private paying residents[3] and publicly-funded residents and usually local authority funded residents were charged lower rates than self-funders. Depending on the local authority area, it is either the care home or the local authority that exercises the major influence on determining the level of the weekly charge for publicly-funded residents. Local authorities can be powerful negotiators, and, in the same way, care homes can be providers with a larger voice. There is no rule in the price negotiations, but care homes which are part of a large chain are usually advertised more frequently than independent homes and they can have a greater influence on the set charge for both private paying and publicly-funded residents as they become more popular[4].

Older people have the right to choose a care home, according to the 1992 Local Authority Circular *1948 National Assistance Act (Choice of Accommodation) Directions*. Nevertheless, it came out during the interviews with social workers that, once the agreement is made, older people are usually given two or three options of care homes. The number of options available often depended on the level of funding available, the local supply of residential care, and the local authority policy on cross-boundary moves. Older people's willingness to exercise choice also affected the number of options explored. Unless older people have already explored affordable care homes and vacancies before the agreement or want to explore alternatives themselves, they tend to choose between these two or three options. Then there is

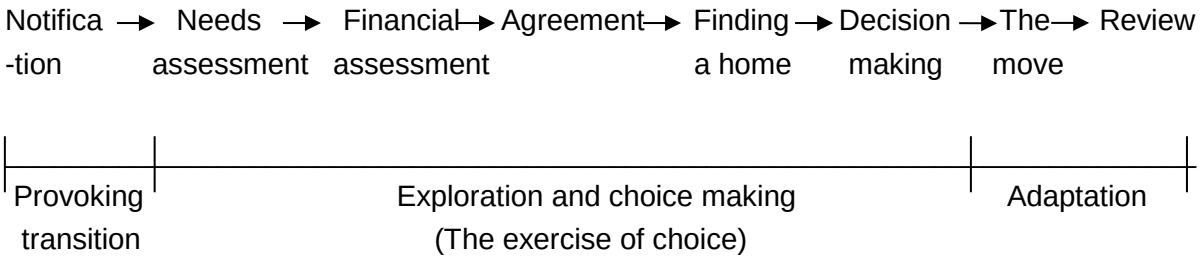
[3] The 'private paying resident' is the term used in the US to refer to self-funders, but it is employed here to make a clear distinction and to stress the difference in funding strategy between local authority funded residents and self-funders.

[4] The researcher was told that some care homes introduced a sudden increase in the weekly charge for publicly-funded residents and that, in one case, 11 residents who were living in a care home in borough C had to make a second move to a different care home. The social worker that the researcher interviewed had to spend nearly half a year (while enduring extra work) finding new residential places and arranging appropriate care for them. There was no other home which could accommodate them all while meeting the price and the users' needs and the users had to move into several different homes. The impact of relocation (after the initial move into a care home) is not covered by the scope of this study, but the literature suggests negative associations between the relocation and the physical and psychological health of older people. The way of making contracts between care homes and local authorities merits further research.

the waiting time after the decision making before the actual move takes place. Once older people have moved into a care home, a review is carried out by the placement team within six weeks of the care home entrance, and finally there is an annual review which is carried out by the review team each year.

Figure A.3 summarises the administrative procedures involved in the local authority-funded care transition and matched them with the process of care transition defined in the research.

Figure A.3. Older people's transition from community care to residential care- timeline (also included in chapter 4)



Source: Author's own elaboration based on interviews with social workers

Fair Access to Care Services (FACS) Guidelines

FACS framework was introduced in 2003 in order to address inconsistencies in the application of eligibility criteria and ensure fairer and more transparent practice in social care (DH 2010*b*). FACS are used as policy and practice guides that are used to determine the eligibility for adult care services funded by the local authority, including residential long-term care and community care services for older people. Local authorities use FACS in prioritising care needs and setting up their own criteria for the provision of universal services and targeted interventions (DH 2010*b*). FACS divided care needs of adults into four

categories (SCIE 2010). Table A.1 introduces the division of care need and its description set out in the FACS.

Table A.1. Eligibility criteria set out in Fair Access to Care Services guidelines

Intensity of need	Description of need
Low	● When there is, or will be, an inability to carry out one or two personal care or domestic routines; and/or ● involvement in one or two aspects of work, education or learning cannot or will not be sustained; and/or ● one or two social support systems and relationships cannot or will not sustained; and/or ● one or two family and other social roles and responsibilities cannot or will not be undertaken.
Moderate	● When there is, or will be, an inability to carry out several personal care or domestic routines; and/or ● involvement in several aspects of work, education or learning cannot or will not be sustained; and/or ● several social support systems and relationships cannot or will not be sustained; and/or ● several family and other social roles and responsibilities cannot or will not be undertaken
Substantial	● When there is, or will be, only partial choice and control over the immediate environment; and/or ● abuse or neglect has occurred or will occur; and/or ● there is, or will be, an inability to carry out the majority of personal care or domestic routines; and/or ● involvement in many aspects of work, education or learning cannot or will not be sustained; and/or ● the majority of social support systems and relationships cannot or will not be sustained; and/or ● the majority of family and other social roles and responsibilities cannot or will not be undertaken
Critical	● When life is, or will be, threatened; and/or ● significant health problems have developed or will develop; and/or ● there is, or will be, little or no choice and control over vital aspects of the immediate environment; and/or ● serious abuse or neglect has occurred or will occur; and/or ● there is, or will be, an inability to carry out vital personal care or domestic routines; and/or ● vital involvement in work, education or learning cannot or will not be sustained; and/or ● vital social support systems and relationships cannot or will not

	be sustained; and/or ● vital family and other social roles and responsibilities cannot or will not be undertaken

Source: SCIE 2010.

Quality control – the Care Quality Commission (CQC)

The Care Quality Commission (CQC) is in charge of regulating the quality of health and social care in the UK and producing inspection reports on individual care homes, home care providers (agencies) and hospitals. The CQC was established in 2009, following the enactment of the 2008 Health and Social Care Act, and it was the result of a merger between three independent regulatory bodies of social and health care, namely, the Commission for Social Care Inspection, the Mental Health Act Commission and the Health Care Commission.

The CQC produces inspection reports on individual care homes and it used a star rating system (with three star denoting excellent quality care and one star denoting poor quality care) to assess the quality of care until June 2010. Full inspection reports for individual homes are available online, but they do not guarantee readability, particularly for older people who often find it difficult to read a lengthy report written in small letters. Nevertheless, the star rating was easily recognisable to service users and therefore was often considered to be a representative measure of care home quality. The star rating for each care home was included in the inspection report, which had to be displayed in the reception area of individual care homes, and was also shown on online care home directories.

However, this measure has been criticised by media and by social work professionals for being too simple and giving little information on the actual quality of the care and other services provided in each care home and thus it ceased to be used. The researcher was

informed by a CQC professional that there is an internal mechanism of compiling and producing an illustrated version of more detailed inspection results, but the detailed illustrations (which resemble fuel gauge symbols or speedometers) were made for internal use only and were not open to public. There is currently a discussion on developing a new measure of the quality of care provided by individual care homes and agencies.

With the change in the rating system, there has also been a change in the rules of inspection and the working arrangements of the CQC staff. In the first couple of years after the establishment of the CQC, the CQC inspectors informed individual care homes of their visits in advance and thus the care home managers and staff usually knew the date and the time of the inspection. The rule of inspection has changed since then and CQC inspectors can now walk into any care home at any time without informing them of their visit. It has also been expected that this change in the inspection procedure would encourage care homes to constantly enhance the quality of the care they provide and reduce the possibility of malpractice being hidden from the inspectors' scrutiny. The change to the working arrangements of the CQC staff can be explained as a shift from office-based work to the practice of working from home. During the early years, CQC staff had to come into the office first then they went out to inspect individual care homes. The CQC professional who was interviewed in this research noted that change in their working conditions enabled the CQC staff to work from home and to communicate online. Meetings are now held in a format of audio/video conference. This change was welcomed by the CQC inspectors who can go and inspect nearby care homes in the region they live in without having to drop by some far away office and this has proved to be more effective in terms of time and cost through the efficient allocation of resources.

Appendix B. Topic Guides

a) Topic guide used for interviews with older people

Introduction
Introduce the researcher
Research aim/motivation
Anonymity/data protection
Consent form
Consent for access to administrative/care data
Consent for recording

Background

gender/ age/ marital status/ ethnicity/ family structure/ household income
length of stay in residential home

History of care arrangements

- informal, community care/formal care
- benefits/subsidies/additional services

Experiences of the care transition

Initiation
- Have you ever thought of moving into a care home before your move? (*vignette* – the researcher explained the research motivation/story of grandmother)
- What provoked the care transition? (disease/ death of a family member/ etc.)
- Who suggested the care transition? (him/herself/ social worker/ carer/ family/ friends/ etc.)
- How did you find the process of assessment?
- Did you feel the need to move into a care home?
- Do you feel that there was enough discussion and agreement about your move into a care home?

