Care of the ageing veteran population: Developing an evidence base for the Royal Hospital Chelsea model of care

Helen Cullen

PhD

2023

Care of the ageing veteran population: Developing an evidence base for the Royal Hospital Chelsea model of care

Helen Cullen MSc

A thesis submitted in partial fulfilment of the requirements of the University of Northumbria at Newcastle for the award of Doctor of Philosophy

Research undertaken in the Faculty of Health and Life Sciences and in collaboration with the Royal Hospital Chelsea, London

July 2023

ABSTRACT

It the midst of a globally ageing population, where and how we live as we get older, matters. The Royal Hospital Chelsea has provided a home, support, and care, for retired British Army veterans since 1692. However, until now there has been an absence of evidence on the impact this provision has on its residents, the Chelsea Pensioner (or, 'In-Pensioner').

This project had two main aims: to explore the Royal Hospital Chelsea model of care and the impact it has on the lives of In-Pensioner's, and to inform future service provision.

A literature review considered theories relating to ageing, specifically ageing 'well' and ageing in [the right] place. The UK residential landscape for those aged 65 years and over, and a Systematic Narrative Review were carried out to explore existing residential care options for veterans and identify what impact this residential care had on health and social care outcomes.

A mixed method, non-traditional convergent design facilitated the collection of qualitative data from 19 Key Staff (Part A), and 25 In-Pensioner participants (Part B), in the form of semi-structured interviews, which allowed participants the flexibility to provide in-depth responses to interview questions. Quality-of-life questionnaires were completed by all In-Pensioners (Part C), and 17 New In-Pensioner (Part D) participants. Qualitative and quantitative data sets were simultaneously analysed using Reflexive Thematic Analysis to facilitate a comprehensive understanding of the findings.

Integrated analysis identified four mutually dependent areas that were fundamental to the Royal Hospital Chelsea model of care. The quasi-military **environment** provided a familiar setting that revived the attachment In-Pensioners experienced whilst serving in the British Army, as many considered the Royal Hospital Chelsea to be home. The changing demographics of the Armed Forces prompted suggestions of the inclusion of other branches of the military, which was met with acceptance and resistance. In-Pensioner **identity** was multidimensional as many primarily identified as Chelsea Pensioners, whilst maintaining strong connections to their individual identities. The blend of accommodation options made the Royal Hospital Chelsea challenging to describe succinctly. This did not impact on service provision but may present

challenges for those outside of the Armed Forces Community and less familiar with its identity. By **staying active**, In-Pensioners maintained their independence, created a sense of purpose, and remained visible, as they engaged in informal hobbies and interests, or took part in more formal civic engagement-style events. **Staying healthy** was facilitated by an integrated medical centre, a social care team, and a collective commitment by all staff to place In-Pensioner wellbeing at the heart of everything they did. This commitment was also evident in residents who, through active peer-support, ensured fellow In-Pensioners were cared for. However, evidence of In-Pensioner stoicism and a reluctance to accept support presented challenges in service delivery. Collectively, these areas positively influenced an In-Pensioners health and social care outcomes, and overall life satisfaction.

The findings from this project generated several recommendations for the Royal Hospital Chelsea, including further research into the changing demographics of future veterans; building on the quality-of-life evidence base created by this project; and sharing best practice with other veteran-specific residential establishments.

Recommendations for service providers include exploring the provision, and impact, of civic engagement for those living in residential establishments; and exploring the impact an onsite medical centre may have on resident outcomes.

Further research recommendations include identifying a potentially ‘hidden’ veteran community within residential establishments to explore the potential need for relocation to veteran-specific residential establishments; to consider the impact employing ex-military staff in quasi-military roles has on the staff member; and to explore ways to facilitate place attachment within residential establishments, to mitigate the impact of moving into higher needs care.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

ACKNOWLEDGEMENTS

It is important to start these acknowledgements by expressing my thanks to the Chelsea Pensioners and staff who agreed to take part in this research. Without you, none of this would have been possible. My thanks and deep gratitude go to those Chelsea Pensioner participants who sadly passed away during the course of this research. I am indebted to you for taking part, and to your families for agreeing to include your interviews within this research. Your involvement was important, and your voice has been heard.

