

**UNIVERSITY OF
BIRMINGHAM**

HSMC

**An Evaluation of the Modernisation of Older
People's Services in Birmingham – final report**

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Executive summary

Background

In 2008, the Adults and Communities Directorate of Birmingham City Council asked the University of Birmingham to carry out a 3-year research study into the closure of local authority Care Homes (CH) for older people and linked Day Centres (DC). After widespread consultation, the Council had decided to close these services and provide support in new special care centres, new housing services and in other forms of residential care. This research explores the impact of these changes on older people living in the care homes affected or attending linked day centres.

Methods

This final report is based on data from a small number of older people (74) about their health and quality of life collected when their social worker first assessed their needs, when their new care package was reviewed after 28 days and when their care was reviewed after 12 months. This was based on outcomes from social care services that older people say are important to them and on an easy to complete but internationally recognised measure known as the EQ-5D. Our interim report (December 2009) summarised early trends after 28 days and focused in more detail on interviews with 49 older people, their families, care staff and assessors to find out what they felt about the resettlement process being delivered.

Findings

The older people who took part were relatively satisfied with their services and with their lives throughout the study. Overall, most people said that things had either stayed the same or got better. Key changes included:

- The majority of respondents suggested they felt valued and were happy with the control they had over their life at all stages of the study;
- Approximately 50% more respondents from DCs and 39% more from CHs rated their services as very clean and tidy at 12 month follow up, compared to initial assessment;
- A number of respondents reported an increase in health related quality of life (59%CH and 42%DC) and a further 31% (CH) and 46% (DC) reported a decrease;
- 42 per cent of respondents from each setting suggested that life had got better following the resettlement programme and a further 35 per cent suggested life had stayed the same;
- Of the 19 per cent who suggested life had got worse following changes, around half of these respondents suggested this was due to deterioration in their actual health rather than due to the services at their current care home.

Summary

Although older people, their families and care staff had been very anxious about the changes when we interviewed them as they were awaiting resettlement, this study suggests that Birmingham City Council has been able to manage the modernisation programme in such a way as to ensure that most outcomes either stayed the same or improved slightly. Given that this was a major upheaval and given that participants were a year older at the end of the study than at the start, this seems a major achievement.

Introduction

In 2008, the Adults and Communities Directorate of Birmingham City Council commissioned a 3-year evaluation of the modernisation of older people's services in the city. Following longstanding debates and a detailed process of engagement and deliberation, the Council had decided to close all its local authority care homes for older people (and attached day centres), reassessing all current service users and finding alternative services for them. As part of this process, a series of new special care centres were to be opened from 2008 onwards and additional capacity was planned in extra care sheltered housing and independent sector residential care (see Birmingham City Council, 2007 for a summary). These changes were justified through a desire to respond to:

- The rising expectations of older people
- The changing and differing needs of people using services
- Financial pressures
- Changing legislation and standards
- The need for different types of services

Throughout this process, Birmingham City Council has been keen to evaluate the processes put in place and the outcomes of the modernisation programme for older people. It therefore commissioned the current study with a view to making changes to its processes as the closures proceeded (if found to be necessary) and sharing lessons learned with other local authorities. As the study was due to report, the closure of care homes became a national topic following high profile problems within the Southern Cross care home provider, and Birmingham volunteered for its data to be made available to inform a national guide to care home closures (Glasby *et al.*, 2011). Since care home closures are often a sensitive and high profile subject, we feel that the City Council is to be commended for its commitment to evaluation and openness.

When planning the assessment and resettlement process, Birmingham City Council commissioned an initial review of the literature from a different research team (Le Mesurier and Littlechild, 2007). While there have been significant closure programmes and local challenges in a number of areas, this study found:

“Very little empirical research evidence on the closure of residential care homes for older people. What there is comes from a limited range of sources and concentrates mainly on the experience of closure in the independent sector” (p.3).

Similarly:

“An extensive review of local authority guidelines of care home closure found that few had been developed and that most were developed ‘in-house’ without reference to experience elsewhere. Consequently there are few, if any, reliable benchmarks available to the Re provision Programme by which to compare performance” (p.3).

However drawing on the very limited evidence available, Le Mesurier and Littlechild made a series of recommendations to the City Council that subsequently helped to shape the nature of the process adopted in Birmingham (see Appendix A for a summary). Perhaps unsurprisingly, key principles included:

- The importance of placing service users' needs and wishes at the heart of care plans and of consulting properly with service users and their families/carers.
- Maintaining continuity of care and relationships with staff wherever possible.
- Paying particular attention to the needs of people with cognitive impairments.
- Providing adequate support for care managers (who may experience complex and stressful demands).
- The importance of training and support to enable care staff to work in different ways in future services.

Given Birmingham's size, we understand that the closure process planned may be one of the most significant attempted to date in the UK. Not only was there very little previous evidence to support the process, but a rapidly deteriorating economic situation is likely to prove very difficult for all public services. Thus, Birmingham City Council has been attempting a profound change in older people's services on a large scale with very little established good practice on which to draw and in a difficult financial environment - and subsequent findings from the evaluation must take account of this very challenging context.

Methods

Given the complex and large-scale changes planned as part of the modernisation process, our evaluation has attempted to be both rigorous *and* realistic. While an external study inevitably places additional demands on the services being evaluated, we have tried to work in collaboration with the City Council to minimise any disruption caused by our presence (in what is already a potentially highly charged and challenging programme of work). Overall, the two main research questions were:

1. What impact has the modernisation of older people's services and the re-provision of local authority care homes/day care had on the health and quality of life of older people currently using services?
2. What lessons can be drawn from the re-provision process in order to make changes to the process locally (if needed) and/or to share nationally?

In consultation with the City Council, our research involved two phases:

1. A quantitative study of the impact of resettlement and re-provision on the health and quality of life of older people currently using services in the first 13 care homes and 7 day centres to be closed. Initial findings from this aspect of the research were summarised in our interim report, but the key data 12 months after resettlement are set out below in more detail.
2. A qualitative study of the process of reassessment and re-provision in one case study care home and one day centre, exploring the (potentially different) perspectives of older people, their families, care staff and assessors. Findings from this phase of the study were reported in detail in our interim report in December 2009.

Throughout, the research focused on those older people currently living in care homes or attending linked day centres in all services scheduled for closure in the early stages of the original modernisation programme. Accessible information sheets and consent forms were prepared for both phases of the research, and distributed to those eligible for the study by care staff and/or assessors. Those people wishing to take part in the study sent completed consent forms to a central contact within the City Council, who collated these and provided details of those wishing to participate to the research team.

Where care staff and/or assessors felt that an older person lacked the mental capacity to consent to taking part in the study, they identified a 'consultee' – often a family member or carer – who was able to comment on whether the person would wish to take part and answer questions on their behalf.

Ethical approval for the study was granted by both the NHS research ethics system and the Birmingham City Council process.

Quantitative (outcomes) research

In order to identify the impact of the modernisation programme on older people currently using services, a short questionnaire (see Appendix B) was completed for each person taking part in the research at three points in time:

- When they were first assessed by the Council's Assessment and Resettlement Team
- At the first 28 day review
- At the first annual review (approx 12 months after start of care package)

The questionnaire concerned combines an internationally recognised measure of health status and health-related quality of life (the EQ-5D) and a modified version of a tool already piloted by the national In Control project (of which Birmingham is a member and a total transformation pilot – see Poll *et al.*, 2005). Together, the questionnaire asked participants about a series of outcomes identified as being important by older people themselves (Glendinning *et al.*, 2006):

1. Outcomes involving change:

- Changes in symptoms or behaviours
- Improvements in physical functioning
- Improving morale

2. Outcomes involving maintenance or prevention:

- Meeting basic physical needs
- Ensuring personal safety and security
- Living in a clean and tidy environment
- Keeping alert and active
- Having control over everyday life

3. Service process outcomes:

- Feeling valued and being treated with respect
- Being treated as an individual
- Having 'a say' and control over services
- A 'good fit' with informal sources of support
- Compatibility with and respect for cultural and religious preferences

The questionnaire was broadly structured as follows:

- Section A asked respondents about their mental capacity.
- Section B collected basic demographic data to allow analysis of outcomes according to key social characteristics (for example, sex or ethnicity).
- Section C collected detail on the types of services received.
- Section D was interested in respondents' views on the impact care services have on their daily life.

- Section E used the EQ-5D, an internationally recognised and validated tool which collects information on respondents' health profile (www.euroqol.org).

At the 12 month follow-up, participants were asked an additional question to explore whether they felt that the new services they had received since the closure of their care home/day centre had helped them to have a better life (or not). This was added in response to informal feedback from assessors, who felt that some older people may be completing initial surveys with such high scores that it might not be possible for them to score outcomes at 12 months any higher, even if they felt things had got better. This was thus an attempt to ask participants that, if they knew then what they know now, would they still have completed the earlier surveys in the same way?.

Further details of the questions and tools used in sections D and E are outlined below and a full version of the questionnaire can be found in Appendix B.

Section D included a series of 14 questions which asked respondents to rate their views on a five point scale ranging from very positive to very negative. For example, when asked to rate their overall physical health respondents had a choice of point one (very good) through to point five (very bad). The questions fall into the following three categories: category one (Q1 and Q2) asked respondents to rate their health and physical well-being; category two (Q3 to Q6) asked respondents about their feelings in relation to the care they receive (for example, how happy are you with care services); and category three (Q7 to Q14) was interested in how respondents feel in terms of the control they have over their lives and their care services.

Section E used the EQ-5D, a validated health state descriptor, to collect information on respondents' functional health status. The EQ-5D is a generic health state descriptor which classifies health in terms of five dimensions. Health profiles are then defined by combining one statement from each of the five dimensions. This then allows for a composite health state descriptor to be developed (see figure 1). The EuroQol produces a total of 243 possible health state scenarios.

Figure 1 The EQ-5D descriptive system

Mobility

1. No problems walking about
2. Some problems walking about
3. Confined to bed

Self-Care

1. No problems with self-care
2. Some problems washing and dressing self
3. Unable to wash or dress self

Usual Activities

1. No problems with performing usual activities (e.g. work, study, housework, family or leisure activities)
2. Some problems with performing usual activities
3. Unable to perform usual activities

Pain/discomfort

1. No pain or discomfort
2. Moderate pain or discomfort
3. Extreme pain or discomfort

Anxiety/depression

1. Not anxious or depressed
2. Moderately anxious or depressed
3. Extremely anxious or depressed

Note: Each composite health state has a five digit code number which relates to the relevant level of each dimension, with the dimensions always listed in the order displayed above. For example 11111 (full health) equals:

- 1 No problems walking about
- 1 No problems with self-care
- 1 No problems with performing usual activities
- 1 No pain or discomfort
- 1 Not anxious or depressed

One of the advantages of the EQ-5D is that it allows for health profiles to be converted into a single summary index, which provides a health state valuation. This involves attaching weights to each of the levels in each dimension. The weights assigned to the EQ-5D are on a scale of 1 (full health) to 0 (death). This formula is based on the valuation of EQ-5D health profiles from the UK population (Dolan *et al.*, 1995; www.euroqol.org).

Data acquisition

These questionnaires were completed by Assessment and Resettlement Team staff as part of the assessment/review process (i.e. face to face with individual service users), and subsequently submitted to the research team. While this added to the workload of the team, this approach meant that all those who consented to take part completed the questionnaires with support from professionally qualified workers, and that this process could be tailored according to individual needs (for example, for people who do not speak English as a first language or people with some form of cognitive impairment). Building data collection in to the standard assessment and review process also enabled us to involve a much broader group of older people in the research than might have been possible if the research team had been required to collect data from individual service users directly. To avoid any potential conflicts of interest for Assessment and Resettlement Team staff, all survey questions focused on overall quality of life (not on specific issues such as the role of Resettlement staff).