Exploration and choice making
- How much did you know about your care home before the move?
- Prior visits to homes/ tentative short-term stays/ any other trial options
- How many homes have you explored/visited?
- Who made the decision to move in? (own decision/shared decision/decision made by someone else)
- Any interactions with social workers after assessment?
- Was it a quick decision/slow decision? Agonised decision?
- Did you choose the care home?
- How did you choose the home you are staying?
- Did you have any choice over the timing of the move?
- Length of stay (temporary/ permanent)
- From whom you obtained information? (social workers/family/friend/church/doctors,

etc.) Was it enough/right info? Did it help? Did it make your choice worse? Were you overwhelmed due to too much information?
- 'Right to request' not to live in residential home/ have you considered any other care options? (very sheltered housing/extracare)
- What did you consider when you made the choice to move in?
- Did you want to have choice?
- How easy/difficult to make a decision?
- Types of conversation exchanged (open discussion/ dialogue/ etc)
- Did it take long to decide?
- Was it the right decision? Do you regret?
- Did you feel any pressure to go in? from whom? Did you feel implicit guilt?
- What other important decisions have you made in your life?

Moving in
- Did you feel anxious about moving in? (*vignette* – the anxiety experienced by researcher's grandmother)
- Is your home close to your family/friends/relatives?
- What did you do before the move?
- Any formal/informal support available during the transition period? (Arrangements for care during the period of transition)
- What have you brought in with you?/ have you regretted leaving anything behind?

Settling in (Adaptation)
- Do you feel that you have adapted to the care home environment?
- What time do you go to bed/have meals?
- How easy/difficult it was to adjust to care home life?
- Did it take long to adjust?
- Any perceived advantages/disadvantages of care home life?
- How much did you know about residential care and how different it is from your expectation?
- What/who helped you to adapt?
- How often do you see your family/friend/relatives after the move? Have they helped you to adapt? Who do you want to see the most?
- Any changes in social/family relationships?
- Did you/do you take part in any activities sessions?
- Have you made any friends in the care home?
- Are you satisfied with the home and the services you are receiving?
- Have you ever complained about the service to the care home staff?
- Have you thought of moving into a different home?
- Have you seen the social worker who arranged your care after the move? How was the review (6 weeks review conducted by local authority social worker)? Were you able to tell your thoughts to the social worker during the review? Did they arrange any extra services for you?

Perceptions of the care transition experience

Choice and identity
- Do you feel that you've become a different person after you came here
- Were you more/less independent before you move in?
- Do you think you have made choices in the way that you would have wanted to?

- What is the life you hoped to live?
- Do you want to have more/less control?
- How much choice do you have in everyday life? Or do you like having routine?
- Do you see yourself as a consumer/customer?

Perceptions of the care transition in general

- How important do you think the transition period is? How does it affect your life?
- Has your perception towards the transition experience changed since you have actually moved into a residential home?
- Would you make the same decision and choices if you can go back to the past? Would you like to consider other measures that can replace residential care? e.g. extra housing (what sorts of things did you explore when you found you cannot live in your own home?) Anything you would do differently?
- What are the difficulties you have faced during the transition period?
- What do you like most living in homes with other people? What are the hardest things? (*vignette*)
- Is there anything you were unsure/uncertain in your choice when you made it?
- Do you think you had enough information to make a decision at that time?
- What did it mean to have choice in your transition?

Perceptions of making choices

- Do you feel that you had much say?
- Do you want to be a chooser? (for choosers: Did you like having choice?)
- Would you like to have more say? Less say? Why?
- How important was it to have choice during the care transition?
- Which choice was the most important for you?
- Do you think people should have a say in other areas – health care/education etc?
- Do you feel that your rights to have a say were allowed for the period of moving in?
- How did you feel during the moving in period? How did you feel about transition?

Suggestions for improvements

- What do you think is the most important thing that affects those who have just moved into a residential home? (residential home staff/ residential home quality/ etc.)?
- Do you think you've adjusted your life? Ever adjusted? If not, why not?
- How long did it take?
- What could be improved? (What would have helped you?)
- What do you think other people need? (*vignette*: Is there anything you would like to suggest to the researcher's grandmother who is thinking of moving in?)

b) Topic guide used for interviews with social workers

Introduction
Introduce the researcher
Research aim/motivation
Anonymity/data protection
Consent form
Consent for recording

Background

- Years of working as a social worker
- The organisation of services for older people in the borough
- Number of cases in charge
- Number of care homes in the area with local authority residents/vacancy situation
- The eligibility criteria (for both community/residential care)
- The funding of residential care
- The maximum weekly charge they can pay for their users
- The process of the care transition and the role of social workers during the transition

Choice in residential care

- Perceptions on choice in residential care
- Perceptions on choice in public services
- The degree of choice allowed for older people
- Provision of alternatives of residential care in the local area (extracare housing/very sheltered housing, etc.)
- Choice of a home – average number of options available for older people
- Choice to move into care homes in other local authority area/ other region in the UK
- Choice of when to move in
- Average waiting time
- Arrangements of care before the move
- Any extra help available during the period of care transition?
- Closure of local authority homes and changing welfare mix (the background)
- The process of needs assessment – any challenges?
- Can older people refuse to move in?
- Changing role of social workers – any perceptions?
- Other legislative changes that might affect user experience

Reviews and local authority policy

- How often do you carry out reviews?
- Do you go to other parts of the UK to undertake reviews?
- Do some people express their concerns during the reviews?
- If older people become stressed after the move, is there any help available?

- If the care home an older person lives in does not meet his/her needs properly, what are the possible interventions?
- Can older people request move to another care home? (procedures)

c) Topic guide used for interviews with care home managers

Introduction
Introduce the researcher
Research aim/motivation
Anonymity/data protection
Permission to use administrative/care data for research purposes
Consent form
Consent for recording

The provision of personal care and other services in the home

- History of care home
- Years worked in the care home
- Types of care provided
- Number of residents (local authority residents/self-funders)
- Vacancy situation
- Facilities/rooms
- Average weekly charge (for local authority residents/self-funders
- Number of staff/carers (part-time/full-time), volunteers/ turnover rate
- The process of local authority arranged care transition
- Care home staff involvement during the transition
- Personal belongings/pets allowed
- Care home routine - meal/bed times
- Activities sessions
- Outings
- Other services
- Administrative records
- Records on older people's care needs
- Meetings with residents' families and friends

The transitional arrangements

- The role of care home staff/managers in the transition
- Common difficulties experienced by older people and how they are handled
- Perception on the average time taken to adjust to care
- Transitional support available for older people
- Transitional support available for families
- Any good practice that can be shared
- Ways to promote older people's 'voice' in care home
- Interaction with local authorities Social Services Departments
- Interaction with families/relatives of older people
- CQC inspections
- Types of choices available inside the care home/degree of autonomy allowed for individuals
- Relocation process/frequency
- Any forthcoming/ongoing changes in the care home facilities/services

d) Topic guide used for interviews with relatives of older people

Introduction

Introduce the researcher
Research aim/motivation
Anonymity/data protection
Consent form
Consent for recording

Background

- Relationship with older people/ place of live
- Occupational status/Marital status
- Informal caring they provided before older people's move (period/intensity)
- Any other caring responsibilities

The role of family/relatives

- The role of relatives during the care transition (initiation/information collection/exploration/choice making/help with adaptation)
- The level of involvement and the reason for their involvement
- Did you have any worry about your mother/aunt's move?
- Do you feel that it was the right decision for your mother/aunt to come into a care home?
- Do you think the services/facilities in the care home are appropriate to meet the needs of your mother/aunt?
- How do you think your mother/aunt is coping?
- What was the most difficult thing during the period of care transition?
- How often do you come to see your mother/aunt?
- How often does your mother/aunt come to visit your place (e.g. on birthday/ Christmas day)?
- Do you sometimes come with other members of family?
- How they felt about their mother/aunt's move into a care home?
- Feelings of sadness, guilt, relief, etc.
- Do you come to relatives' meetings regularly?
- Did you make any suggestions for improvement of services provided in the care home?
- Is there anything you are worried about your mother/aunt or about the services provided in the care home?
- Have you ever thought of moving into a care home when you need extra help with coping in daily life? Would you like to be a chooser?
- Do you think it is important to have choice in other public services?
- Is there anything you would like to advice people who are preparing to move into a care home? (*vignette*)

e) Topic guide used for interviews with the CQC professional

Introduction

Introduce the researcher
Research aim/motivation
Anonymity/data protection
Consent form
Consent for recording

Background

- Areas of expertise
- Years of working in the CQC/social care area
- CQC organisation/ organisational changes
- Targets/goals
- Funding/organisational independence
- Types of inspections
- Changes in rules and practice of inspection
- The current rating system
- Publication of inspection reports and requirements for care homes
- What differentiates CQC from previous inspection bodies?