To the Royal Hospital Chelsea, firstly, thank you for funding this PhD, and for placing your trust in me to deliver this important research on your behalf. It has been a privilege to gain insight into this historical establishment. Secondly, thanks go to those within the Royal Hospital Chelsea who have supported me, particularly Professor Mackworth-Young and the Research Oversight Committee for their guidance, to the Project Steering Group, and to Nicola Seccombe, who has been instrumental in so many ways and without whom, I could not have completed this research.

I would like to sincerely thank my supervisory team for their tireless supervision and guidance. To Dr Gemma Wilson-Menzfeld, thank you so much for your continued support throughout some challenging times, and steep learning curves, and for returning to work after your maternity leave! To Dr Alison Osborne, thank you for always being there and guiding me through so many stages of this PhD. To Professor Matthew Kiernan, thank you for your guidance and for encouraging me to embark on this research. Thanks also to Professor Darren Flynn for your brief, but valuable, support and guidance.

Thank you to everyone at the Northern Hub for Veteran and Military Families Research for your support, especially Dr Gill McGill who has been a constant support and friend.

To my PhD peer-buddies Jess Gates and Dr Kate Cowan, thank you. For keeping me going throughout this journey, thank you. For recognising that whatever I was feeling, you were feeling too! I could not have got through this without you.

A shout out to Radio 2 for keeping me smiling throughout some tough times, including the Covid-19 pandemic. You feel like family.

Heartfelt thanks go to my family and friends who have supported me through this journey. You are too many to mention individually but you know who you are, I thank you from the bottom of my heart. Special thanks to my wonderful friend Michaela for being there on my many trips to London, for your guidance and encouragement.

To my simply amazing sister Valerie, and her husband John, thank you. Not only have you been the constants throughout this PhD, you have also been by my side and guided me throughout my life. Your encouragement, faith and love have kept me going. It is an understatement to say I could not have done this without you.

Finally, I would like to thank my mum and dad, Mary & Bill. Sadly, you are not here to see me cross the finish line with this PhD, but I know you are watching over me. Thank you for instilling values in me that have served me well. Thank you for making me who I am today, for your guidance, faith, and love. I dedicate this PhD to you.

DECLARATION

I declare that the work contained in this thesis has not been submitted for any other award and that it is all my own work. I also confirm that this work fully acknowledges opinions, ideas, and contributions from the work of others. The work was done in collaboration with the Royal Hospital Chelsea, London.

Any ethical clearance for the research presented in this commentary has been approved. Approval has been sought and granted through the Researcher's submission to Northumbria University's Ethics Online System on 16 October 2020 (Ref: 24587) and the London Camberwell St Giles Research Ethics Committee on 18 February 2021 (Ref: 21/LO/0058; IRAS Ref: 288952).

I declare that the Word Count of this Thesis is 77,562 words.

Name: Helen Cullen

Date: 01 July 2023

GLOSSARY OF TERMINOLOGY & ABBREVIATIONS

ADL	Activities of Daily Living
AFH	Adult Family Home
ALF	Assisted Living Facility
ALPP	Assisted Living Pilot Program
Berth	Single en-suite living accommodation within Long Ward(s) at the Royal Hospital Chelsea
Blues	Day (informal) uniform worn by Chelsea Pensioners
Board of Commissioners	Appointed individuals responsible for the strategic direction, policy, financial decisions, and governance of the Royal Hospital Chelsea
Captain of Invalids (CoI)	Historical title of ex-military staff members who support In-Pensioners. Commonly referred to as 'Captains'.
Chelsea Pensioner	Resident of the Royal Hospital Chelsea. Also referred to as an In-Pensioner
Civvies	Informal term for people who have not served in the military. Also refers to non-military clothing
Commissioned Officer	A member of the military who holds a commissioned rank derived from the head of state
Company(s)	A collective number of Long Wards, similar to a small unit within the military, supported by a Captain of Invalids
Covid-19	The Coronavirus Pandemic
CQC	Care Quality Commission
EAC	Elderly Accommodation Counsel
Ex-military	An individual who has previously served in the military/armed forces
GDPR	General Data Protection Regulations
Governor	Role appointed by the Monarch to oversee the running of the Royal Hospital Chelsea
GP	General Practitioner
HBPC	Home Based Primary Care service delivered by the US Veterans Health Administration
IADL	Instrumental Activities of Daily Living
IBM® SPSS®	Statistical analysis software platform
ICECAP-A	ICEpop CAPability Adult (Quality of Life Questionnaire)
'in the ranks'	Individuals who enlist in the military but do not hold a commissioned rank (e.g., Private, Corporal, Sergeant)
In-Pensioner	A resident of the Royal Hospital Chelsea. Also referred to as Chelsea Pensioner
Lockdown	Period of time when people's movements were restricted by the UK Government during the Covid-19 pandemic