At the research team's suggestion, the City Council identified a relevant officer to co-ordinate the research process, checking out whether incomplete returns over time were due to a desire to withdraw on the part of the individual older person, a death or failure on the part of care staff to give out consent forms or of the Assessment Team to submit completed questionnaires. The person identified was a very experienced manager, who was able to handle this process in a sensitive manner – striking a difficult balance between ensuring those that wished to participate were able to do so, but that people were not placed under pressure to take part.

Completed questionnaires were collated by the co-ordinating officer and returned to the research team in batches as the modernisation process progressed. Surveys were coded and entered in an Access database, where they were analysed using Excel and SPSS.

Qualitative (process) research

To supplement this survey data about the outcomes of the modernisation programme, we also carried out more detailed case study research into the process adopted. With support from the City Council, we identified one day centre and one care home for this phase of the research. This decision was reached with a view to:

- Choosing two case studies from units that were far enough into the process to avoid any inevitable teething problems but that were early enough to enable any lessons to be taken on board for the future.
- Including people with physical and mental health problems.
- Avoiding services where there had been a high level of staff turnover and/or significant use of agency staff.
- Including service users who were from a minority ethnic community.

This element of the research was carried out in the summer of 2009 and results were set out in detail in our interim report in December 2009. Although interviews were

tape-recorded in case additional analysis was required, we relied primarily upon detailed field notes taken during the interviews themselves (particularly as some settings were very noisy and using a tape-recorder was not always possible). Although most interviews took place face-to-face, a small number of interviews with family members took place out of hours over the telephone (at a time convenient to family members). These interviews asked older people, their families, care staff and assessors their views about:

- How people felt about the closure of their care home/day centre
- What impact people felt it was having
- The information and support provided
- Overall views on the process adopted (including positives and negatives)
- Future areas for improvement

For further details, please see the interview schedule in Appendix C.

The data collected from this aspect of the research were analysed using a grounded approach (that is, we searched our data for key themes and issues, which were coded and extracted, constantly looking back over previous notes to make sure that our themes continued to represent a satisfactory explanation of the data). This was done manually rather than electronically.

At the request of Birmingham City Council, we have since conducted an additional telephone interview with the independent information and advocacy service commissioned by the City Council to support older people through the closure process in order to explore their perceptions of the resettlement process (see below for further details).

Summary of interim findings

In our interim report, we identified three overall limitations to our study:

- We only have health and quality of life data from a small number of older people – so any themes identified in the interim report would need to be tested further in the future and over a longer time period.
- Our interviews took place when the older people who participated were waiting for their service to close, but did not yet know where they would be going instead. This was a very uncertain time for them - possibly when they were feeling at their most unsettled - and our initial results may have been different if we had talked to people at a different stage in the process.
- More people took part in our interviews from day care than from residential care. As we discussed in our interim report, the changes were seen by many as much more positive in residential care – so our qualitative results may have been affected by the fact that many people in day care did not want their service to close.

Initial quantitative data

Overall, there was a small increase in positive responses at the 28 day review for people living in care homes. The main change was in people's views of the cleanliness of their home (which improved). In contrast, there was a very small negative impact for people in day care. This was also supported by the views expressed by older people and families during interviews.

At this early stage it was difficult to interpret such trends – however, given the scale of the changes being undertaken, it is perhaps surprising that older people's sense of health and well-being was not much worse at 28 day review than at initial assessment. Indeed, it is possible that the fact that very little seemed to have got any worse for the older people who took part (and that some things improved slightly) may actually be a **major success** in the short-term. Equally, it is possible that the attention given to individual service users in the short-term may have improved their sense of well-being, and that this could decline over time as they settle in to new services.

Interviews

The different people who took part in our interviews told us different things:

- Older service users, many families and care staff did not want services to close and were still angry and upset. Although we understand that detailed consultation had taken place, they did not feel as if they had been able to have a say in this decision. This is probably to be expected, and may reflect a

natural sense of loss and fear of change. We would hope that this changes over time when people move to new services or to new jobs.

- Many service users, families and care staff talked about the friendships that had been made with other service users and with staff. People often wanted to stay with their friends and to carry on going to a local service.
- There was a general feeling of uncertainty as services were about to close, but new services not yet in place for many people. Changes to the closure process seemed to have added to this sense of uncertainty.
- Those who took part were often positive about the role of the assessment team, and felt that they had done a hard job in a positive and proactive way.
- Assessors felt that the changes taking place were right for older people in Birmingham, but some were worried about a number of current service users during the transition. Many people talked about the positive impact this was already having and would have in the future.
- Assessors felt that the team had been able to build good relationships with service users, families and care staff, and that they had been able to work in a very positive and person-centred way. They were keen that this good practice could be continued in the future in other services.
- There was a sense that the process for closing care homes was more rigorous than the process for closing linked day centres – with the latter seen as being caught up in the changes a little bit by accident. People were often more upset about their day centre closing than about their care home closing.

In terms of potential improvements to the current process, different stakeholders suggested:

- Involving key stakeholders (especially older people themselves) upfront in initial decisions about services, rather than after the key decision is taken.
- Keeping friends (service users and staff) together as much as possible.
- Opening alternative services before closing previous units.
- Spacing out the closure programme so as to prevent rushed decisions and overloading care staff and assessors.
- Providing as much certainty as is feasible by being clear with people as soon as possible where they may be going in future.
- Avoiding placing people in services that are in imminent risk of shutting in the near future.

- Continuing to recognise the importance some older people attach to attending local services.
- Providing more personal, individual information – rather than older service users hearing most of their information in a group in the day centre lounge.
- Ensuring all information is accurate and making sure that any early pledges or deadlines are subsequently met.
- Greater attention to the strengths and limitations of current day services so that these are not seen as an ‘add on’ to the residential home closure – indeed the perceived failure to plan day centre closures as rigorously as care home closures is a key theme to emerge from our interviews.
- Greater attention to the training and support needs of care staff – both to discharge a duty of care to local authority employees but also to ensure a better supported workforce for the frail older people they work with.

In our discussions with the City Council, we understand that such issues were anticipated in advance as part of the detailed planning which took place and that there is significant ongoing work to build on the positives of the process so far and limit any potential negatives. Ultimately, what may be at stake here is an issue of *‘reality v the perception of reality’*. While the Council may feel that several of the views expressed did not fully reflect the detailed and careful planning which had gone into the modernisation process, the fact remains that this is how these different stakeholders were feeling at the time – and so these issues are *true to them*. As a result, we concluded that it will be important for the Council to recognise and work with the distress which some key stakeholders expressed, building on the views and experiences shared by participants in our interim report during future closures.

Information and advocacy services

At the request of the City Council we have since conducted an additional interview with the independent information and advocacy team commissioned to support older people during the closure process.

The role of the team: as independent partners, the information and advocacy team’s role was to provide an outreach service to support older service users, their relatives and other members of their immediate support networks. The information and advocacy service also produced written updates via a newsletter every two months. In practice, the team feels that this work has made a dual contribution, complementary to the work of the assessment team. Firstly, they communicated key information about the process from Birmingham City Council, providing clarification and explanation to ensure that all older people could understand key messages. Secondly, they feel that their independent status allowed service users and families access to an impartial forum where they could openly voice concerns and questions. As such the service feels it acted to reassure as well as inform.

Reflections on the process: although the team had contact with several stakeholders (for example, managers, assessors, care home staff etc), their main focus and contact has been with service users and families. They identified three phases of the closure process in terms of service users' reactions and responses. Initially, team members described anxiety about changes among older people and their relatives and carers, along with a wider scepticism that changes would be implemented. There was then a sense of acceptance of the process once facilities actually began to close. For re-homed residents, advocacy and information team members perceive a positive long-term impact in terms of user satisfaction, including rising expectations for their everyday environment and care in some cases.

Strengths: a key strength of the process was felt to be the dedicated group of assessors. Giving a specific social work team the opportunity to focus on the assessment and resettlement process was seen as crucial, and a key success factor was felt to be the commitment and enthusiasm of individuals within the social work team. It was also felt that the advocacy team was able to enhance genuine consultation. For many service users, careful explanation of local authority plans was needed in order to achieve an understanding of future events. This was especially the case for older people with dementia, where trained staff on both social work and advocacy teams worked with individuals to keep them informed and to minimise the upheaval experienced.

Challenges: as with any major change, it was felt that conflicting views and different interpretations of information by various stakeholders have existed throughout the process. A primary objective for the advocacy team was to communicate accurate and consistent information from a single source and they feel that they were able to achieve this. However, a gap was identified in terms of information provision for care staff. Information and advocacy teams were aware that the information they disseminated via the newsletter (designed for service users/families) also gained an audience among the care staff of residential and day care facilities. It was suggested that improving information flow to care staff might have had a beneficial impact on the process. Concern was also voiced around how the end of the closure process will be organised – with fears that the advocacy team and the assessment team may not necessarily be in place long enough to oversee the remaining closures/moves and to deliver the same level of service to residents of these later-closing facilities as has been the standard throughout the process to date.

Summary

Our interim report gave an early overview of some of the issues that were emerging from the closure of local authority care homes and linked day centres in Birmingham. Although numbers were initially too low to be sure, there was a suggestion that outcomes for the older people who took part had improved slightly after 28 days – and this could be a very positive finding. However, it was recognised that it will be important to study this again after more people have moved and after one year in new services.

Our interviews took place when people were very uncertain about what would happen next, and this may have contributed to the natural sense of loss which older

people, some families and care staff talked about. Although we understand that detailed consultation had taken place, many people did not feel fully involved in the decision to close services and some were understandably worried about what would happen in future. The key recommendations were to keep friends together, to help people to carry on going to local services and to reduce uncertainty as much as possible – and we understand that the Council was already trying to do this. Assessors were much more positive about the long-term benefits of the process and were keen that the good practice that had been developed continues.