CQC Inspections

- The process of inspection (the formal procedures, notification to care homes, etc)
- Frequency of inspections
- Pros and cons of current rating system
- Changes in the star rating system/ new model for inspection
- The process of consultation
- Any reflection of users' views in the care quality evaluation?
- Users' access to reports and relevant information (formats)
- Internal measures for care home quality
- Measures for care homes failing to meet the standards
- Follow-up actions
- Quality assurance measures
- Co-operation with local authorities
- Difficulties/challenges

Appendix C. A Sample Letter to Individual Care Homes

(To be printed on Departmental headed paper)

Name
Address1
Address2
Address3

Date

Dear _____

My name is Min-Young Tak, a D.Phil. student reading Social Policy at the University of Oxford.

As a final project, I am currently doing research on older people's experiences of moving into residential homes in London. From the last six years of studying issues relating to older people and their carers, I have come to realise the importance of the care transition period. My research has been reviewed by the University Research Ethics Committee.

I was informed by the Social Services Department in _____ that they have arranged some residents' move into your care home in the last 12 months. As I am exploring transition experiences of older people who are receiving publicly-funded residential care, it seems to me that _____ is an ideal place to carry out my research.

I would like to visit your care home sometime in November, if your time allows. Any day except Thursday (I am involved in teaching on Thursdays) works for me. Please let me know a convenient date and time.

I would like to talk to you and/or to a member of staff about my research on my visit. I will prepare information leaflets about my research. If you or the member of staff agree that I could chat with older people in your home, I would like to meet the residents and have some casual talks with them on the day of my visit.

I would like to carry out formal interviews with the residents on my second visit. I would be grateful if you could help me with finding older people in your residential home who can potentially take part in the interview. I am looking for people who are aged 65 or over and who have spent enough time (between 6-12 months) in your care home. I would like to interview them in person and ask them to tell their stories to me. The length of the interview can vary, but it usually lasts about an hour.

Pseudonyms will be used in the thesis, and the interviewees' personal information will not be exposed in any way. Having mild dementia is not a problem, as long as they have the cognitive ability to tell their stories to me. I will explain my research again to the interviewees and obtain their consent before the interview.

This is the most important research of my life both academically and personally, as my grandmother is preparing to move into a residential home as well. Your help will be much appreciated.

My contact details are as follows:

Address: Min Tak
Department of Social Policy and Social Work
University of Oxford
32 Wellington Square
Oxford
OX1 2ER
Email: min.tak@socres.ox.ac.uk
Mobile: 078 2801 4321

Thank you very much.
I look forward to hearing from you.

Yours sincerely,

Min-Young Tak

Appendix D.

Information leaflet for potential research participants

Transition and Choice in Residential Long-Term Care in England

Older People's Experiences of Moving into Care Homes

University of Oxford

Department of Social Policy and Social Work

Dear sir or madam

I am writing to request your help with an important piece of research.

I am reading for a doctoral degree in Social Policy at the University of Oxford.

I have studied policies affecting older people since I was an undergraduate student, including state pensions and policies for older carers and their families.

As a doctoral research project, I have decided to study older people's experiences of moving into residential care homes. There are several reasons why I am planning to carry out this research. First, it is because of my academic interests and desire to understand older people's experiences of moving into a care home, and to contribute to the development of policies that could help those who are experiencing changes in their care environment. It is also because of the fact that my grandmother is suffering from Parkinson's disease and is preparing to move into a care home as well.

There is a lack of research in this area, and I believe that understanding the views of those who are using the service is a good way to connect policy and practice.

I would be most grateful if you could share your stories with me.

Please tear here, put the reply slip in the enclosed envelope
And pass it to one of the home staff

My name is _____

I would like to participate in the research.
(Optional: If you have a preferred date or time for an interview, please state:)

Has this research been ethically approved?

This research has received ethics clearance through the University of Oxford's ethics approval process. This research will fully comply with the UK Data Protection Act. The researcher has a first degree and a master's degree in Social Policy, and has experience of interviewing older people for different research projects.

How will my story/information be used?

Your story will only be used for research purposes, and none of your personal information will be exposed. Anonymity and confidentiality will be guaranteed when collecting and using your stories. Audio files and transcripts generated after the interviews will be stored in a locked office at the Department of Social Policy and Social Work. The audio files will be erased upon completion of the study.

Can I withdraw my participation?

Yes. If you want to withdraw from the research, you can do so by informing the researcher about your decision.

Taking part in this research is completely voluntary and, in the same way, you can withdraw from the research at any stage if you want.

If you feel that you can share your story with me, please fill in the enclosed advice slip and pass it to your home staff. Alternatively, you can let me know your decision directly.

If you agree to tell your story, I will visit you and will listen to your story during an interview of approximately 1 hour.

I have tried to include all the important information in this pamphlet, but please contact me if you have any questions about the research.

Thank you very much in advance for your help.

Yours sincerely,
Min

Contact details:

Researcher: Ms Min Young Tak
Department of Social Policy and Social Work
University of Oxford
32 Wellington Square
Oxford, OX1 2ER

Telephone: 078 2801 4321
Email: min.tak@socres.ox.ac.uk

Supervisor: Professor Peter Kemp (Dept. of Social Policy)
Telephone: 01865 280553
Email: peter.kemp@socres.ox.ac.uk

Am I a potential participant?

I would like to ask you to participate in the research if you:

- are aged 65 or over;
- moved into a residential home last year, between October 2009 and April 2010;
- moved into a residential home for the first time;
- lived in your own home before the move; and
- Have received an assessment by your local authority's Social Services.

If you are not sure whether you fall into these categories or need any help, please do not hesitate to contact me.

What happens after I decide to participate?

After I receive your reply (via completed slip, phone call, email, etc.), I will contact you and will make an appointment to meet you for an interview. You can choose when and where (in your residential home) to have an interview. Please find the place that you find most comfortable to talk about your experience.

The interview will take place once and will last approximately 1 hour.

What happens during the interview?

There are no fixed questions to ask you like in a survey, but rather a list of topics which will help you share your story in a more flexible manner. For research purposes, the interview will be recorded and transcribed.

Confidentiality will be guaranteed during the interviews. Interviews will take place in an environment that allows no other people, except the researcher, to hear what you say.

As is explained in more detail on the next page, all the information that is collected through the interview will be used for research purposes only, and no personal information that enables you to be identified will be exposed.

What happens after the interview?

A summary of findings (a short report) will be sent to you at the end of the research, and you are welcome to see this. If there were to be anything you would like to discus after the interview, you can feel free to contact me at any time.

Appendix E. To be printed on Departmental headed paper

CONSENT FORM FOR RESEARCH STUDY

Title of Project: Transition and Choice in Residential Long-Term Care in England

Name of Researcher: Min Young Tak

Please tick to confirm

I confirm that I have read and understand the information sheet for the above study. ☐

I have had the opportunity to consider the information, ask questions and have had them answered satisfactorily. ☐

I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected. ☐

I understand that my personal information will be kept confidential. ☐

In exceptional circumstances, any information that would identify me will not be released or printed without asking me first. ☐

I understand that the data collected through the interviews will be used for research purposes only. ☐

I agree to take part in the above research study. ☐

Name of Participant _____ Name of Researcher _____

Signature _____ Signature _____

Date _____ Date _____

A copy of the consent form was given to those who agreed to take part in the study.