Long Ward(s)	Accommodation floors at the Royal Hospital Chelsea
MTI	Margaret Thatcher Infirmary: In-Pensioner Nursing care facility located within the Royal Hospital Chelsea
MFH	Medical Foster Home
MoD	Ministry of Defence
NHS	National Health Service
Non-commissioned officer	A military person who does not hold a commission, but holds a senior position as a result of promotion (e.g., Sergeant, Warrant Officer)
NVIVO-12	Software used for qualitative data analysis
ONS	Office for National Statistics
Out-Pensioner	Historical title for former soldiers in receipt of an Army pension who lived elsewhere but were required to collect their pension payments from the Royal Hospital Chelsea in person
QM	Quartermaster: Officer position traditionally held in the British Army, responsible for accommodation and provisions
RAF	Royal Air Force
RBL	Royal British Legion
RCF	Residential Care Facility
REC	Research Ethics Committee
RHC	The Royal Hospital Chelsea
RSM	Regimental Sergeant Major: Rank/position traditionally held in the British Army
Scarlet(s)	The dress uniform worn by Chelsea Pensioners
Shako	Informal headdress worn with Royal Hospital Chelsea uniform
Tricorne	Formal headdress worn with Royal Hospital Chelsea uniform for ceremonial events
UIN	Unique Identifying Number
US(A)	United States (of America)
Veterans Affairs (VA)	Government body that supports eligible military veterans in the USA
Veterans' Health Administration (VHA)	Government body that supports the healthcare needs of eligible military veterans in the USA
Veteran	An individual who has been previously served in the military
WHO	World Health Organisation
WHOQOL-BREF	World Health Organisation Quality of Life BREF (Quality of Life Questionnaire)

CHAPTER ONE

INTRODUCTION

1.1 Chapter Overview

This chapter will present the project and overall context of the PhD. It will outline the rationale for the project, describe its format by summarising the content of each chapter and include the contributions of this PhD.

1.2 Ageing Population

The global population of adults over 65 years of age is currently 10%, with growth predictions indicating this is expected to rise to 22% by 2050, or in numbers: 1,548.9 million (United Nations, 2020). Global average life expectancy is expected to reach 77.2 years by 2050 (United Nations, 2022) with those over 80 years of age numbering 426 million by 2050 (WHO, 2022a).

Military veterans form part of this ageing population and although global numbers are unclear, evidence indicates they make up 7% of the adult population in the USA (Vespa, 2020), and 5% in the UK (MoD, 2019a). Further, there are believed to be 641,000 veterans in Australia (Australian Institute of Health; Welfare, 2018) and 629,300 in Canada (Veterans Affairs Canada, 2020).

Of the two and a half million veterans living in Great Britain in 2017, 60% were adults over 65 years of age, compared with 20% of the non-veteran population within the same age demographic (MoD, 2019a). Of these, 31% of veterans were between 75 and 84 years of age and 16% over the age of 85 (MoD, 2019a). The disparity between the older veteran and non-veteran population is attributed to those who served in the military during the Second World War and those who completed National Service until the 1960's (MoD, 2019a).

As people age, changes in personal circumstances or health status may result in the need to consider alternative living options that best suit their requirements and enable them to continue to live as safely and independently as possible whilst accessing any support that may be needed (Abramsson & Andersson, 2016). The environment in

which an individual lives impacts on life satisfaction and health outcomes. Environments which offer security, access to activities, and access to the natural environment have a positive influence on ageing ‘well’ and health status (Wong et al., 2021).

Whereas some individuals may seek alternative accommodation, others, where possible and practicable, may choose to remain in their current home, seeking changes to their home environment such as home adaptions, to support them to remain ‘in place’ (Age UK, 2022). However, this is not always possible. The desire to remain in their current home may be restricted by their existing living arrangements, such as rented accommodation or homes in high-rise buildings, where adaptations may not be feasible or affordable. Equally, challenges exist for those who are willing to move into more suitable accommodation but are prevented from doing so including choice, availability, and affordability (Pannell et al., 2012).