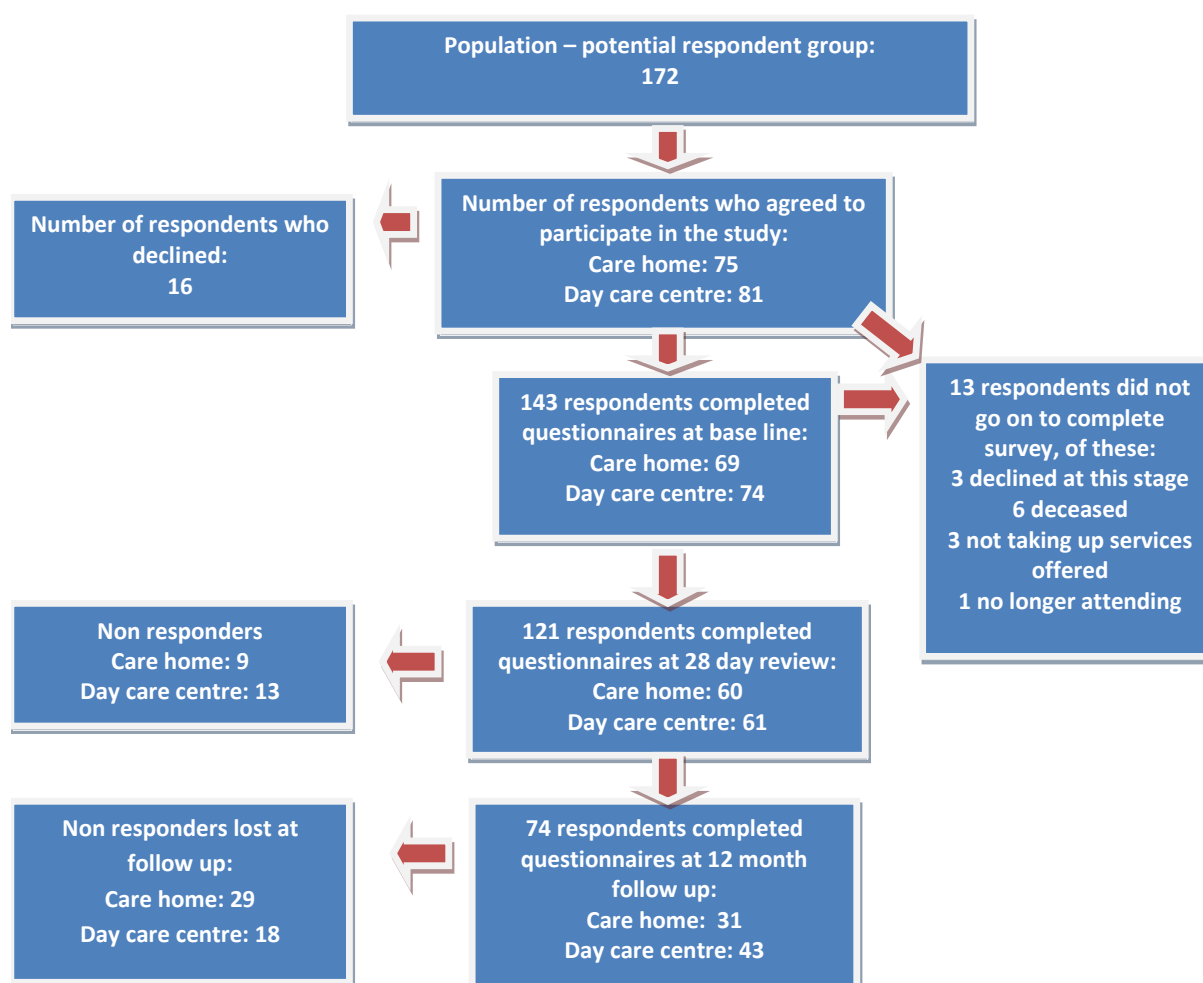
Our more recent interview with the information and advocacy team confirms many of these themes, with evidence of initial anxiety, subsequent acceptance and the potential for longer-term positive outcomes. While there were many perceived positives in the process adopted in Birmingham, key areas for improvement were felt to be around the provision of information to care staff and ensuring that the good practice developed to date would continue till the very end of the closure process.

Overall, Birmingham has been planning big changes for lots of people in a difficult economic situation. At the time of our interim report, there was a natural sense of loss from people currently using or working in services, but also signs of potential positives for the future. Given the scale of the changes, the fact that many things seemed to have got a little better rather than worse in the short-term might actually be a major success – although much would clearly depend on the results reported in our final report 12 months later (see below).

Results

The following section summarises findings from data collected via the questionnaire administered at Initial Assessment (IA), 28 Day Review (28DR) and 12 Month Follow Up (12MFU). There were a total of 172 potential participants. However, only 156 suggested they wanted to participate in the study and, of these, a total of 143 respondents completed questionnaires at IA. This figure reduced to 121 at 28DR and down to 74 respondents at 12MFU. The flow chart in Figure 2 outlines the number of respondents who completed questionnaires at each stage.

Figure 2 Flow chart of respondent participation rates for each stage of the study



Thus, a total of 74 respondents (31 Care Homes (CH), 43 Day Centres (DC)) completed questionnaires at all three stages. When interpreting the findings from our study one needs to be mindful of the fact that relatively small response rates (such as those presented here) mean that a shift in responses by one or two individuals can have a big impact on figures when expressed as percentages. We are currently undertaking further work with Birmingham City Council to judge how representative

or otherwise our participants may be, but at present, we can only comment on the data for these 74 individuals.

At initial assessment, 65 per cent of CH respondents completed the questionnaire themselves. This reduced to 51 per cent at 28DR and increased slightly to 54 per cent at 12MFU. A further 31 per cent of respondents at IA completed the questionnaire with the help of a family member or friend. This rose to 41 per cent at 28DR and reduced to 32 per cent at 12MFU. The remaining respondents answered with help from a paid member of staff (4% IA, 8% 28DR, 14% 12MFU). At initial assessment, 57 per cent of respondents from day care self-completed the questionnaire. This increased to 68 per cent at 28DR and decreased to 51 per cent at 12MFU. The number of respondents from DCs who had assistance from family members decreased from 33 per cent at IA to five per cent at 12MFU. At 12MFU almost half of respondents (44%) from day care had assistance from a paid member of staff when completing the questionnaire (an increase of 34% from IA). Table 1 outlines the percentage and number of respondents who self-completed, or received help from other individuals such as family, friends or staff members.

Table 1: How respondents completed the questionnaire

	Respondent completed	Help from family member	Help from paid member of staff
Care home			
Initial assessment	65%	31%	4%
28 day review	51%	41%	8%
12 month follow up	54%	32%	14%
Day centre			
Initial assessment	57%	33%	10%
28 day review	68%	25%	7%
12 month follow up	51%	5%	44%

Demographic information

Table 2 provides a full break down of demographic details for all respondents (reported from information collated at IA). Our findings suggest that the average age was higher for respondents in CHs (83 years) than those in DCs (77 years). The majority of respondents from CHs (39%) tended to be in the higher age range of 85-89 years, whereas respondents from the DCs were more dispersed across the different age ranges. The majority of respondents who completed the questionnaires were white British (CH 65%; DC 33%). In CHs, respondents included white Irish (16%) and black or black British (14%) people. Whilst the majority of respondents from DCs tended to be white British, this respondent group included a number of individuals from other ethnic groups, including: 23% Chinese; 14% Black or Black British; 12% Indian or British Indian and 12% Pakistani or British Pakistani.

A larger proportion of respondents were females in both CH and DC settings. At initial assessment, 45 per cent (14) of respondents from CHs and 37 per cent (16) from DCs reported a history or diagnosis of mental illness. This increased to 58 per cent (18) for respondents from CHs, with a further 10 per cent (3) respondents

stating they had been diagnosed with dementia at 28DR and 12MFU. The number of respondents reporting a history or diagnosis of mental illness at DCs decreased to 30 per cent (13), with one respondent stating they no longer felt depressed. Further demographic details can be found in Table 2.

Table 2: Respondent demographics reported at IA

	Care home respondents	Day centre respondents
Number of participants	31	43
Age mean (std)	83 (7.38)	77(9.74)
Range	64-97	53-91
<i>Age group (n) %</i>		
53-64	(1) 3%	(4) 9%
65-79	(2) 6%	(9) 21%
75-79	(5) 16%	(9) 21%
80-84	(7) 23%	(9) 21%
85-89	(12) 39%	(7) 16%
90-100	(4) 13%	(5) 12%
Sex (n) % Male	11 (35%)	11 (26%)
<i>Marital status n*</i>		
Single	9	5
Married/co-habiting	1	12
Living alone	-	9
Widowed	20	22
Divorced/separated	2	1
Living with family	-	12
<i>Ethnicity (n) %</i>		
White British	(20) 65%	(14) 33%
White Irish	(5) 16%	(2) 4%
Indian or British Indian	(0) 0%	(5) 12%
Pakistani	(0) 0%	(5) 12%
Black or Black British	(4) 13%	(6) 14%
Chinese	(0) 0%	(10) 23%
Missing	(2) 6%	(1) 2%

**some respondents reported more than one category (e.g. widowed and living with family)*

Use of care services

Over half of total respondents attended a DC (58%). The average number of days respondents attended day centres was three at all stages of the study. The number of respondents who reported they received home care reduced at each stage of the study (11 IA; 7 28DR; 3 12MFU). The questionnaire was interested in exploring the number of respondents who received direct payments/individual budgets for services and the average amount of any such payments received. Our results suggest that only one respondent from a CH reported receiving any direct payment and this was recorded as a one off start up fee, with no actual payment details being recorded. One further respondent from DC reported receiving a direct payment (value of £210.44 per week) at 28DR and 12MFU. Further details of the services received can be found in Table 3 below.

Table 3: Service use

	Care home			Day centre		
	IA	28DR	12MFU	IA	28DR	12MFU
<i>Services receiving</i>						
Payments	(1)	(0)	(0)	(0)	(1) £210.44 per wk	(1) £210.44 per wk
Direct payments (n) average amount per month	One off start up fee no cost recorded					
Day centre average days a week	NA	NA	NA	3 days per week range 1-5 (11) 8.4 hrs range 1-15	3 days per week range 1-5 (7) 9.21 hrs range 1-14	3 days per week range 1-5 (3) 6 hrs range 1- 10
Home care (n) average hours per week	NA	NA	NA			
Meals (n) average days per week	NA	NA	NA	(5) 3 days per week	(2) 4 days per week	(0)
Short breaks (n) average weeks per year	NA	NA	NA	(1) 3 times a year	(1) occasionally	(0)

Impact of care services

The study was interested in exploring the impact of 'care services' more generally and the questionnaire posed 15 different questions which covered the broad areas of health and physical well-being; feelings in relation to services received; and feelings of control, self worth and independence. The questions asked respondents to rate their services on a five item likert scale which included a positive response (such as very good) through to a negative response (such as very bad), with the mid-point offering a neutral response of neither good nor bad. While it is relatively easy to answer and interpret results for people in 24 hour residential care, it is potentially harder to interpret results for people attending a day centre (who may also be receiving a range of additional services that continue in much the same manner even

if their current DC closes). The following section reports findings separately for residential and DC respondents.

Health and physical well-being

This category included two questions which asked respondents to rate their overall physical health (Q1) and quality of life (Q2). A number of respondents from CHs and DCs rated both their physical health and quality of life as neutral (that is, they rated it neither good nor bad). The highest category rating for respondents in CHs for both physical health and quality of life was good, with over half of respondents at all stages of the study rating their quality of life as being good. However, two respondents rated their quality of life as bad at all stages of the study and one respondent suggested their quality of life was very bad at 12MFU. In relation to physical health there was an increase of one respondent at 28DR and a further respondent at 12MFU who rated their physical health as bad and an additional respondent who rated it as very bad at 12MFU. However, there was a positive shift in the number of respondents who rated their physical health as good or very good after resettlement (IA: 42%, 28DR: 48%, and 12MFU: 52%).

For respondents attending DCs, the second highest category in relation to physical health, after neutral, varied at different stages of the study. For example, at IA 28 per cent of respondents rated their physical health as bad. However, at 28DR and 12MFU there was a positive shift in that a higher percentage of respondents rated their physical health as good or very good (IA: 30%, 28DR: 39% and 12MFU: 49%)

When asked about their quality of life, a high percentage of respondents from the DC (28% at IA) were indifferent, in that they suggested their quality of life was neither good nor bad. However, a further 49 per cent of respondents at IA suggested their quality of life was good. Compared to IA there was an increase in the number of respondents who rated their quality of life as 'very good' at both 28DR and 12MFU. Tables 4 provides a full break down of results.