Appendix F. Interview Schedule

Residents Receiving Local Authority Funded Care

Active Planners

Name (psuedony-m)	**Gender**	**Age**	**Marital status**	**Length of stay in a care home (months)**	**Date interviewed**
Amy	Female	96	Widowed	6	23 Aug 2010
Anne	Female	78	Single	9	30 Nov 2010
Ben	Male	78	Divorced	8	16 Mar 2011
Brian	Male	71	Single	10	25 May 2011
Chris	Male	75	Widowered	9	20 Apr 2010
Claire	Female	80	Single	8	11 Oct 2010
Debra	Female	83	Single	8	20 Apr 2010
Elizabeth	Female	80	Widowed	6	19 Apr 2011
Gilbert	Male	79	Widowered	12	22 Feb 2011
Jennifer	Female	88	Widowed	10	1 Jun 2011
Joanna	Female	87	Single	9	18 May 2011
Mary	Female	81	Divorced	7	30 Apr 2010
Rebecca	Female	94	Widowed	12	15 Sep 2010
Rose	Female	68	Single	6	1 Jun 2011
Steve	Male	82	Widowered	8	19 May 2010
Sue	Female	86	Single	9	19 Apr 2011
Vivian	Female	76	Single	8	24 Aug 2010

Conformists

Name	**Gender**	**Age**	**Marital status**	**Length of stay (months)**	**Date interviewed**
Amanda	Female	98	Single	7	9 Aug 2010
Daniel	Male	89	Widowered	10	12 Apr 2011
Emma	Female	77	Single	9	30 Nov 2010
Emily	Female	76	Widowed	10	23 Apr 2010
Frank	Male	76	Widowered	6	15 Mar 2011
Graham	Male	87	Widowered	6	1 Jun 2011
Helen	Female	86	Single	11	28 Jun 2011
Howard	Male	86	Widowered	12	14 Sep 2010
Josephine	Female	91	Widowed	7	25 May 2011
Margaret	Female	87	Widowed	6	12 Oct 2011
Mark	Male	88	Divorced	9	24 Aug 2010
Matthew	Male	86	Widowered	8	16 Mar 2011
Rachael	Female	96	Divorced	10	7 Jun 2010
Victoria	Female	87	Married	8	15 Sep 2010

The Unsettled

Name	Gender	Age	Marital status	Length of stay (months)	Date interviewed
Adrian	Male	72	Single	11	15 Mar 2011
Catherine	Female	86	Married	10	18 May 2011
Clara	Female	92	Single	12	11 Oct 2010
Colin	Male	83	Widowered	9	23 Nov 2010
Erica	Female	86	Single	10	15 Sep 2010
Jill	Female	87	Divorced	6	12 Oct 2010
Katie	Female	87	Single	9	19 Apr 2011
Kristy	Female	98	Widowed	8	11 Oct 2010
Laura	Female	85	Widowed	11	2 Jun 2011
Louise	Female	88	Widowed	8	23 Nov 2010
Sylvia	Female	78	Married	10	14 Sep 2010

Shelter Seekers

Name	Gender	Age	Marital status	Length of stay (months)	Date interviewed
Alice	Female	66	Married	7	23 Nov 2010
Barbara	Female	86	Divorced	6	22 Feb 2011
Charlotte	Female	70	Widowed	12	8 Aug 2011
Claudia	Female	72	Married	7	12 Apr 2011
Grace	Female	65	Married	10	7 Jun 2010
Patricia	Female	74	Married	8	2 Jun 2011

Social Workers

Name	Gender	Department/ team	Borough	Years of working	Date interviewed
Lisa	Female	Placement team	A	7	18 Aug 2009
Corrinne	Female	Review team	A	6	17 Sep 2009
Eric	Male	Older people's team	B	6	6 Nov 2009
Lorna	Female	Review team	C	7	18 Nov 2009

Older People's Family and Relatives

Name	Gender	Relation to older people	Borough the older people belonged to	Date interviewed
Angela	Female	Daughter	A	1 Jun 2011
Gabriella	Female	Daughter	A	15 Sep 2010
Alfie	Male	Son	B	11 Oct 2010
Genevieve	Female	Niece	C	23 April 2010

Care Home Managers and Staff

Name	Gender	Position	Years of working in the home (Borough)	Date interviewed
Hailey	Female	Care home manager	8 years (B)	7 April 2011
Freja	Female	Care home manager	3 years (C)	8 April 2010
Beatrice	Female	Care home manager	4.5 years (C)	7 Sep 2010
Georgia	Female	Care home manager	2 years (A)	6 Oct 2010
Laila	Female	Care home manager	6.5 years (A)	11 Feb 2011
Vanessa	Female	Care home manager	4 years (A)	10 Nov 2010
Paulina	Female	Care home manager	9 years (C)	13 Apr 2011
Leonie	Female	Care home staff (carer)	5-6 months (C)	26 May 2011
Isabella	Female	Care home staff (carer)	2 years (A)	28 Jul 2011
Caitlin	Female	Care home staff (carer)	1 year and 2 months (B)	14 Jul 2011
Maddy	Female	Care home staff (carer)	3.5 years (B)	7 April 2011
Lewis	Female	Care home staff (carer)	10 months (A)	6 Oct 2010

Care Quality Commission Staff

Name	Gender	Areas of expertise	Date interviewed
Zoe	Female	Regulatory design	30 Mar 2011

References

Age Concern and British Institute of Human Rights (2009) *Older People and Human Rights – Research and Mapping Report*, London, Age Concern and the British Institute of Human Rights.

Allen, I., Hogg, D. and Peace, S. (1992) *Elderly People: Choice, Participation and Satisfaction*, London, Policy Studies Institute.

Allen, R. and Pickett, R.S. (1987) 'Forgotten streams in the family life course: utilisation of qualitative retrospective interviews in the analysis of lifelong single women's family carers', *Journal of Marriage and Family*, vol.49, no.3, pp. 517-526.

Aronson, J. (1994) 'A pragmatic view of thematic analysis', *The Qualitative Report*, vol.2, no.1, Retrieved on 8 August 2014 from: http://www.nova.edu/sss/QR/BackIssues/QR2-1/aronson.html

Association of Directors of Adult Social Services (2012) *The Case for Tomorrow: Facing the Beyond*, A joint discussion document on the future of services for older people, London, ADASS.

Baldock, J. (1991*a*) 'The national context of social innovation: England and Wales', in Kraan, R.J., Baldock, J., Davies, B., Evers, A., Johansson, L., Knapen, M., Thorslund, M. and Tunissen, C. (eds) *Care for the Elderly: Significant Innovations in Three European Countries*, Colorado, Westview Press, pp. 45-69.

Baldock, J. and Evers, A. (1991*b*) 'Citizenship and frail older people: changing patterns of provision in Europe', in Manning, N. (ed.), *Social Polciy Review 1990-91*, London, Longman, pp. 101-127.

Baldock, J. and Ungerson, C. (1994) *Becoming Consumers of Community Care: Households within the Mixed Economy of Welfare*, York, Joseph Rowntree Foundation.

Baldock, J. and Ungerson, C. (1996) 'Becoming a consumer of care: developing a sociological account of 'new community care' in Edgell, S., Hetherington, K. and Warde, A. (eds) *Consumption Matters: The Production and Experience of Consumption*, Oxford, Blackwell Publishers.

Baldock, J. (1997) 'Social care in old age: more than a funding problem', *Social Policy and Administration*, vol.31, no.1, pp. 73-89.

Baldock, J. (2003) 'On being a welfare consumer in a consumer society', *Social Policy and Society*, vol.2, no.1, pp. 65-71.

Baldwin, M. (2008) Social care under Blair: Are social care services more modern? In: Powell, M., ed. *Modernising the Welfare State: The Blair legacy*, Bristol, The Policy Press, pp. 73-90.

Barnes, M. and D. Prior (1995) `Spoilt for choice?: how consumerism can disempower public service users', *Public Money and Management*, vol.15, no.3, pp. 53-8.

Barter, C. and Renold, E. (1999) 'The use of vignettes in qualitative research', *Social Research Update*, vol. 25, http://www.soc.surrey.ac.uk/sru/SRU25.html

Beck, U. (1992) *Risk Society: Towards a New Modernity*, London, Sage.

Bennett, J. and Dixon, M. (2006) *Single Person Households and Social Policy: Looking Forwards*, York, Joseph Rowntree Foundation.

Biedenharn, P.J. and Normoyle, B.J. (1991) 'Elderly community residents' reactions to the nursing home: An analysis of their nursing home-related beliefs', *The Gerontologist*, vol. 31,107-115.

Biggs, S. (1993) *Understanding Ageing*, Buckingham, Open University Press.

Blake, S. (2009) 'Subnational patterns of population ageing', *Population Trends*, vol. Summer 2009, vol. 136, pp. 43-63.

Boocock, S.S. (1978) 'Historical and sociological research on the family and life cycle: methodological alternatives', in Demos, J. and Boocock, S.S. (eds) *Turning Points: Historical and Sociological Essays on the Family*, Chicago, University of Chicago Press, pp. 366-394.

Bowers, H., Clark, A., Crosby, G., Easterbrook, L., Macadam, A., MacDonald, R., Macfarlane, A., Maclean, M., Patel, M., Runnicles, D., Oshinaike, T. and Smith, C. (2009) *Older People's Vision for Long-Term Care*, York, Joseph Rowntree Foundation.

Boyle, D. (2013) *Barriers to choice: A Review of Public Services and the Government's Response*, London, The Cabinet Office.

Braun, V. and Clarke, V. (2006) 'Using thematic analysis in psychology', *Qualitative Research in Psychology*, vol.3, pp. 77-101.

Brearley, P., Hall, F., Gutridge, P., Jones, G. and Roberts, G. (1980) *Admission to Residential Care*, London, Tavistock Publications.