What it means to age ‘well’, ‘successfully’, or ‘positively’, can be subjective and open for debate depending on the context in which it is being discussed (Bowling, 1993). It is acknowledged that ageing ‘well’ (‘successfully, or ‘positively’) can encompass several factors including an individual’s capacity to remain physically and mentally healthy, maintain mental agility, be socially active, and involve the ability to maintain autonomy, i.e., to be in charge of one’s own life direction (Brownie & Horstmanshof, 2012; Rowe & Kahn, 1997).

However, there are disparities between what academics, or those in medical professions, term as ageing ‘well’ (‘successfully, or ‘positively’) when compared with the general population, who also consider areas such as life satisfaction, achievements, and financial security as contributing towards ‘successful’ ageing (Bowling & Dieppe, 2005). Therefore, it could be argued that determining levels of ‘successful’ ageing are subjective and that considering both the clinical assessment and the individual’s opinions of their own self-reported health and wellbeing may help to provide a more accurate evaluation of their levels of ageing ‘well’.

1.3 The Residential Landscape for Older Persons

Research within the United Kingdom (UK) suggests that the majority of older people prefer to live within their own home for as long as possible, either independently or with an assisted care package (Centre for Ageing Better, 2019). For those who choose to live independently, influences on positive well-being include living in a safe and secure location, in accommodation that may have adaptations to support individuals as they age, and with close proximity to an existing social network (Mulliner et al., 2020).

Irrespective of the growing UK ageing population, and increasing need for supported living accommodation, there appears to be a reluctance to increase residential capacity. This may be due to diminished government grants or a lack of enthusiasm from potential private sector providers to develop such housing stock, particularly in areas where the financial incentive to do so is lower than in more affluent areas of the UK (Robinson et al., 2020). In their report 'Strategic Housing for Older People' the Housing Learning and Improvement Network (LIN) found private developers appeared reluctant to invest in building housing for the older population in areas where the need is potentially unknown (2011). However, evidence indicates that the housing needs of the older population are being considered as developers and government agencies work collaboratively to address these needs (Local Government Association, 2022). In contrast, however, the Communities and Local Government Committee 'Housing for Older People' report found private providers were interested in expanding the provision of accommodation but were restricted by planning rules and regulations (2018, p.50).

It is widely acknowledged that the provision of adequate housing for the UK population is a priority (House of Commons, 2023a). Notwithstanding the financial investment required to provide adequate housing, further obstacles include navigating a protracted and complex planning process, as discussed above, engagement by local authorities and housing providers, and ensuring the house builders have the capacity to meet demand (House of Commons, 2023a). In recognising these challenges, the UK Government stated its intention to establish a 'taskforce' to address the housing needs of older people in their 'Levelling up of the United Kingdom' action plan (2022a,

p.256). This intention was realised as the “Older People’s Housing Taskforce” was officially launched on 17th May 2023 (UK Government, 2023).

However, and despite an awareness of the different supported housing options available, there is evidence of an unwillingness to move home as people get older, with many preferring to remain in place, or possibly relocate to a single storey dwelling, but still live independently (Mulliner et al., 2020).

For those older people who may need, and are able, to move to more supported, ‘specialised’ or ‘extra care’ housing, the residential options in the UK are numerous and varied (Table 1). The definition of ‘specialised housing’ is designated accommodation for people aged 55 years or older, offering additional support which varies depending on the accommodation type and needs of the individual (Pannell et al., 2012). Extra Care Housing recognises the requirement for suitable accommodation that meets the needs of individuals alongside the desire to remain independent, offering various accommodation options and degrees of care and support (Department for Levelling Up, Housing and Communities., 2019; EAC, 2021).

Table 1. UK Residential Options

Residency Type	**Description**	**Age Criteria**	**Funding Criteria**
Sheltered Housing	Sheltered (also called retirement) accommodation comprises of a number of dwelling types including flats or bungalows for those who are able to mostly live independently but who may require minimal assistance which could be in the form of access to a helpline or emergency alarms within their homes, or from a nominated individual who is employed to oversee the residences and offer support as required [(a)(b)]	Usually, 55 years of age and older	Self-funding (with/without financial support from the State, subject to financial assessment)