Table 4: Respondents' ratings of their health and physical well-being

Question	Care home Initial assessment	28 day follow up	12 mnth review	Day centre Initial assessment	28 day follow up	12 mnth review
How would you rate your overall physical health?						
Very good	6% (2)	3%(1)	10% (3)	7% (3)	9% (4)	5% (2)
Good	36% (11)	45% (14)	42% (13)	23% (10)	30% (13)	44% (19)
Not good or bad	45% (14)	39% (12)	29% (9)	33% (14)	33% (14)	26% (11)
Bad	10% (3)	13% (4)	16% (5)	28% (12)	26% (11)	19% (8)
Very bad	0	0	3%(1)	7% (3)	0	5% (2)
missing	3%(1)	0	0	2%(1)	2%(1)	2% (1)
How would you rate your quality of life?						
Very good	10% (3)	13% (4)	13% (4)	9%(4)	19% (8)	19% (8)
Good	42% (13)	52% (16)	58% (18)	49% (21)	47% (20)	44% (19)
Not good or bad	39% (12)	29% (9)	19% (6)	28% (12)	28% (12)	23% (10)
Bad	6%(2)	6%(2)	6%(2)	12% (5)	5% (2)	14% (6)
Very bad	0	0	3%(1)	2%(1)	2% (1)	0
missing	3% (1)	0	0	0	0	0

Respondents' feelings about the care they receive

Questions 3 to 6 asked respondents about their feelings towards the care they receive (that is, the overall package of care, rather than day care or residential care *per se*). Over 80 per cent of respondents in both CH and DC gave a positive response to each of these questions, suggesting that they were satisfied/very satisfied with current service provision. This was similar for all three stages of the study. The percentage change in respondents' rating of services tended to be positive for both settings at each stage of the study (with questions relating to security and cleanliness of services receiving very positive responses at all stages). The greatest response changes occurred in the DC setting and related to the questions around cleanliness, security and happiness (with around 50% more respondents rating the DC as very clean and tidy at 12MFU compared to IA and an increase of 26% of DC respondents saying they felt very safe at 12MFU). Thirty per cent more DC respondents suggested they felt very happy with the care they received. Whilst the response change was less for respondents in CHs, all shifts were positive. The biggest shift was again around the cleanliness of care home services with 39 per cent more respondents rating homes as very clean and very tidy at 12MFU (29% IA, 68% 12MFU). Very few respondents reported negative ratings for any of the questions and where they did these tended to be reported at initial assessment and 28DR. However one respondent did report that they were fairly unhappy with the CH services at 12MFU.

A full break down of responses for each question can be found in Table 5.

Table 5: Respondents' ratings in relation to their feelings on their care services

Question	Care home			Day centre		
	Initial assessment	28 day follow up	12 mnth review	Initial assessment	28 day follow up	12 mnth review
Are you happy with the care services you receive?						
Very happy	45% (14)	55% (17)	52% (16)	58% (25)	53% (23)	81% (35)
Fairly happy	42% (13)	32% (10)	39% (12)	33% (14)	37% (16)	16% (7)
Neither happy nor unhappy	10% (3)	10% (3)	6% (2)	9% (4)	2% (1)	2% (1)
Fairly unhappy	0	0	3% (1)	0	5% (2)	0
Very unhappy	0	0	0	0	0	0
Missing	3% (1)	3% (1)	0	0	2% (1)	0
How well do your care services meet your physical needs?						
Very well	32% (10)	45% (14)	45% (14)	49% (21)	42% (18)	63% (27)
Well	55% (17)	48% (15)	45% (14)	41% (18)	44% (19)	35% (15)
Neither well nor not very well	10% (3)	3%(1)	10% (3)	5% (2)	5% (2)	2% (1)
Not well	3%(1)	3%(1)	0	5% (2)	7% (3)	0
Not very well at all	0	0	0	0	0	0
Missing	0	0	0	0	2% (1)	0
How safe and secure do your care services make you feel?						
Very safe	45% (14)	48% (15)	65% (20)	44% (19)	47% (20)	70% (30)
Safe	39% (12)	45% (14)	29% (9)	53% (23)	49% (21)	28% (12)
Neither safe nor unsafe	10% (3)	0	3%(1)	2% (1)	2% (1)	2% (1)
Unsafe	0	0	0	0	0	0
Very unsafe	0	0	0	0	0	0
Missing	6% (2)	6% (2)	3% (1)	0	2% (1)	0
Is the place where you live clean and tidy?						
Very clean & very tidy	29% (9)	68% (21)	68% (21)	23% (10)	53% (23)	72% (31)
Clean & tidy	58% (18)	26% (8)	0	67% (29)	40% (17)	19% (8)
Neither clean nor unclean/ neither tidy nor untidy	6% (2)	3% (1)	32% (10)	7%(3)	5% (2)	2% (1)
Unclean & untidy	0	0	0	0	0	0
Very unclean & very untidy	0	0	0	0	0	0
Missing	6% (2)	3% (1)	0	2% (1)	2% (1)	7% (3)

Feelings of control, self worth and independence

The study was interested in exploring respondents' feelings around the control and influence they have in relation to the care and services they received, and how valued and respected individual service users felt within residential and day care. The study also asked respondents how active and able they were to participate in community life and sought their views as to whether their cultural and religious feelings had been respected. With the exception of the question around control over care services, over half of total respondents (i.e. from both CH and DC settings) provided a positive response to the questions posed at IA, 28DR and 12MFU. Again some respondents provided a neutral response, although the number tended to be less than for the previous questions around health and physical well-being. Responses suggest that the majority of respondents definitely felt valued and respected, and a very large majority reported that they had been treated as an individual at the end of 28DR and at 12MFU. Eighty-one per cent of respondents receiving DC services suggested they were very happy with the control they had over their life at 12MFU. This is an increase of 53 per cent from initial assessment and 51 per cent from 28DR. Further, all respondents from the DC (missing data for two respondents) suggested they felt generally happy with the control they had over their care services at 12MFU.

Table 6 outlines all responses for each of the questions on control and influence.

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Table 6: Respondents' ratings around feelings of control, self worth and independence

Question	Care home Initial assessment	28 day follow up	12 mnth review	Day centre Initial assessment	28 day follow up	12 mnth review
How far do your care services help you to stay alert and active?						
Definitely	13% (4)	52% (16)	45% (14)	53% (23)	60% (26)	72% (31)
To some extent	52% (16)	32% (10)	39% (12)	42% (18)	35% (15)	21% (9)
Neither yes or no	19% (6)	13% (4)	16% (5)	2% (1)	2% (1)	5% (2)
No	6% (2)	0	0	2% (1)	0	2% (1)
Definitely not	3% (1)	0	0	0	0	0
Missing	6% (2)	3% (1)	0	0	2% (1)	0
How happy are you with the control you have over your life?						
Very happy	10% (3)	23% (7)	26% (8)	28% (12)	30% (13)	81% (35)
Happy	45% (14)	39% (12)	26% (8)	51% (22)	53% (23)	12% (5)
Neither happy nor unhappy	29% (9)	32% (10)	35% (11)	12% (5)	12% (5)	7% (3)
Unhappy	6% (2)	0	10% (3)	7% (3)	5% (2)	0
Very unhappy	3% (1)	0	0	2% (1)	0	0
Missing	6% (2)	6% (2)	3% (1)	0	0	0
How far do you feel valued and treated with respect?						
Definitely	39% (12)	71% (22)	68% (21)	74% (32)	88% (38)	96% (41)
To some extent	48% (15)	23% (7)	19% (6)	14% (6)	7% (3)	2% (1)
Neither yes or no	6% (2)	3% (1)	10% (3)	5% (2)	5% (2)	2% (1)
No	3% (1)	0	0	2% (1)	0	0
Definitely not	0	0	0	2% (1)	0	0
Missing	3% (1)	3% (1)	3% (1)	2% (1)	0	0
How far do you feel as if you are treated as an individual?						
Definitely	45% (14)	71% (22)	61% (19)	65% (28)	79% (34)	93% (40)
To some extent	35% (11)	23% (7)	23% (7)	28% (12)	16% (7)	7% (3)
Neither yes or no	10% (3)	3% (1)	13% (4)	5% (2)	5% (2)	0
No	3% (1)	0	0	2% (1)	0	0
Definitely not	0	0	0	0	0	0
Missing	6% (2)	3% (1)	3% (1)	0	0	0
How far do you feel as if you have 'a say' and control over your care services?						
Definitely	26% (8)	35% (11)	35% (11)	42% (18)	44% (19)	72% (31)
To some extent	35% (11)	35% (11)	13% (4)	40% (17)	40% (17)	23% (10)
Neither yes or no	13% (4)	19% (6)	42% (13)	9% (4)	7% (3)	0
No	16% (5)	3% (1)	3% (1)	2% (1)	7% (3)	0
Definitely not	3% (1)	0	3% (1)	2% (1)	2% (1)	0
Missing	6% (2)	6% (2)	3% (1)	5% (2)	0	5% (2)
How far do your care services help you to stay in touch with family and friends?						
Definitely	39% (12)	52% (16)	48% (15)	49% (21)	42% (18)	44% (19)
To some extent	32% (10)	23% (7)	23% (7)	28% (12)	35% (15)	26% (11)
Neither yes or no	26% (8)	13% (4)	16% (5)	12% (5)	19% (8)	16% (7)
No	0	6% (2)	6% (2)	7% (3)	0	5% (2)
Definitely not	0	3% (1)	0	5% (2)	0	0
Missing	3% (1)	3% (1)	6% (2)	0	5% (2)	9% (4)

Table 6: continued

Question	Care home Initial assessment	28 day follow up	12 mnth review	Day care Initial assessment	28 day follow up	12 mnth review
How far do you feel that your care services try to help you to take part in community life?						
Definitely	23% (7)	35% (11)	26% (8)	49% (21)	51% (22)	72% (31)
To some extent	35% (11)	32% (10)	38% (12)	44% (19)	37% (16)	12% (5)
Neither yes or no	26% (8)	23% (7)	26% (8)	5% (2)	5% (2)	12%(5)
No	13% (4)	3% (1)	6% (2)	2% (1)	5% (2)	2%(1)
Definitely not	0	3% (1)	0	0	0	2%(1)
Missing	3% (1)	3% (1)	3% (1)	0	2% (1)	2%(1)
How far do you feel that your cultural and religious preferences are respected?						
Definitely	29% (9)	29% (9)	48% (15)	49% (21)	53% (23)	77% (33)
To some extent	26% (8)	48% (15)	19% (6)	33% (14)	26% (11)	9%(4)
Neither yes or no	35% (11)	23% (7)	29% (9)	14% (6)	16% (7)	14% (6)
No	3% (1)	0	0	5%(2)	2%(1)	0
Definitely not	3% (1)	0	0	0	0	0
Missing	3% (1)	0	3%(1)	0	2%(1)	0

Health and well-being (EQ-5D)

Our study was also interested in exploring the potential impact of service changes on individual service users' health and well-being. As outlined above, the EQ-5D instrument allows for the collation of information on respondents' functional health status. The EQ-5D classifies health into five dimensions: mobility, self-care, usual activities, pain/discomfort and anxiety/depression. Each of these five dimensions has three different levels with: 1= no problem; 2= moderate or some problems; and 3 = severe problems. Respondents in this study were asked to rate their quality of life against the EQ-5D dimensions. This allowed for an EQ-5D health state description of each respondent's health-related quality of life to be generated. For respondents in full health a five digit code of 11111 would be generated to represent the fact that they recorded no problems (1) for each of the five dimensions. The following section reports the EQ-5D data generated in this study. Data reported at IA, 28DR and 12MFU was compared to explore any changes in respondents' health-related quality of life following resettlement.