Bryman, A. (2004) *Social Research Methods*, 2nd ed., Oxford University Press, Oxford.

Bury, M. (2001) ‘Illness narratives: fact or fiction?’, *Sociology of Health and Illness*, vol.23, pp. 263-85.

Cain, C. (1991) ‘Personal stories: identity acquisition and self-understanding in Alcoholics Anonymous, *Ethos*, vol.19, pp. 210-253.

Carers UK (2009) *Facts about Carers*, London, Carers UK.

Cassell, C., Buehring, A., Symon, G., Johnson, P., and Bishop, V. (2005) ‘Qualitative management research: a thematic analysis of interviews with stakeholders in the field’, *ESRC Benchmarking Good Practice in Qualitative Management Research*, ESRC.

Centre for Policy on Ageing (2009) *Ageism and Age Discrimination in Social Care in the United Kingdom: A Review from the Literature*, London, Centre for Policy on Ageing.

Chenitz, W.C. (1983) ‘Entry into a nursing home as status passage: a theory to guide nursing practice’, *Geriatric Nursing*, vol.4, no.2, pp. 92-97.

CIPFA (2009) *Adult Social Services in England: Market Review 2008*, CIPFA and Tribal Consulting.

Clark, H., Gough, H. and Macfarlane, A. (2004) *It Pays Dividends: Direct Payments and Older People*, Bristol, Polity Press.

Clark, P.G. (1995) Quality of life, values and teamwork in geriatric care: do we communicate what we mean?, *The Gerontologist*, vol.35, no.3, pp. 402-411.

Clarke, J. (2006) ‘Consumers, clients or citizens?: politics, policy and practice in the reform of social care’, *European Societies*, vol.8, no.3, pp. 423-442.

Clarke, J. (2007). ‘Unsettled connections: citizens, consumers and the reform of public services’, *Journal of Consumer Culture*, vol.7, no.2, pp. 159-178.

Clarke, J., Newman, J., Smith, N., Vidler, E., and Westmarland, L. (2007) *Creating Citizen-Consumers*, London, Sage.

Colliers International (2010) *Care Homes Review*, London, Colliers International.

Colliers International (2012) *Care Homes Review*, London, Colliers International.

Colliers International (2013) *Care Homes Review*, London, Colliers International.

Comas-Herrara, A., Butterfield, R., Fernandez, J.L., Wittenberg, R. and Wiener, J.M. (2012) *Barriers and Opportunities for Private Long-Term Care Insurance in England: What Can We Learn from Other Countries?*, PSSRU Discussion Paper 2780, London, London School of Economics.

Commission on Funding of Care and Support (2011) *Fairer Care Funding: The Report of the Commission on Funding of Care and Support*, Crown Copyright.

Cooney, A., Murphy, K. and O'Shea, E. (2009) 'Resident perspectives of the determinants of quality of life in residential care in Ireland', *Journal of Advanced Nursing*, vol. 65, pp. 1029–1038.

Cram, F. and Paton, H. (1993) 'Personal possessions and self-identity', *Australian Journal on Ageing*, vol.12, pp. 19-24.

Cumming E. and Henry W. (1961) *Growing Old: The Process of Disengagement*, New York, Basic Books.

Daly, G. (2012) 'Citizenship, choice and care: an examination of the promotion of choice in the provision of adult social care', *Research, Policy and Planning*, vol.29, no.3, pp. 179-189.

Davis, S., & Nolan, M. (2003). 'Making the best of things: relative's experience of decisions about care-home entry', *Ageing and Society*, vol.23, pp. 429-450.

Deakin, N. and Wright, A. (1990) *Consuming Public Services*, London, Routledge.

Dellasega, C. and Nolan, M. (1997) 'Admission to care: facilitating role transition amongst family carers', *Journal of Clinical Nursing*, vol.6, no.6, pp. 443-451.

Department of Environment, Transport and the Regions (2000) *Quality and Choice: A Decent Home for All*, London.

Department of Health (1989) *Caring for People: Community Care into the Next Decade and Beyond*, London.

Department of Health (1992) *LAC (92)27: National Assistance Act 1948 (choice of accommodation) directions 1992.*

Department of Health (1998) *Modernising Social Services: Promoting independence, improving protection, raising standards*, Cm4169.

Department of Health (2003) *Care Homes for Older People: National Minimum Standards and the Care Homes Regulations 2001*, London, TSO.

Department of Health (2004) *LAC (2004)20: Guidance on National Assistance Act 1948 (Choice of Accommodation) Directions 1992 and National Assistance (Residential Accommodation) (Additional Payments and Assessment Of Resources) (Amendment) (England) Regulations 2001*.

Department of Health (2005) *Independence, Choice and Wellbeing: Our Vision for the Future of Social Care for Adults in England*, Cm6499.

Department of Health (2006) *Our Health, Our Care, Our Say: A New Directions for Community Services*, London, The Stationery Office, Cm 6737.

Department of Health (2008) *LAC (DH)(2008)1: Transforming Adult Social Care*, London, Department of Health.

Department of Health (2010a) *A Vision for Adult Social Care: Capable Communities and Active Citizens*, London, Department of Health.

Department of Health (2010b) *Prioritising Need in the Context of Putting People First: A Whole System Approach to Eligibility for Social Care*, London, Department of Health.

Department of Health (2011) *Safeguarding Adults: The Role of Health Service Practitioners*, London, Department of Health.

Department of Health (2012) *Caring for Our Future: Reforming Care and Support*, London, The Stationery Office, Cm8378.

Department of Health (2013) *Caring for our future: Consultation on Reforming What and How People Pay for Their Care and Support*, London, Department of Health.

Dowding, K. (1992) 'Choice: its increase and its value', *British Journal of Political Science*, vol.22, pp. 301-314.

Dowding, K., John, P., Mergoupis, T. and van Vugt, M. (2000) 'Exit, voice, and loyalty: analytic and empirical developments', *European Journal of Political Research*, vol.37, no.4, pp. 469–95.

Dowding, K. and John, P. (2008) 'The value of choice in public policy', *Public Administration*, vol. 87, no.2, pp. 219-233.

Dowding, K. and Peter, J. (2011) 'Voice and choice in health care in England: Citizen responses to dissatisfaction', *Public Administration*, vol.89, no.4, pp. 1403-18.

Epstein, L.G. and Kopylow, I. (2005) *Cognitive Dissonance and Choice*, University of Rochester Working Paper.

Ettelt, S., Perkins, M., Wittenberg, R. and Mays, N. (2014) *Direct Payments in Residential Care: Trailblazer Programme Evaluation (Preliminary Report)*, London, London School of Hygiene and Tropical Medicine, Policy Innovation Research Unit.

Festinger, L. (1957) *A Theory of Cognitive Dissonance*, Evanston, IL: Row & Peterson.

Fotaki, M., Boyd, A.,Smith, L., McDonald, R., Roland, M., Sheaff, R., Edwards, A. and Elwyn, G. (2005) *Patient Choice and the Organisation and Delivery of Health Services: Scoping Review*, NCCSDO.

Fox, A. (2011) *Shared Lives and the NAAPS Approach*, Pflenary presentation at the NIHR SSCR Annual Meeting 2011 (18 April 2011), London, LSE.

Gabriel, Y. and Laing, T. (2006) *The Unmanageable Consumer*, London, Sage.

Gabriel, Z. and Bowling, A. (2004) 'Quality of life from the perspectives of older people', *Ageing and Society*, vol.24, no.5, pp. 675-691.

George, L.K. (1982). 'Models of transitions in middle and later life', *Annals of the American Academy of Political and Social Science*, vol. 464, pp. 22-37.

George, L.K. (2002) 'Research design in end-of-life research: state of science', *The Gerontologist*, vol.42, special issues no.3, pp. 86-98.

Gerson, K. and Horowitz, R. (2002) 'Observation and interviewing: options and choices in qualitative research', in May, T. (ed.) *Qualitative Research in Action*, Sage, London, pp. 194-224.

Giddens, A. (1991) *Modernity and Self-Identity*, Cambridge, Polity Press.

Giddnes, A. (1994) 'Living in a post-traditional society', in Beck, U., Giddens, A. and Lash, S. (eds) *Reflecxive Modernisation*, Cambridge, Polity Press.

Giddens A. (2003) 'Introduction: neoprogressivism: a new agenda for social democracy', in Giddens, A. (ed.) *The Progressive Manifesto*, Cambridge, Polity Press.

Gitlin, L.N., Corcoran, M., Winter, L., Boyce, A., Hauck, W.W. (2001) ‘A randomized, controlled trial of a home environmental intervention: effect on efficacy and upset in caregivers and on daily function of persons with dementia’, *The Gerontologist*, vol.41, no.1, 4-14.