Table 1. UK Residential Options Cont.,

Residency Type	Description	Age Criteria	Funding Criteria
Residential Care Home	Establishments that provide around-the-clock support are termed residential care homes or assisted living and offer more dependent living options with residents having their own rooms (with or without private bathroom facilities) and receiving support with their daily living needs such as personal hygiene, medicine management, and the provision of meals. These establishments may also provide some form of social engagement with other residents [(c)]	Not stated	Self-funding (with/without financial support from the State, subject to financial assessment)
Retirement Village	Retirement Villages are communities that offer individuals the opportunity to live independently with access to leisure facilities and social opportunities within a secure environment. Some villages may offer access to care facilities however this is usually dependent on the size of the retirement village. Residents may own their accommodation entirely, or rent, or part-own-part-rent, subject to each individual village composition [(d)]	Usually, 55 years of age and older	Self-funding (with/without financial support from the State, subject to financial assessment)
Extra Care Housing	Similar to Sheltered Accommodation and Retirement Villages, Extra Care Housing options offer independent living in a variety of bespoke accommodation types including apartments or bungalows, with the addition of communal areas and facilities such as hairdresser, dining rooms for meals, emergency alarm services, and access to varying levels of care dependent on need and residency type. Designed to support individuals with increasing needs whilst offering levels of independence. Extra Care Housing providers include local authorities, private providers, registered social landlords, and charitable organisations [(e)(f)]	Usually, 55 years of age and older	Self-funding (with/without financial support from the State, subject to financial assessment)

Table 1. UK Residential Options Cont.,

Residency Type	Description	Age Criteria	Funding Criteria
Nursing Home	Nursing homes, also referred to as care homes, offer the highest level of support with around-the-clock nursing care to individuals with the greatest level of need and who are unable to live either independently or semi-independently. Some nursing homes offer specialist support such as dementia care, however this is not available in all nursing homes [g]	Not stated	Self-funding (with/without financial support from the State, subject to financial assessment)
Almshouses	Almshouses have provided accommodation for those in need, who are primarily residents of retirement age, for over 1000 years, and are independently run by registered charities and look to provide accommodation to residents for the remainder of their lives.[h] Commonly houses or flats, the term 'Almshouse' is a historical one with the majority of residences now referred to as a 'college', 'hospital' or 'home' [i]	Usually retirement age and older	Charity-funded. Residents pay a weekly maintenance contribution
Veteran-specific Establishments	In addition to the accommodation options already discussed, former members of the British Armed Forces (veterans) also have access to accommodation primarily provided by military charities. This ranges from support for those who are homeless (or at risk of homelessness), or in need of support with accommodation [i][j][k], independent or semi-independent living, to nursing home care which may include specialist care such as dementia care [l][m][n][o]	Various criteria including: Any age subject to need [j][k][l][m] 65 years or older [n][o]	Various criteria including charitable funding [j][k] self-funding (with/without financial support from the State, subject to financial assessment) [l][n][o] and combined Army Pension and self-funding contribution(s)[n]

[a]EAC, 2018; [b]EAC, 2022a; [c]EAC, 2022b; [d]EAC, 2022c; [e]DLUHC, 2019; [f]EAC, 2021; [g]EAC, 2022d; [h]Almshouse Ass., 2022a; [i]Almshouse Ass., 2022b; [j]Alabaré, 2022a; [k]Alabaré, 2022b; [l]Haigh, 2022; [m]Erskine, 2022; [n]RHC, 2018; [o]RBL, 2022

Living in accommodation considered unsuitable to meet people's needs can be detrimental to physical and mental well-being (Communities and Local Government Committee, 2018), and it could be argued that it potentially increases the use of healthcare facilities and impacts state finances. Some residents in specialist housing

have been found to show an increase in their health and well-being and, subsequently, reduce state expenditure on health and social care provision by, for example, decreasing the number of hospital visits (Communities and Local Government Committee, 2018, p.41-42).

Contributors towards positive quality of life outcomes for those living in residential care settings include accepting the setting in which people are living, establishing relationships with fellow residents and staff, reductions in loneliness, and ensuring their needs are sufficiently met (Bradshaw et al., 2012; O'Neill et al., 2022). In addition to these factors, feeling at home, retaining control, and having a sense of purpose had positive influences on quality of life (Bradshaw et al., 2012; Slettebo, 2008).

However, the antithesis to positive quality of life experiences within supported accommodation include difficulties in developing new friendships, losing autonomy and a sense of identity, and adapting to new rules and regulations (Cooney et al., 2008; O'Neill et al., 2022), which may be seen as barriers to considering this type of living arrangement.