EQ-5D: description of respondents' functional health state

The EQ-5D health states reported in this study tended to span the whole range of EQ-5D health state descriptions, with some individuals reporting no problems on any of the five dimensions through to respondents reporting severe problems on a number of dimensions. Table 7 provides detail on respondents' ratings for each of the EQ-5D dimensions.

The majority of respondents reported a change on at least one EQ-5D dimension. However, very few respondents reported a change for more than three dimensions (between initial assessment and 12MFU). Only three CH respondents and five DC respondents did not report any change for all five EQ-5D dimensions at 12MFU (in relation to initial assessment). Thirty-five per cent of care home respondents reported a change in two or more of the EQ-5D dimensions. The dimension which saw the greatest change from CH respondents was 'usual activities' with over half of respondents reporting a change in this dimension. For 31 per cent of respondents this change was positive (i.e. the quality of life for this dimension improved), but a further 28 per cent of respondents suggested that their quality of life around usual activities declined. Thirty per cent of DC respondents saw a change in two or more of the dimensions. The dimension with the greatest overall change was 'self care', with half of respondents suggesting they had a change in relation to quality of life and their abilities around self care (28% of respondents reported a positive change and 23% a negative change). Thirty per cent of DC respondents also noted a negative change in relation to their ability to perform their usual activities.

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Table 7: Respondents' EQ-5D scores for each of the 5 dimensions

	Care home Initial assessment *	28 day follow up*	12mnth review	Day centre Initial assessment	28 day follow up	12mnth review
Mobility						
I have no problems in walking about	21%(6)	17%(5)	29%(9)	14%(6)	23%(10)	26%(11)
I have some problems in walking about	76%(22)	83%(24)	64%(20)	84%(36)	74%(32)	74%(32)
I am confined to bed	3%(1)	(0)	7%(2)	2%(1)	2%(1)	(0)
Self-care						
I have no problems with self-care	31%(9)	17%(5)	26%(8)	33%(14)	30%(13)	42%(18)
I have some problems washing and dressing	52%(15)	59%(17)	45%(14)	56%(24)	56%(24)	42%(18)
I am unable to wash and dress myself	17%(5)	24% (7)	29%(9)	12%(5)	14%(6)	16% (7)
Usual activities (e.g. work, study, housework, etc)						
I have no problems with performing usual activities	28%(8)	21%(6)	26%(8)	16%(7)	21%(9)	21%(9)
I have some problems with performing usual activities	45%(13)	48%(14)	42%(13)	67%(29)	67%(29)	44%(19)
I am unable to perform my usual activities	28%(8)	31%(9)	32%(10)	16% (7)	12%(5)	35%(15)
Pain/ discomfort						
I have no pain or discomfort	24% (7)	31%(9)	45% (14)	16%(7)	14%(6)	19%(8)
I have moderate pain and discomfort	72% (21)	69%(20)	52%(16)	67%(29)	70%(30)	49%(21)
I have extreme pain and discomfort	3%(1)	0%(0)	3%(1)	16%(7)	16%(7)	33%(14)
Anxiety and depression						
I am not anxious or depressed	45%(13)	62%(18)	61%(19)	42% (18)	60%(26)	54%(23)
I am moderately anxious and depressed	45% (13)	31% (9)	39%(12)	53% (23)	35%(15)	44%(19)
I am extremely anxious and depressed	10% (3)	7%(2)	(0)	5%(2)	5%(2)	2%(1)

* missing data for 2 respondents

Figures 3 and 4 provide detail on the total number of respondents who reported having problems on the different EQ-5D dimensions (this captures those who reporting some problems as well as those reporting severe problems). It can be seen from Figure 3 that over half of all respondents reported having problems on each of the different dimensions at initial assessment. For mobility, self-care, and performing usual activities, this was around 70 per cent of individuals. The total number of respondents reporting problems with self care and usual activities increased at 12MFU (although numbers are very small). The total number of respondents reporting problems with pain and anxiety and depression declined at 12MFU.

Within day care, with the exception of problems with anxiety and depression, over 60 per cent of respondents reported having problems on each of the EQ-5D dimensions. For each dimension the total number of respondents reporting problems declined at 12MFU.

Figure 3: Total number of CH respondents reporting across the different EQ-5D dimensions at each stage of the study

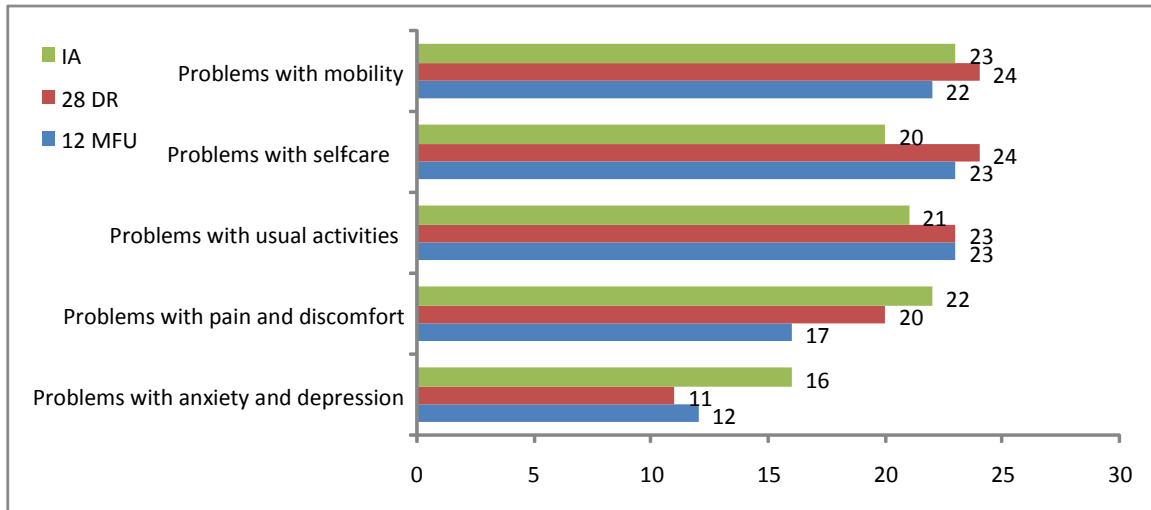
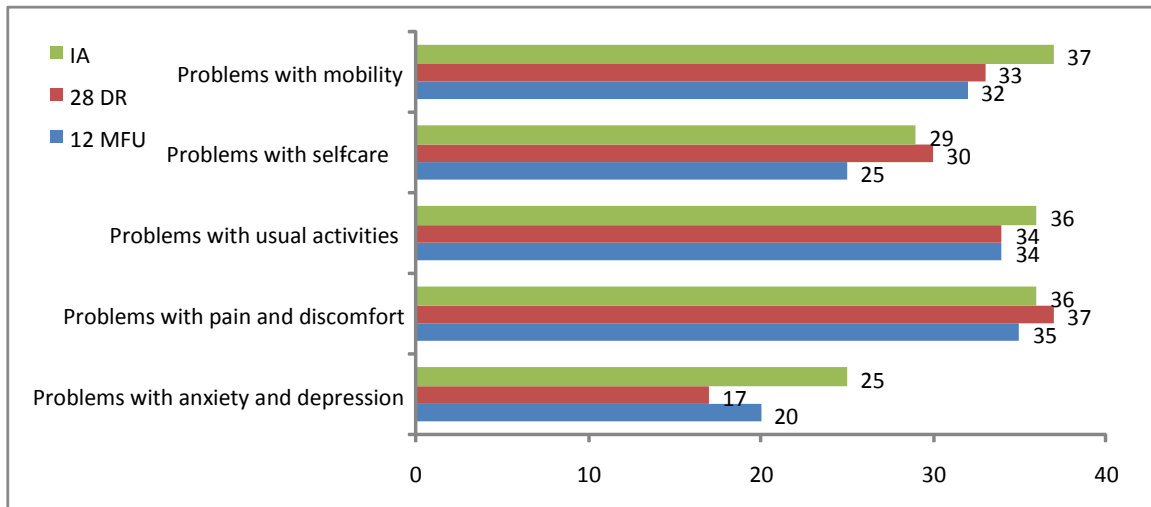


Figure 4: Total number of DC respondents reporting problems across the different EQ-5D dimensions at each stage of the study



EQ-5D: Health state valuations

This study was interested in exploring how respondents valued their quality of life following resettlement. Whilst it was felt that it would be too onerous and insensitive to ask respondents to value their own health-related quality of life, it is possible to map respondent EQ-5D descriptors of health to previously published population values. Such health state valuations are widely used to calculate

Quality Adjusted Life Years (QALYs) used in economic evaluations (Drummond, 2005). Further, using population values would also allow for exploration of what value the general population would ascribe to living in the health state descriptions provided by respondents in this study. Therefore, data analysis included converting each individual EQ-5D profile into a single summary index, which provided a health state valuation. This involved mapping each individual respondent EQ-5D descriptor to a previously published set of population base values.¹

Figures 5 and 6 represent respondent EQ-5D data after the UK population values have been applied. The values rated negative (i.e. -0.00) represent states that have been valued as 'worse than death' by the general public. The application of the UK population values suggests that the general public would value most health states at less than 0.80 (80% of perfect health) with a number of health states actually being valued as worse than death. This is similar across the two settings (i.e. CH and DC)

The next section will explore the impact resettlement had on perceived quality of life. Only 10 per cent (3) of CH respondents reported no change in health-related quality of life between initial assessment and 12MFU, with 59 per cent (17) reporting a positive change in health-related quality of life and 31 per cent (9) reporting a negative change (see figure 5 for graphical representation). Twelve per cent (5) of respondents from the DCs reported no change in health-related quality of life at initial assessment and 12MFU. A further 42 per cent (18) reported a positive change and 46 per cent (20) reported a negative change in health-related quality of life (see Figure 6 for graphical representation). Statistical analysis using Wilcoxon signed ranks suggests there is no significant difference between valuations at IA and 12MFU.

¹ The health state values (weights) used were generated from a population based study which asked respondents to value the different health state descriptors generated by the EQ-5D health state descriptor (Dolan *et al.*, 1995).