Glasby, J. and Littlechild, R. (2002), *Social Work and Direct Payments*, Bristol, Policy Press

Glendinning, C. (1998*a*) ‘Health and social care services for frail older people in the UK: changing responsibilities and new developments’, in Glendinning, C. (ed) *Rights and Realities*, Bristol, The Policy Press, pp. 11-27.

Glendinning, C. (1998*b*) ‘Convergence or diversity in the provision of long-term care for frail older people?’, in Glendinning, C. (ed) *Rights and Realities*, Bristol, The Policy Press, pp. 1-9.

Glendinning, C. (2009) ‘The consumer in social care’, in Simmons *et al* (eds) *The Consumer in Public Services: Choice, Values and Difference*, Bristol, The Policy Press, pp.177-196.

Glendinning, C., Clarke, S., Hare, P., Kotchetkova, I., Maddison, J. and Newbronner, L. (2006) *Outcomes-Focused Services for Older People*, London, Social Care Institute for Excellence.

Glendinning, C. Challis, D., Fernández, J-L., Jacobs. S., Jones, K., Knapp, M., Manthorpe, J., Moran, N., Netten, A., Stevens, M. and Wilberforce, M. (2008) Evaluation of the Individual Budgets pilot programme: Final Report, York, Social Policy Research Unit, University of York.

Goldthorpe, J.H., Lockwood, D., Bechhofer, F. and Platt, J. (1968) *The Affluent Worker*, Cambridge, Cambridge University Press.

Graham, H. (1983). `Caring: A Labour of Love', in J. Finch and D. Groves, (eds.) *A Labour of Love: Women, Work and Caring*. London, Routledge and Kegan Paul.

Granville, G., Carrier, J., Patel, M. and Barker, S. (2014) *Commissioning Relationship-Centered Care in Essex: An Evaluation*, York, Joseph Rowntree Foundation.

Greener, I. (2009) ‘Towards a history of choice in UK health policy’, *Sociology of Health and Illness*, vol.31, no.3, pp. 309-324.

Greener, I. and Powell, M. (2008) ‘The evolution of choice policies in UK housing, education and health policy’, *Journal of Social Policy*, vol.38, no.1, pp. 63-81.

Greve, B. (2010) ‘Can choice in welfare states be equitable?’, in Greve, B. (ed.) *Choice: Challenges and Perspectives for the European Welfare States*, Oxford, Wiley-Blackwell.

Griffiths, R. (1988) *Community Care: Agenda for Action*, London, HMSO.

Grundy, E. and Jitlal, M. (2007) 'Socio-demographic variations in moves to institutional care 1991-2001: a record linkage study from England and Wales', *Age and Ageing*, vol.36, no.4, pp. 424-430.

Gu, Y., Botti, S. and Faro, D. (2103) ‘Turning the page: The impact of choice closure on satisfaction’, *Journal of Consumer Research*, vol.40, no.2, pp. 268-283.

Guardian (2004) ‘Top ten fast growing affluent areas’, *The Guardian*, 07 July 2004, Retrieved from http://www.guardian.co.uk/business/2004/jul/07/money1

Hampshire City Council (2012) *Paying for Residential Care*, Hampshire County Council Adult Services Department.

Hancock, R., Arthur, A., Jagger, C. and Matthews, R. (2002) ‘The effects of older people's economic resources on care home entry under the UK long-term care financing system’, *Journals of Gerontology*, vol.57B, no.5, pp. S285-S293.

Harris, J. and Tanner, D. (2007) *Working with Older People*, London, Routledge.

Hayek, F, A. (1976) ‘Law, Legislation and Liberty: A new Statement of the Liberal Principles and Political Economy’, *The Mirage of Social Justice*, London, Routledge.

Henwood, M. (2011) *Journeys Without Maps: The Decisions and Destinations of People Who Self-Fund*, London, Putting People First Consortium.

Hirschman, A.O. (1970) *Exit, Voice, and Loyalty: Responses to Decline in Firms, Organizations and States*, Cambridge, MA: Harvard University Press.

HMSO (1948) *National Assistance Act*, London, HMSO.

HMSO (1983) *Mental Health Act 1983*, London, HMSO.

HMSO (1988*a*) *Education Reform Act*, London, HMSO.

HMSO (1988*b*) *Residential Care: A Positive Choice*, National Institute for Social Work, London, HMSO.

HMSO (1989) *Caring for People: Community Care in the Next Decade and Beyond*, London, HMSO.

HMSO (1990) *National Health Service and Community Care Act 1990*, London, HMSO.

HMSO (1994) Education Act 1994, London, HMSO.

HMSO (1996) *Community Care (Direct Payments) Act*, London, HMSO.

HMSO (1998) *Human Rights Act 1998*, London, HMSO.

HMSO (2000) *Care Standards Act 2000*, London, HMSO.

HMSO (2005) *Mental Capacity Act 2005*, London, HSMO.

HMSO (2008) *Health and Social Care Act 2008*, London, HMSO.

HMSO (2010*a*) *Building the National Care Service*, London, HMSO, Cm7854.

HMSO (2010*b*) *Equality Act 2010*, London, HMSO.

HMSO (2011) *Open Public Services*, London, HMSO.

HMSO (2013) *Care Bill Explained Including a Response to Consultation and Pre-legislative Scrutiny on the Draft Care and Support Bill*, London, HMSO.

HMSO (2014) *Care Act 2014*, London, HMSO.

Humphries, R. (2011) *Integrating Health and Social Care*, London, the King's Fund.

Humphries, R. (2013) *Paying for Social Care: Beyond Dilnot*, London, The King's Fund.

Hunter, D.J. (2009) 'The case against choice and competition', *Health Economics, Policy and Law*, vol. 4, no. 4, pp. 489-501.

Impallomeni, M. and Starr, J. (1995) 'The changing face of community and institutional care for the elderly', *Journal of Public Health Medicine*, vol.17, no.2, pp. 171-178.

Iwasiw, C., Goldenberg, D., MacMaster, E., McCutcheon, S. and Bol, N. (1996) 'Residents' perspectives of their first two weeks in a long-term care facility', *Journal of Clinical Nursing*, vol. 5, pp. 381-388.

Iyengar, S.S. (2010) *The Art of Choosing*, London, Little Brown.

Iyengar, S.S. and Lepper, M.R. (2000) ‘When choice is demotivating: Can one desire too much of a good thing?’, *Journal of Personality and Social Psychology*, vol.79, no.6, pp. 995-1006.

Johnson, J., Rolph, S., and Smith, R. (2010) *Residential Care Transformed*, Basingstoke, Palgrave Macmillan.

Johnson, N. (1999) ‘The personal social services and community care’, in Powell, M. (ed) *New Labour, New Welfare State?*, Bristol, The Policy Press.

Jokinen, P., Lappalainen, M., Merilainen, P., and Pelkonen, M. (2002) ‘Ethical issues in ethnographic nursing research with children and elderly’, *Scandinavian Journal of Caring Science*, vol.16, pp. 165-170.

Joseph Rowntree Foundation (2004) *Older People’s Shaping Policy and Practice*, York, Joseph Rowntree Foundation.

Kellaher, L.A. (2000) *A Choice Well Made*, London, Centre for Policy on Ageing.

King, N. (2004) ‘Using interviews in qualitative research’, in Cassell, C. and Symon, G. (eds) *Essential Guide to Qualitative Methods in Organisational Research*, London, Sage, pp. 11-22.

Knapp, M., Challis, D, Fernández, J. and Netten, A (2005) *Long-term care: Matching Resources and Needs*, Aldershot, Ashgate.

Kristiansen, C.M. (1999) Book reviews – ‘Qualitative Research Methods: A Health Focus’, *Chronic Disease in Canada*, vol.21, no.3, pp. 137-138.

Laing & Buisson (2013) Care of Elderly People: UK Market Survey 2012/2013, London, Laing & Buisson.

Land, H. and Himmerweit, S. (2010) *Who cares: Who pays?*, London, Unison.

Langellier, K.M. (2001) ‘Personal Narrative’, in Jolly, M. (ed.) *Encyclopaedia of Life Writing: Autobiographical and Biographical Forms*, vol.2, London, Fitzroy Dearborn.

Law Commission (2011) *Adult Social Care*, London, The Stationery Office, HC941.

Le Grand, J. (1991) ‘Quasi-markets and social policy’, *The Economic Journal*, vol. 101, pp. 1256-1267.

Le Grand, J. (2003) *Motivation, Agency, and Public Policy: of Knights and Knaves, Pawns and Queens*, Oxford, Oxford University Press.

Le Grand, J. (2007) *The Other Invisible Hand: Delivering Public Services Through Choice and Competition*, Princeton, Princeton University Press.