Figure 5: Population values applied to CH respondent EQ-5D descriptors

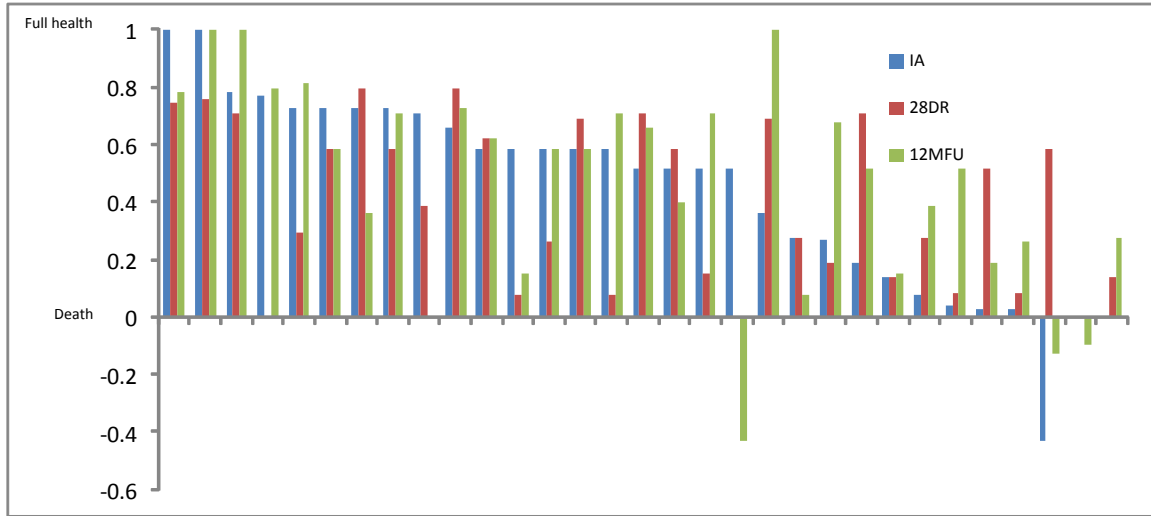
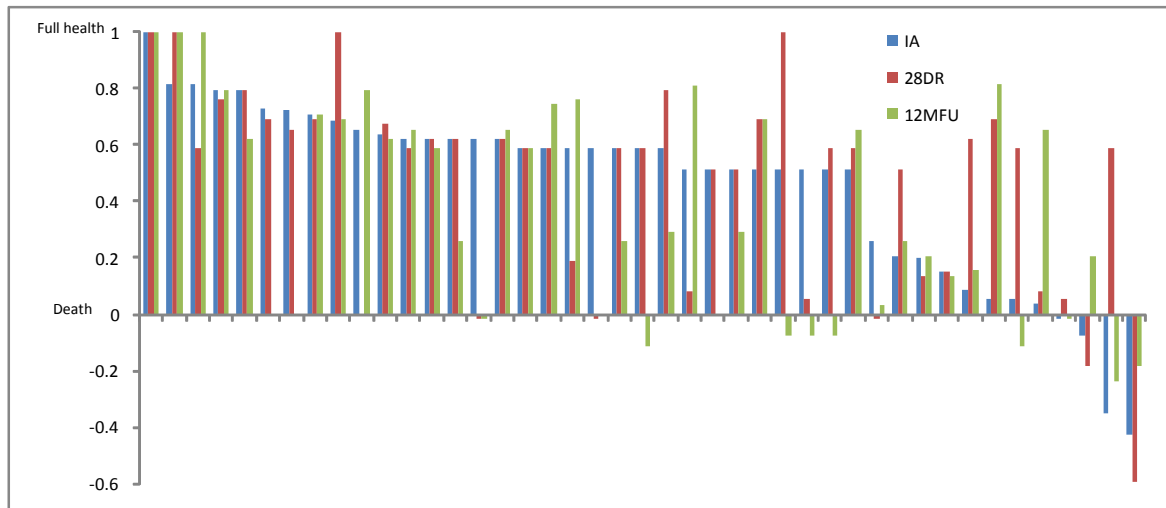


Figure 6: Population values applied to DC respondent EQ-5D descriptors



Exploring differences in EQ-5D valuations

In order to explore how typical or not the health-related quality of life of our sample was in relation to the 'normal' population, we compared our data against normal population values for similar age groups. The comparator group used data drawn from the UK general population survey conducted by Dolan *et al* (1995)². We also compared our results against the Partnership for Older People

² The population values (published by Dolan *et al*, 1995) were further analysed and stratified according to age and sex by Kind *et al* (1999)

Projects (POPP) which used EQ-5D to collect health state valuations of older people who were accessing a number of different health and social care related services (Windle *et al.*, 2009). Caution should be aired when making comparisons with other studies as the small sample size in our study does have an impact on the results. For example, a large change in quality of life of one respondent can have a substantial impact on the overall average. Further, one would expect the population values for the general population to be higher than those of respondent groups, such as ours, who are accessing health and social care services. This is due to the fact that the general population values include many relatively healthy individuals. In contrast our respondent group includes a majority of individuals who have some form of long-term or chronic illness that could well impact on their overall quality of life (Windle *et al.*, 2009).

Table 8 demonstrates that when compared against general population norms our sample reported substantially lower health-related quality of life than those associated with the overall ‘normal’ population. Results show that for a ‘normal’ population the health-related quality of life ranged from 0.80 (80% of perfect health) for individuals aged 55-64, to 0.73 (73% of perfect health) for individuals aged 75 and over. In contrast, quality of life reported across our total sample at IA ranged from 0.21 for those aged 55-64 (21% of perfect health) to 0.48 (48% of perfect health). It is not surprising that respondents in our study reported lower levels of quality of life (compared to population norms), as individuals who are in contact with health and social care services are likely to have some form of long-term or chronic illness (Windle *et al.*, 2009). Respondents in our study who were aged 55-64 and those aged over 75 years reported lower health-related quality of life (at IA and 12MFU) than those in the POPP study (Windle *et al.*, 2009), whilst those in the age range 65-74 reported similar health-related quality of life.

Table 8: Health-related quality of life valuations compared to ‘normal’ population and the POPP study

Age range of participant	Overall sample			UK population	POPP Study
	IA	28DR	12MFU		
Aged 55 -64	0.21	0.26	0.16	0.80	0.54
Aged 65 -74	0.57	0.61	0.59	0.78	0.58
Aged 75+	0.48	0.48	0.42	0.73	0.54

During the interim analysis of data collected at IA and 28DR, it was noted that responses to questions around the impact of care services were generally very positive. Whilst this might be good news, there was some concern by the research team that the questions we posed may not be sensitive enough to capture any changes (either positive or negative) following changes to service provision. Therefore, an additional question was included at 12MFU. This asked respondents for their views (with the benefit of hindsight) on the impact (if any) changes in services had on their life.

The majority of respondents in care homes (42%) suggested that life had got better following the changes to services, and a further 35 per cent suggested life had stayed the same. A smaller number of respondents (19%) suggested that life had got worse following changes to services. On closer inspection of the data, around half of respondents who reported life as getting worse at 12MFU suggested this was due to deterioration in their actual health, rather than due to the services received at their current care home. Figure 7 outlines respondents' written responses in relation to this question.

Results demonstrate that, for the majority of respondents attending day centres (47%), service changes had only had a limited impact on life at 12MFU (that is, they recorded that life had stayed the same). A similar number of respondents (42%) suggested that life had got better following changes to services, with only 12 per cent of respondents suggesting that life had actually got worse. Furthermore, around half of these respondents (three of the five) suggested that it was their actual health state rather than the services which was making life worse at 12MFU. Figure 8 outlines a number of written responses relating to this specific question.

The findings from this study suggest that for the majority of respondents life improved or stayed the same following changes to services. A number of respondents who reported life as staying the same or getting worse at 12MFU suggested that their response was due to the fact that their actual health state was deteriorating, rather than due to changes to services. However, for some respondents (approximately 10%CH; 8%DC) changes did have a negative impact on their lives at 12MFU, and these respondents suggested that changes in services had meant that life had got worse.

Table 9 reports the responses to the additional question relating to the perceived impact of changes to services on respondents' lives (i.e. did life get better, worse, or stay the same) at 12MFU. Figures 7 and 8 provide detail of respondents' written responses in relation to this question.

Table 9: The impact of changes to services on respondents life, responses at 12 month follow up

Impact of services on respondents life	Care home	Day centre
Got better	42% (13)	42% (18)
Stayed same	35% (11)	47% (20)
Got worse	19% (6)	12% (5)
Missing	3% (1)	0

Figure 7: Respondents' feelings on their life following changes to care home services

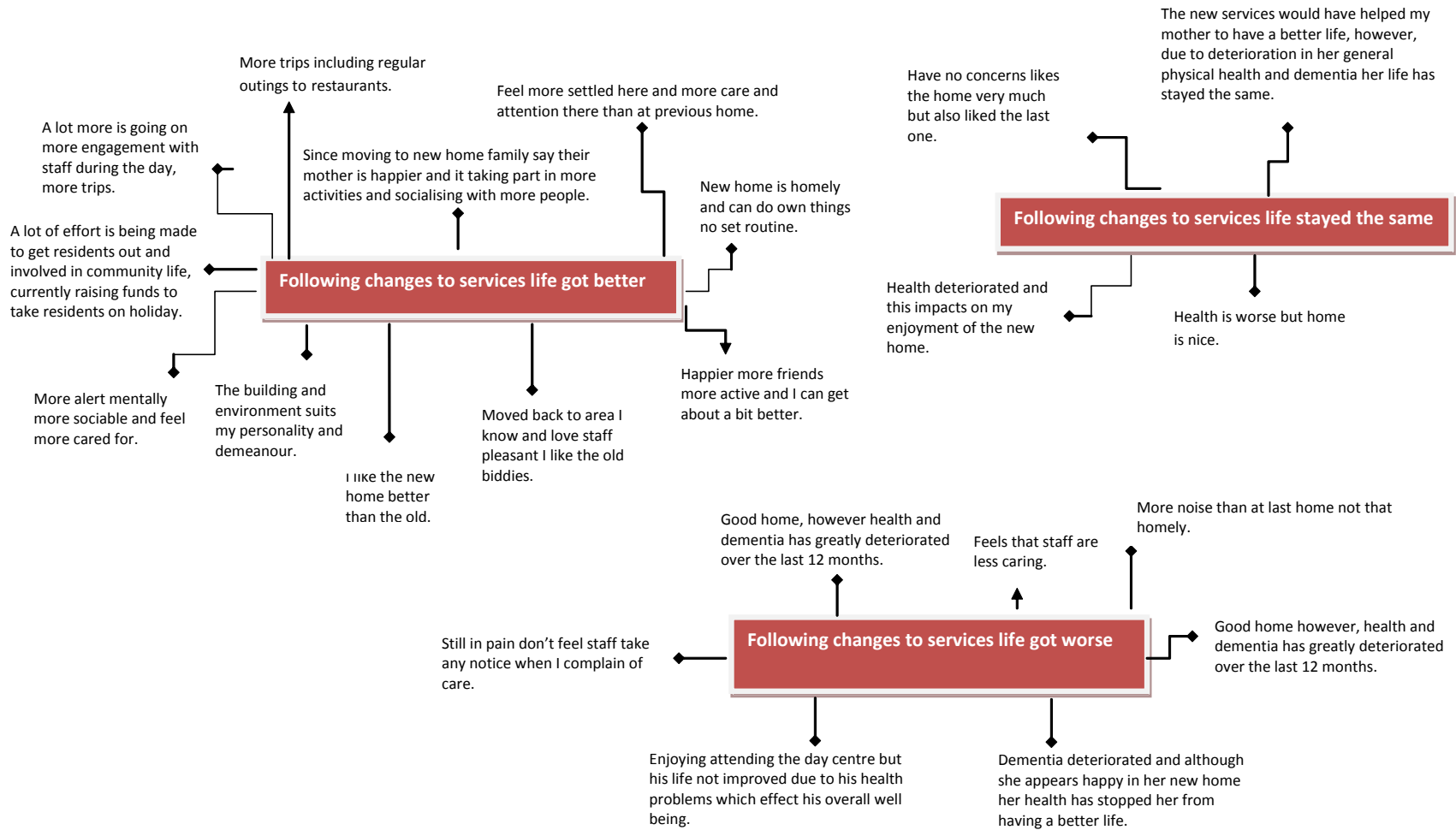
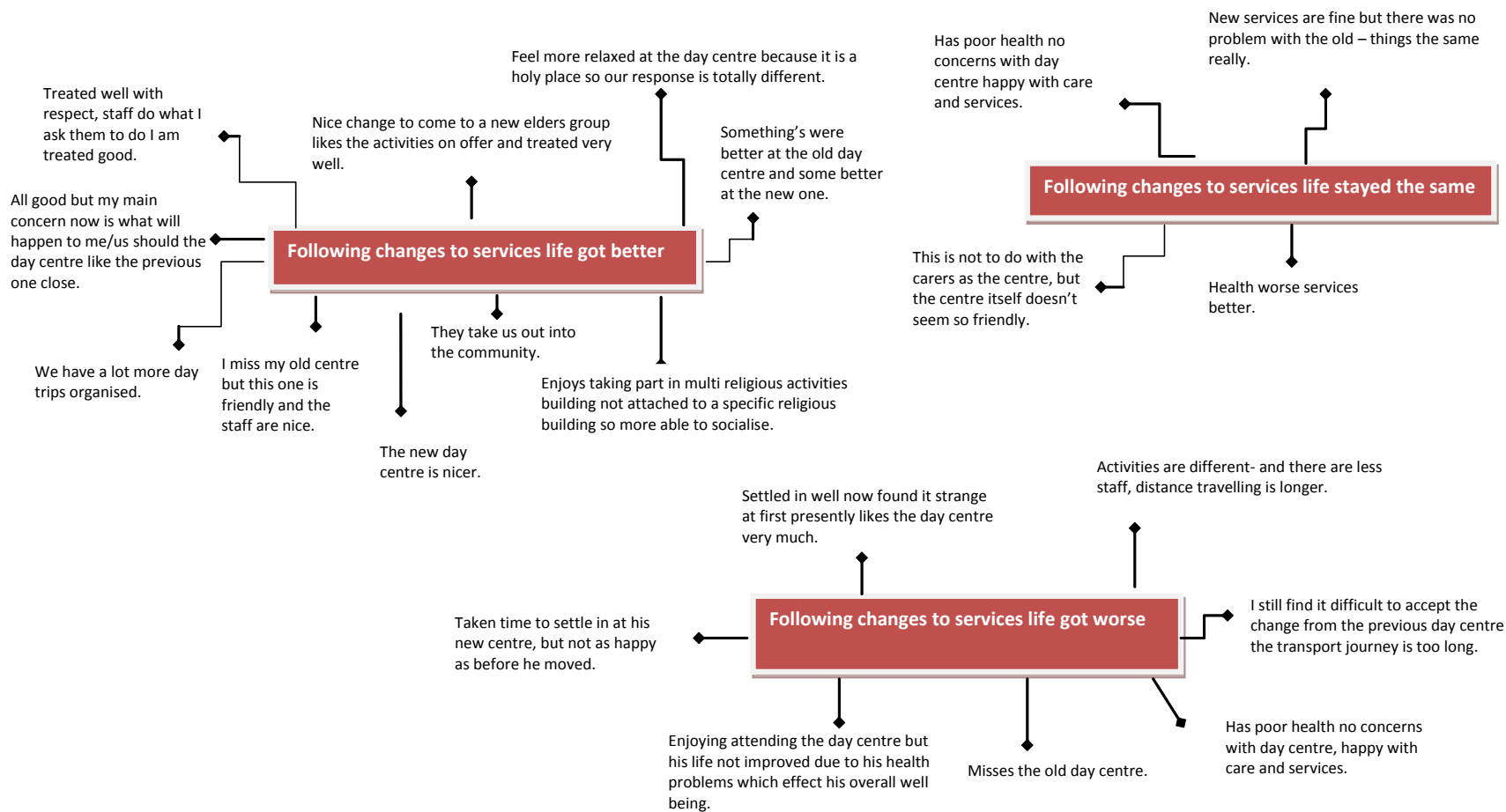


Figure 8: Respondents' feelings on their life following changes to day centre services



Discussion and Conclusions

This study aimed to evaluate Birmingham City Council's programme of care home and day centre closures. The study compared survey data collected at: initial assessment; 28 day review and 12 month follow up. The research team also conducted interviews with a number of key stakeholders (service users, family members, care staff and social workers) prior to their resettlement.

Overall, the questionnaire data collected at all stages of the study tended to be very positive. Whilst all questions tended to receive very positive responses, there was a noticeable positive shift in terms of questions around cleanliness, security and happiness. The majority of respondents suggested they felt valued, respected and treated like an individual throughout the resettlement process. The resettlement did not seem to lead to any major change in terms of quality of life, although when asked directly about how life had been since changes to their services, the majority said life had got better or stayed the same. These results are perhaps surprising given the fact that participants in the study were a year older at the end of the study than at the start and that they had experienced a major upheaval in their previous services. However, results from our study suggest that policy and process adopted by BCC seemed to have limited any potential negative impact on individual's health and well-being, achieving a slight improvement in outcomes for some people.

Overall, key changes included:

- The majority of respondents suggested that they felt valued throughout the resettlement process and at 12 month follow up;
- The majority of respondents suggested they felt happy with the services they received at all stages of the study. This was particularly evident for DC respondents at 12 month review – with over 81 per cent suggesting they were very happy with the control they had over their life. This is an increase of 53 per cent from initial assessment and 51 per cent from 28DR;
- Around 50 per cent more DC respondents rated their services as very clean and tidy at 12MFU, compared to IA;
- Thirty-nine per cent more respondents rated care homes as very clean and very tidy at 12MFU (29% IA, 68% 12MFU);
- A number of respondents reported an increase in EQ- 5D health related quality of life (59% CH and 42% DC) and a further 31 per cent (CH) and 46 per cent (DC) reported a decrease;
- 42 per cent of respondents from each setting suggested that life had got better following the resettlement programme and a further 35 per cent suggested life had stayed the same;

- Of the 19 per cent who suggested life had got worse following changes, around half of these respondents suggested this was due to deterioration in their actual health rather than due to the services at their current care home.

Despite these positives, the study suggested low uptake of direct payments. While some service usage seems to have declined at 12 month follow up, most people using day or residential care were still using it after being assessed and resettled. Although our sample is small, it seems as though the resettlement process has been able to place people in new services without a major decline in their quality of life and with some positive impacts on health and well-being. However, it does not seem to have changed the underlying service model, and questions remain as to how Birmingham's work around its home closures links to its work around personalisation and transformation. To some extent this is fully understandable as the focus of the initial project was to re-provide care in better environments – but this longer-term issue of the nature and ethos of support remains.

Overall, the study suggests a number of key features of Birmingham's approach which seem to have contributed to positive outcomes:

Preparation and strategy:

Having a clear strategy and policy that could be easily articulated to stakeholder groups was seen as important. This was particularly apparent with the policy around day centre closure, which was less clear for a number of stakeholders and for many it felt like an 'add on' to residential home closure. A related point is that information needs to be accurate and any early pledges or deadlines need to be met. It was suggested during interviews that (especially delaying) deadlines raised anxiety and stress amongst stakeholders.

Engagement and involvement: Involving key stakeholders (especially older people themselves) upfront in initial decisions about services seemed important to BCC success. Anxiety and stress is often increased when service users are facing a perceived loss or change to services, and it is important that people feel able to influence what happens to them during resettlement even if they cannot influence the original decision to close a service. Providing as much certainty as is feasible by being honest and clear with people as soon as possible about where they may be going in the future also helps to reassure service users and their families.

Implementation and operational capacity: assessment provides the primary mechanism by which new services are determined and getting this right is crucial to the health and well-being of service users, both short- and long-term. A key strength of the BCC process suggested by stakeholders (including the information and advocacy service) was a dedicated group of assessors with the

time and space to carry out detailed and holistic assessments, get to know people well, work closely with care staff and provide information and reassurance. Also important is the role of care staff, who are well placed to provide help, support and information to older people and their families. Whilst staff may themselves feel anxious and insecure about the changes, supporting them to support others seems crucial.

Overall, whilst there was a natural sense of loss from those individuals who lived and worked in services that have now closed, our study of the BCC modernisation programme suggests that, if the process is conducted well (with high levels of respect, communication and empathy), then the risks of a major decline in quality of life can be reduced and some positive outcomes achieved. In a complex and rapidly changing policy and financial context, this seems a major achievement. However, even a process as detailed and in-depth as that reported in this study does not seem to have changed the underlying nature of services being offered to older people – and this will remain a key challenge going forwards.

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Appendix A: Recommendations from the literature

Reproduced below is the executive summary from Le Mesurier and Littlechild's (2007) review of the published literature on the experience of closure of residential care homes in the UK:

1. This literature review has been written in support of the Birmingham City Council Adults and Communities Directorate (BCC hereafter) Reprovision Programme. This programme will see the closure over the next five years of all 29 residential care homes for older people currently owned and operated by BCC and the development of 8 Special Care Centres with half of the beds in each centre providing long-term stay. The centres will also provide intermediate care and rehabilitation. Extra Care Housing will be expanded, with enhancements made to existing provision and new development schemes undertaken.
2. This review provides an overview of policy and practice literature on issues related to the effects of closure of residential care homes for older people on their health and wellbeing, and on the policies governing the way care homes are closed. The experience of residents and their families / informal carers is prioritised, as is the role and quality of assessment.
3. No information has been made available to the research team on the needs or characteristics of the residents who will be affected by the reprovision programme, though it is expected that some, perhaps many, people will be very frail.
4. A scope of the published academic and professional literature found very little empirical research evidence on the closure of residential care homes for older people. What there is comes from a limited range of sources and concentrates mainly on the experience of closure in the independent sector.
5. An extensive review of local authority guidelines of care home closure found that few had been developed and that most were developed 'in-house' without reference to experience elsewhere. Consequently there are few, if any, reliable benchmarks available to the Reprovision Programme by which to compare performance.
6. Principles informing current government policy and legal obligations imposed by the Human Rights Act 1988 emphasise the responsibilities of local authorities to place service users' needs and wishes at the heart of care plans and to implement preventive strategies where possible. In the context of closure and reprovision of residential care, this means a duty to

consult properly with residents and their families or informal carers and to provide care that is appropriate and responsive to changes in individual needs.

7. The impact of resettlement on the health of frail elderly people is a natural cause of concern. It is difficult to establish a correlation however, mainly because the population under consideration is likely to be very frail in the first place and often in need of high levels of care. Such evidence as there is suggests that adverse effects can be minimised if continuity of care is maintained and there is good consultation and planning. The importance of relationships with staff, in particular key worker relationships, should not be overlooked.
8. People with cognitive impairments have preferences and wishes and should not be excluded from the resettlement process. Interpretation of cognitive ability should be undertaken with the service user's participation and on the basis of detailed and comprehensive assessment.
9. The role of care managers is crucial in the process of reprovion. Demands placed upon them are likely to be complex and stressful. As assessors they may have to make controversial decisions or recommendations, sometimes contrary to the wishes of residents or their families, or indeed of their own local authorities. They should receive adequate support and guidance.
10. Emphasis is placed within this programme of reprovion on the role of Extra Care housing, which offers a disseminated form of provision with care and accommodation being provided under many roofs rather than one, albeit often on one site. It is more difficult to monitor and maintain levels of security and support in these circumstances. Technology can help, but should not be seen as a replacement for human contact.
11. The role and legal status of occupiers of Extra Care housing is different from that of traditional residential care services. People living in Extra Care housing are normally owners or tenants of individual properties.
12. Provision of alternative housing alone will not assure that goals of independence and autonomy are achieved. There is some evidence that residents of good quality traditional care homes are able to feel as empowered and in control as those in extra care settings of equal quality. The key here seems to be quality of care. Some older people may therefore benefit from or prefer the extra security and support offered by traditional residential care provision.
13. Staff are likely to have to work in different ways in Extra Care settings if they are to facilitate the 'doing-with-rather-than-doing-for' culture that is

envisaged. A different relationship is likely to exist between staff and residents compared to traditional care homes. This relationship will need training and good management and support if it is to be more than tokenistic. Economies of scale may be harder to achieve in Extra Care settings.