Lee, D.T.F., Woo, J. and Mackenzie, J.E. (2002) 'A review of older people's experiences with residential care placement', *Journal of Advanced Nursing*, vol.37, no.1, Blackwell Science, pp. 19-27.

Lent, A. and Arend, N. (2004) *Making Choices*, London, New Local Government Network.

Lewis, J. and West, A. (2014) 'Re-shaping social care services for older people in England: policy development and the problem of achieving 'good care'', *Journal of Social Policy*, vol.43, no.1, pp.1-18.

Lewis, R.B. (2004) 'NVivo 2.0 and ATLAS.ti 5.0: a comparative review of two popular qualitative data-analysis programs', *Field Methods*, vol.16, pp. 439-464.

LGiU (2013) *Independent Ageing 2013: Council Support for Care Self-Funders*, London, LGiU.

Lievesley, N., Crosby, G. and Bowman, C. (2011) *The Changing Role of Care Homes*, London, BUPA and Centre for Policy on Ageing.

London's Poverty Profile (2009) 'An overview of London's Boroughs', Retrieved from http://www.londonspovertyprofile.org.uk/about/an-overview-of-londons-borough/

Lymbery, M. (2010) 'A new vision for adult social care?: Continuities and and change in the care of older people', *Critical Social Policy*, vol.30, no.1, pp.5-26.

Maas, M.L., Kelley, L.S., Park, M., and Specht, J.P. (2002) 'Issues in conducting research in nursing homes', *Western Journal of Nursing Research*, vol.24, no.4, pp. 373-389.

Marsh, A., Cowan, D., Cameron, A., Jones, M., Kiddle, C. and Whitehead, C. (2004) *Piloting Choice Based Lettings: An Evaluation*, London, ODPM

Martikainen, P., Moustgaard, H., Murphy, M., Einiö, E.K., Koskinen, S., Martelin, T., and Noro, A. (2009) 'Gender, living arrangement, and social circumstances as determinants of entry into and exit from long-term institutional care at older ages', *The Gerontologist*, vol.49, no.1, pp.34-45.

Mills, W.L. (2010) *Personality and Adjustment to Assisted Living*, Doctoral thesis, University of South Florida.

Moriarty, J., Sharif, N. and Robinson, J. (2011) *SCIE Research Briefing: Black and Minority Ethnic People with Dementia and Their Access to Support and Services*, London, Social Care Institute for Excellence.

Morris, J. (2006) 'Independent living: the role of the disability movement in the development of government policy', in Glendinning, C. and Kemp, P. (eds) *Cash and Care: Policy Challenges in the Welfare State*, Bristol, The Policy Press, pp. 235-248.

National Audit Office (2013) *Oversight of User Choice and Provider Competition in Care Markets*, London, The Stationery Office.

Nay, R. (1995) Nursing home residents' perceptions of relocation, *Journal of Clinical Nursing*, vol. 4, pp. 319-325.

Needham, C. (2003) *Citizen-Consumers: New Labour's Marketplace Democracy*, London, Catalyst Forum.

Needham, C. (2007) *The Reform of Public Services Under New Labour: Narratives of Consumerism*, Basingstoke, Palgrave Macmillan.

Netten, A., Bebbington, A., Darton, R. and Forder, J. (2001) *Care Homes for Older People: Volume 1. Facilities, Residents and Costs*, Canterbury, University of Kent: Personal Social Services Research Unit.

Netten, A., Jones, K., Knapp, M., Fernandez, J., Chalis, D., Glendinning, C., Jacobs, S., Manthorpe, J., Moran, N., Stevens, M., and Wilberforce, M. (2012) 'Personalisation through Individual Budgets: Does it work and for whom?', *British Journal of Social Work*, vol.42, no.8, pp.1556-1573.

Nolan, M. and Dellasega, C. (2000) 'I really feel I've let him down: Supporting family carers during long-term care placement for elders', *Journal of Advanced Nursing*, vol.31, no.4, pp. 759-767

Nolan, M. and Grant, G. (1992) 'Helping new carers of the frail elderly patient: the challenge for nurses in acute care settings', *Journal of Clinical Nursing*, vol.1, pp. 303-7.

Nolan, M., Walker, G., Nolan, J., Williams, S., Poland, F., Curan, M. and Bent, B.C. (1996) 'Entry to care: positive choice or fait accompli?', *Journal of Advanced Nursing*, vol.24, no.2, pp. 265-274.

Nussbaum, J.F. (1991) 'Communication, language, and the institutional elderly', *Ageing and Society*, vol.11, pp. 149-165.

Office for Fair Trading (2005) *Care Homes for Older People in the UK*, London, OFT.

Office for Fair Trading (2010) *Choice and Competition in Public Services: A Guide for Policy Makers*, London, OFT.

Office for National Statistics (2001) *Census 2001*, London, ONS.

Office for National Statistics (2005) *Census 2001 Quality Report for England and Wales*, London, ONS.

Office for National Statistics (2009) *Ageing in the UK* (An Interactive Mapping Tool), Retrieved on the 21st November 2012, from, http://www.statistics.gov.uk/ageingintheuk/agemap.html

Office for National Statistics (2014) *Changes in the Older Resident Care Home Population between 2001 and 2011*, London, ONS.

Owen, T., Meyer, J., Cornell, M., Dudman, P., Ferreira, Z., Hamilton, S., Moore, J. and Wallis, J. (2012) *My Home Life: Promoting Quality of Life in Care Homes*, York, Joseph Rowntree Foundation.

Patterson, B.J. (1995) 'The process of social support: adjusting to life in a nursing home', *Journal of Advanced Nursing*, vol.21, pp. 682-689.

Pearson, V., Hockings, S., Mott, S. and Riggs, A. (1993) 'Quality of care in nursing homes', *Journal of Advanced Nursing*, vol. 18, pp. 20-24.

Perry 6 (2002) 'Giving consumers of British public services more choice: what can be learned from recent history?', *Journal of Social Policy*, vol.32, no.2, pp. 239-270.

Phillips, J. (1992) *Private Residential Care*, Aldershot, Avebury.

Phillips, J. and Davies, M. (1990) *Admission to Residential Care*, Norwich, University of East Anglia.

Phillips, J. (1992) *Private Residential Care: The Admission Process and Reactions of the Public Sector*, Aldershot, Avebury.

Phillipson, C. (1982) *Capitalism and the Construction of Old Age*, London, Macmillan.

Pickard, S. (2008) ‘The surveillance gaze: A New Paradigm for Long-term Care of Older People in the UK National Health Service’, in Garner, J.B. and Christiansen, T.C. (eds) *Social Sciences in Health Care and Medicine*, New York, Nova Publishers, pp. 85-115

Poverty Site (2009) ‘Older people in low income’, Retrieved from http://www.poverty.org.uk/64/index.shtml?2#g6

Prior, P.M. and Hayes, B.C. (2003) *Gender and Health Care in the UK: Exploring the. Stereotypes*, Basingstoke, Palgrave Macmillan

Qureshi, H., Patmore, C., Nicholas, E. and Bamford, C. (1998) Overview: Outcomes of Social Care for Older People and Carers, York, University of York, Social Policy Research Unit.

Ratzan, R.M. (1980) ‘Being old makes you different: the ethics of research with elderly subjects’, *The Hastings Centre Report*, vol.10, no.5, pp. 32-42.

Ray, M., Bernard, M. and Phillips, J. (2009) *Critical Issues in Social Work with Older People*, Basingstoke, Palgrave Macmillan.

Redfern, S. and Ross, F. (1999) *Nursing Older People*, Edinburgh, Churchill Livingstone.

Reed, J., Cook, G., Sullivan, A. and Burridge, C. (2003) ‘Making a move: care-home residents’ experiences of relocation’, *Ageing and Society*, vol. 23, pp. 225–41.

Reed, J., Stanley, D. and Clarke, C. (2004) *Health, Well-being and Older People*, Bristol, Policy Press.

Reissman, C.K. (2005) ‘Narrative analysis’, in Kelly, N., Horrocks, C., Milnes, K., Roberts, B. and Robinson, D. (eds) *Narrative, Memory and Everyday Life*, University of Huddersfield, Huddersfield, pp. 1-7.

Rice, P.L. and Ezzy, D. (1999) *Qualitative Research Methods: A Health Focus*, South Melbourne, Oxford University Press

Richards, L. and Richards, T. (1994) ‘From filling cabinet to computer’, in Bryman, A. and Burgees, R.G. (eds) *Analysing Qualitative Data*, London, Routledge.

Ritchie, J. (2003) ‘The application of qualitative methods to social research’, in Ritchie, J. and Lewis, J. (eds) *Qualitative Research Practice*, London, Sage, pp. 24-46.