14. Assessment provides the primary mechanism by which an individual's need for support is determined, and as such is likely to embody not only the thresholds of eligibility offered by providers, but the philosophy and ethos of the monitoring authority and its partners and agents. It is possible that, for some, re-assessment may identify needs that are more suitably met in nursing homes or in NHS Continuing Care provision.
15. Assessments of need should not focus solely on a person's impairments, but should take into consideration the context of the way help is provided in the environment in which they may live. They should not be used to predict workload.

Appendix B: Survey

Modernisation of Older People's Services		ID NUMBER: _ _ _ _
PARTICIPANT'S INITIALS: _ _	DATE OF COMPLETION: _ _ / _ _ / _ _ _ _	STUDY PERIOD: _ _
ASSESSOR/REVIEWER'S INITIALS: _ _		00 = Initial assessment 01 = 28 day review 12 = 12 month review

A. Note for assessor/reviewer to emphasise to the research participant:

You may remember that you agreed to be interviewed for a research project about how you feel about your life and your care following the planned closure of Birmingham residential homes and linked day centres. I want to ask you a few questions for the project and make a note of your answers. This is confidential as we said before, and is to help the Council should any other homes or day centres need closing in future. Is it Ok to go on?

For the assessor: Does this participant have a history/diagnosis of a mental health problem (e.g. dementia, depression)?

Yes No

If yes, please specify: _____

B. About you:

Date of Birth: **Gender:** Male Female

Age group:

50 – 64

65 - 74

75 - 79

80 - 84

85 -89

90 +

Are you: (please tick as appropriate)

Single	<input type="checkbox"/>	Married / Co-habiting	<input type="checkbox"/>	Living alone?	<input type="checkbox"/>
Widowed	<input type="checkbox"/>	Divorced / Separated	<input type="checkbox"/>	Living with family?	<input type="checkbox"/>

Ethnicity - please specify: _____

- | | |
|----------------------------------|---|
| 1. White British | 9. Pakistani or British Pakistani |
| 2. White Irish | 10. Bangladeshi or British Bangladeshi |
| 3. Other White Background | 11. Other Asian or British Asian Background |
| 4. Mixed White & Black Caribbean | 12. Black or Black British Caribbean |
| 5. Mixed White & Black African | 13. Black or Black British African |
| 6. Mixed White & Asian | 14. Other Black or Black British Background |
| 7. Other Mixed Background | 15. Chinese |
| 8. Indian or British Indian | 16. Any Other Background |

C. About the care services that you receive:

Before the modernisation process, were you living in a Birmingham City Council care home or going regularly to a linked day centre? (please tick as appropriate)

Care home	<input type="checkbox"/>	Day centre linked to a Council care home	<input type="checkbox"/>
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What care services are you receiving?

(Note to Assessors/Reviewers, please set out the person's current care plan in full, including the amount, frequency and type of services being received. This needs to be as detailed as possible so that we can cost and compare the services the person was receiving when first assessed with services received as a result of their assessment and new care package).

As an example, you might be receiving one hour of home care 3 times a day (from 9am to 6pm) and five days a week (Monday to Friday)...

Alternatively, someone else might be receiving a direct payment of £X in order to meet X, Y and Z assessed needs, and may be spending this money on....

Do you receive:

Direct payments/individual budgets? *How much do you get? £_____*

Day care? *If so, how often? _____*

Home care? *If so, how many hours a week? _____*

Residential care?

Meals? *If so, how often? _____*

Short breaks? *If so, how often? _____*

For the assessor, please give details:

D. About the impact that your care services have on your life:

1. How would you rate your overall physical health? *(please tick as appropriate)*

Very good	Good	Neither good nor bad	Bad	Very bad
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. How would you rate your quality of life? *(please tick as appropriate)*

Very good	Good	Neither good nor bad	Bad	Very bad
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Are you happy with the care services you receive? *(please tick as appropriate)*

Very happy	Fairly happy	Neither happy nor unhappy	Fairly unhappy	Very unhappy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. How well do your care services meet your basic physical needs? *(please tick as appropriate)*

Very well	Well	Neither well nor not very well	Not well	Not very well at all
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. How safe and secure do your care services make you feel? *(please tick as appropriate)*

Very safe	Safe	Neither safe nor unsafe	Unsafe	Very unsafe
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. Is the place where you live clean and tidy? *(please tick as appropriate)*

Very clean
and very tidy

Clean
and tidy

Neither clean nor
unclean/neither tidy
nor untidy

Unclean
and untidy

Very unclean
and very untidy

7. How far do your care services help you to stay alert and active? *(please tick as appropriate)*

Definitely

To some extent

Neither yes or no

No

Definitely not

8. How happy are you with the control you have over your life? *(please tick as appropriate)*

Very happy

Happy

Neither happy
nor unhappy

Unhappy

Very unhappy

9. How far do you feel valued and treated with respect? *(please tick as appropriate)*

Definitely

To some extent

Neither yes or no

No

Definitely not

10. How far do you feel as if you are treated as an individual? *(please tick as appropriate)*

Definitely

To some extent

Neither yes or no

No

Definitely not

11. How far do you feel as if you have 'a say' and control over your care services? *(please tick as appropriate)*

Definitely

To some extent

Neither yes or no

No

Definitely not

12. How far do your care services help you to stay in touch with family and friends? *(please tick as appropriate)*

Definitely	To some extent	Neither yes or no	No	Definitely not
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

13. How far do you feel that your care services try to help you to take part in community life? *(please tick as appropriate)*

Definitely	To some extent	Neither yes or no	No	Definitely not
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

14. How far do you feel that if your cultural and religious preferences are respected? *(please tick as appropriate)*

Definitely	To some extent	Neither yes or no	No	Definitely not
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Note to assessors – Q. 15 (below) is a new question to be asked at 12-month review only

15. Do you think that the new services you have received since the closure of your care home/day centre have helped you have a better life?

Has life:	Got better?	<input type="checkbox"/>
	Stayed the same?	<input type="checkbox"/>
	Got worse?	<input type="checkbox"/>

Please include an explanation of your views on this issue if you would like to:

E. About your health and well-being:

Note for assessor/reviewer: I am now going to read some statements and ask which is closest to your every day healthy status today:

Mobility

I have no problems in walking about

I have some problems in walking about

I am confined in bed

Self-care

I have no problems with self care

I have some problems washing or dressing myself

I am unable to wash or dress myself

Usual activities (e.g. work, study, housework, family or leisure activities)

I have no problems with performing my usual activities

I have some problems with performing my usual activities

I am unable to perform my usual activities

Pain / Discomfort

I have no pain or discomfort

I have moderate pain and discomfort

I have extreme pain and discomfort

Anxiety / Depression

I am not anxious or depressed

I am moderately anxious or depressed

I am extremely anxious or depressed

Compared with my general level of health over the past 12 months, my health state today is:

Better than it was

Much the same

Worse than it was

How did you answer the questions in this survey? *(please tick as appropriate)*

I answered the questions myself

I answered the questions with help from a friend/family member

I answered the questions with help from a paid staff member

Someone else mainly

Thank you for taking the time to complete this survey. Please give this completed survey to your social worker, who will return it to the research team.

We will come back to see you again in the future and ask the same questions, to see how things have gone for you over the coming weeks and months.

Appendix C: Interview schedule (qualitative research) – see our interim report for full details

Background note to researchers

This guide is designed to ensure that interviews cover the key areas required for the study which Birmingham City Council has commissioned.

However, it should only be used as a guide/a prompt – the aim of talking direct to older people, their families, care staff and assessors is to have a meaningful conversation about the key issues that also allows those taking part to share things that are important to them. With this in mind, the questions below may not necessarily need to be asked directly, as relevant answers/perspectives may emerge naturally. The order and phrasing will also depend on the flow of the conversation and on the priorities and perspectives of the person being interviewed.

The questions/topics below have been compiled from a number of sources, including:

- Previous literature (including a literature review commissioned by Birmingham City Council to help inform the resettlement process).
- Some of the more process-based outcomes being explored in the quantitative phase of the research (for example, how the process is making people feel).

The aim throughout is to identify good practice that can be built upon and/or to identify areas for future improvement.

Interview Schedule

Welcome and introductions – to include:

- Brief and accessible summary of the project aims
- Check people understand what is required and are still happy to take part
- Stress that people can withdraw at any time with no negative consequences
- Remind people that no one will be able to be identified from the research

For older service users - if the researcher feels that the person is unable to consent to take part in the study (but this hasn't been identified by Birmingham City Council), then please stop the interview and raise with BCC.

Opening question to all - please tell me a bit about yourself. (Note: this is an introductory question to put the person at ease and to get some brief context. For a resident/family member it could be about how long the older person has used the service. For a member of care staff it could be about how long they have worked here. For an assessor it could be about why they chose to work for the assessment team etc)

Questions for older people (to be adopted for family members as appropriate)

How do you feel about the closure of this care home/day centre? *(Note: initial question to explore people's hopes/aspirations/fears etc)*

How have staff consulted you about this and involved you in the process?

What impact do you think resettlement is having on your current quality of life? What impact might it have in future?

How do you feel about the process being adopted to assess people and find new services? *(Note: if needed, prompt around issues such as:*

- *Relationship with care staff*
- *Relationship with assessors*
- *Steps taken to support and reassure people*
- *The amount of choice and control people feel they have*
- *The extent to which they feel respected and treated like an individual*
- *The extent to which their religious/cultural needs have been taken into account*
- *The extent to which family/friends have been involved, if appropriate)*

What has been good about this process that the Council should build on when working with other older people?

What could have been improved?

Is there anything else you would like to add that we haven't covered?

Thank you very much for your time.

Questions for care staff

How do you feel about the closure of this care home/day centre? *(Note: initial question to explore care staff's hopes/aspirations/fears; impact on care staff etc)*

How have you been consulted and involved in the process?

What support has there been for you as a member of staff?

What impact do you think resettlement is having on current service users? What impact might it have in future?

How do you feel about the process being adopted to assess people and find new services? *(Note: if needed, prompt around issues such as:*

- *Relationship with care staff*
- *Relationship with assessors*
- *Steps taken to support and reassure people*
- *The amount of choice and control people have*
- *The extent to which older people are respected and treated like an individual*
- *The extent to which people's religious/cultural needs are taken into account*
- *The extent to which family/friends have been involved, if appropriate)*

What has been good about this process that the Council should build on when working with other older people?

What could have been improved?

Is there anything else you would like to add that we haven't covered?

Thank you very much for your time.

Questions for assessors

How do you feel about the closure of this care home/day centre? (*Note: initial question to explore assessors' hopes/aspirations/fears*)

How have older people and care staff been consulted and involved in the process?

What support has there been for you as an individual during this process?

What impact do you think resettlement is having on current service users? What impact might it have in future?

How do you feel about the process being adopted to assess people and find new services? (*Note: if needed, prompt around issues such as:*

- *Relationship with care staff*
- *Relationship with assessors*
- *Steps taken to support and reassure people*
- *The amount of choice and control people have*
- *The extent to which older people are respected and treated like an individual*
- *The extent to which people's religious/cultural needs are taken into account*
- *The extent to which family/friends have been involved, if appropriate*

What has been good about this process that the Council should build on when working with other older people?

What could have been improved?

Is there anything else you would like to add that we haven't covered?

Thank you very much for your time.

End of all interviews - as appropriate reiterate the aim of the research (to use this information to improve future practice and services) and key messages about participation (people are free to withdraw at any stage, no one will be identified through the research etc).