Ritchie, J., Spencer, L. and O’Conner, W. (2003) ‘Carrying out qualitative analysis’, in Ritchie, J. and Lewis, J. (eds) *Qualitative Research Practice*, London, Sage.

Roberts, K. and Chapman, T. (2001) *Realising Participation*, Surrey, Ashgate.
Royal Commission on Long-Term Care (1999) *With Respect to Old Age*, London, The Stationery Office, Cm 4192.

Roberts, S., Steele, J. and Morse, N. (1991) *Finding Out About Residential Care: Results of a Survey of Users*, Working Paper 3, London, Policy Studies Institute.

Royal Commission on Long-Term Care (2003) *Long-term Care: Statement by Royal Commissioners*, London, HMSO.

Roulstone, A. And Morgan, H. (2009) 'Neo-liberal, individualism or self-directed support: are we all speaking the same language on modernising adult social care?', *Social Policy and Society*, vol.8, no.3, pp. 333-345.

Ryff, C.D, Singer, B.H and Seltzer, M.M. (2002) 'Pathways through challenge: implications for well-being and health' in Pulkkinen, L. and Caspi, A (eds) *Paths to successful development: Personality in lifecourse*, Cambridge, Cambridge University Press, pp. 302-328.

Salecl, R. (2010) *Choice*, London, Profile Books.

Sandberg, J., Nolan, M.R. and Lundh, U. (2002) 'Entering a new world: empathic awareness as the key to positive family/staff relationships in care homes', *International Journal of Nursing Studies*, vol.39, pp. 507-515.

Schulz, R., and Brenner, G. (1977) 'Relocation of the aged: a review and theoretical analysis', *Journal of Gerontology*, vol.32, no.3, pp. 323-333.

Schwartz, B. (2004) *The Paradox of Choice: Why More is Less*, New York, Harper Perennial.

Scourfield, P. (2007) 'Helping older people in residential care remain full citizens', *British Journal of Social Work*, vol.37, pp 1135-1152.

Scottish Executive (2000) *Response to the Royal Commission on Long-Term Care*, Retrieved on the 11th January 2012, from
http://www.scotland.gov.uk/Resource/Doc/158704/0043067.pdf

Senior, B. (1989) 'Residential care: what hope for the future?' in Langan, M. and Lee, P. (eds), *Radical Social Work Today*, Unwin Hyman.

Shaw, E. (2009) 'The consumer and New Labour: the consumer as king?', in Greener, I., Simmons, R. and Powell, M. (eds) *The Consumer in Public Services*, Bristol, The Policy Press, pp. 19-38.

Simmons, R., Powell, M. and Greener, I. (2009) *The Consumer in Public Services*, Bristol, The Policy Press.

Sinclair, I. (1988) *Residential Care: The Research Reviewed*, HMSO, London.

Snape, D. and Spencer, L. (2003) 'The foundations of qualitative research', in Ritchie, J. and Lewis, J. (eds) *Qualitative Research Practice*, London, Sage, pp. 1-23.

Social Care Institute for Excellence (2010) *Facts about FACS 2010: A guide to Fair Access to Care Services*, London, SCIE.

Social Care Institute for Excellence (2012) *Safeguarding and Quality in Commissioning Care Homes*, London, SCIE.

Spencer, L., Ritchie, J. and O'Conner, W. (2003) 'Analysis: practices, principles and processes', in Ritchie, J. and Lewis, J. (eds) *Qualitative Research Practice*, London, Sage, pp. 199-218.

Spicker, P. (2012) 'Personalisation falls short', *The British Journal of Social Work*, vol.43, no.7, pp.1259-1275.

Stilwell, P. and Kerslake, A. (2004) 'What makes older people choose residential care, and are there alternatives?', *Housing, Care and Support*, vol.7, no.4, pp.4 - 8

Strang,V.R., Koop, P.M., Dupuis-Blanchard, S., Nordstrom, M., and Thompson, B. (2006) 'Family caregivers and transition to long-term care', *Clinical Nursing Research*, vol.15, no.1, pp.27-45.

Strauss, A. and Corbin, J. (1998) *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory*, London, Sage.

Summerfield, C. and Babb, P. (2004) *Social Trends 34*, Office for National Statistics, London, TSO.

Szczepura, A., Clay, D., Nelson, S., Wild, D., and Spilsbury, K. (2008) *Improving Care in Residential Care Homes: A Literature Review*, York, Joseph Rowntree Foundation.

Tak, M. (2007) *Who Cares for Older Carers?*, MA thesis, London, London School of Economics and Political Science.

Thompson, P. (1981) ‘Life histories and the analysis of social change’, in Bertaux, D. (ed.) *Biography and Society: The Life History Approach in the Social Sciences*, Beverley Hills, Sage, pp. 289-306

Tobin, S.S. (1989) ‘The effects of institutionalisation’, in Markides, K.S. and Cooper, C.L. (eds) *Ageing, Stress and Health*, New York, Wiley.

Tobin, S.S. and Lieberman, M.A. (1976) *Last home for the aged: Institutionalization effects and their cause*, San Francisco, Jossey-Bass.

Tomorrow’s Guide Limited (2009) *Care Homes & Nursing Homes UK: Care Home and Nursing Home UK Guide*, Hungerford, Carehome.co.uk.

Townsend, P. (1957) *The Family Life of Old People*, Middlesex, Pelican Books Ltd.

Townsend, P. (1962) *The Last Refuge: A Survey of Residential Institutions and Homes for the Aged in England and Wales*, London, Routledge and Kegan Paul.
Townsend, P. (1981) ‘The structured dependency of the elderly: a creation of social policy in the twentieth century’, *Ageing and Society*, vol.1, no.1, pp. 5-28.

Trydegård, G.B. (2000) *Tradition, Change and Variation: Past and Present Trends in Public Old-Age Care*, Stockholm, Stockholm University.

Tuckett, A.G. (2005) ‘Applying thematic analysis theory to practice: a researcher’s experience’, *Contemporary Nurse*, vol.19, pp. 75-87.

Ungerson, C. (2002) ‘Institutional care’, in Alcock, P. (ed.) *The Blackwell Dictionary of Social Policy*, Oxford, Blackwell Publishing.

United Nations (1991) ‘46/91 Implementation of the international plan of action on ageing and related activities’, *General Assembly – forty six sessions*.

Vaillant, G.E. (2002) *Ageing Well: Surprising Guideposts to a Happier Life from the Landmark Harvard Study of Adult Development*, Boston, MA: Little, Brown and Company.

Van de Bovenkamp, H., Vollaard, H., Trappenburg, M. and Grit, K. (2012) 'Voice and choice by delegation', *Journal of Health Politics, Policy and Law*, vol.38, no.1, pp. 57-87.

Victor, C.R. (1992) ‘Do we need institutional care?’ in Laczko, F. and Victor, C.R. (eds) *Social Policy and Elderly People*, Aldershot, Avebury.

Victor, C.R. (2005) *The Social Context of Ageing*, London, Routledge.

Waine, B., Tunstill, J., Meadows, P. and Peel, M. (2005) *Developing Social Care: Values and Principles*, Bristol, SCIE.

Walker, A. (1981) 'Towards a political economy of old age', *Ageing and Society*, vol.1, no.1, pp. 73-94.

Walker, A. (1982) 'Dependency and old age', *Social Policy and Administration*, vol.6, no.2, pp.115-135.

Walker, A. and Warren, L. (1994) 'The care of frail older people in Britain', in Olson, L.K. (ed.) *The Graying of the World*, New York, Haworth Press.

Wanless, D. (2006) *Securing Good Care for Older People,* King's Fund

Warren, C.A.B. (2002) 'Qualitative interviewing', in Gubrium, J.F. and Holstein, J.A. (eds) *Handbook of Interview Research: Context and Method*, Thousand Oaks, Sage.

Weaver, T. Willcocks, D. and Kellaher, L. (1985) *The Business of Care*, CESSA Report No.1, Poliytechnic of North London, London.

Willcocks, D. Peace, S. and Kelleher, L. (1987) *Private Lives in Public Places*, Hampshire, Tavistock Publications.

Williams, G. (1984) 'The genesis of chronic illness: narrative reconstruction', *Sociology of Health and Illness*, vol.6, no.2, pp. 175-200.

Williams, J. (2005) *Consumer Behaviour and Care Homes – A Literature Assessment (Annexe K of Care Homes for Older People in the UK)*, London, OFT.

Williams, J., Netten, A. and Ware, P. (2003) *The Closure of Care Homes for Older People: Relatives' and Residents' Experiences and Views of the Closure Process*, Kent, University of Kent, Personal Social Services Research Unit.

Wilson, S.A. (1997) 'The transition to nursing home life: a comparison of planned and unplanned admission', *Journal of Advanced Nursing*, vol.26, pp. 864-871.