1.4 Setting the Scene – The Royal Hospital Chelsea

As outlined above (Table 1), UK military veterans have access to residential options that recognise their military service and are tailored to meet their needs. This tailored provision is not exclusive to British Armed Forces veterans, as other countries offer similar options to their military veterans, however little is known about the impact of living in these establishments. This is explored in greater detail in the systematic literature review (2.3).

Established in 1692, following a decree by King Charles II *"as a place of refuge and shelter for such Land Soldiers as are or shall be old, lame or infirm in the service of the Crown"* (RHC 2022a, p.7), the Royal Hospital Chelsea (RHC) is the largest veteran-specific establishment in the UK and is home to approximately 300 former soldiers of the British Army, known as Chelsea Pensioners, or 'In-Pensioners'.

© Royal Hospital Chelsea

Figure 1. Aerial view of the Royal Hospital Chelsea

However, despite supporting veterans for more than three centuries, there is a paucity of evidence to support the impact of care delivery on the Chelsea Pensioner experience. The only current evidence available are the Royal Hospital Chelsea Annual, and Care Quality Commission (CQC), reports which focus on strategic and operational nursing care matters rather than the impact of wider social care or the environment.

Historically, in addition to the Chelsea Pensioners (or 'In-Pensioners') who live at the Royal Hospital, there were also 'Out-Pensioners'. These were former soldiers in receipt of an Army pension who lived elsewhere but were required to collect their pension payments from the Royal Hospital in person (Ascoli, 1974), a practice that continued until 1845 (Wynn & Wynn, 2017). The Royal Hospital continued to manage Army pension payments until 1955, without the requirement for individuals to attend in person (Pailthorpe & Nuttall, 2003).

In-Pensioners live independently with access to supported healthcare and social provision, including exclusive access to an embedded medical practice, a stand-alone nursing home, the Margaret Thatcher Infirmary (MTI), governed by CQC regulations (CQC, 2022), and a social welfare team.

When compared to other non-veteran specific residential options for the older population, as outlined earlier (Table 1), the Royal Hospital offers a blend of supported accommodation, sheltered housing, retirement village and extra care housing with

elements of each being available to In-Pensioner residents. In addition, the MTI mirrors the provision available in residential care and nursing home options.

In addition to providing care and support to its residents, key Royal Hospital objectives are to offer In-Pensioners opportunities to engage in activities and represent both the Royal Hospital and the wider armed forces community and reduce any loneliness or isolation that they may have experienced prior to moving into the Royal Hospital (RHC, 2022a).

To be eligible to live at the Royal Hospital, individuals must have served in the British Army in a non-commissioned rank (or have served at least 12 years 'in the ranks' prior to becoming a commissioned officer), be 66 years of age or older, or in receipt of a UK Government State Pension, free of any financial obligations to dependents, and at the time of admission, be able to live independently (RHC, 2022b). Individuals accepted to live at the Royal Hospital are required to surrender their Army Service Pension or War Disability Pension or, for those who do not receive a pension, make a financial contribution towards their residency which is calculated during the application process (RHC, 2022b). Traditionally a male-only residence, the Royal Hospital welcomed its first female Army veteran in 2009 (Wynn & Wynn, 2017).

In his account of the Royal Hospital, Ascoli writes: *"The word 'hospital' was used by Charles in his original Royal Warrant in its old and proper sense of 'a place of refuge and shelter' […] It is, in effect, a self-contained village centred around its own chapel, its communal dining hall, its infirmary, its post office, and its social club…"* (Ascoli, 1974, p.17). Further, a Royal Hospital Chelsea official guidebook states *"the word 'hospital' means a place of 'refuge and shelter'"* (Pailthorpe & Nuttall, 2003, p.5), reinforcing this interpretation.

Chelsea Pensioners are globally recognised by their iconic uniform, known generally as the 'Scarlets' comprising of a scarlet coat, black trousers and two types of headdresses, the Shako for informal use and the Tricorne for ceremonial events. A second, less formal, uniform, referred to as 'Blues' is worn within the grounds of the Royal Hospital or within the immediate vicinity (Wynn & Wynn, 2017).

© Royal Hospital Chelsea

Figure 2. Chelsea Pensioners wearing Scarlets and Shako headdress

© Royal Hospital Chelsea

Figure 3. Chelsea Pensioners wearing Scarlets and Tricorne headdress

In-Pensioners are accommodated in wings that are referred to as Long Wards with each having their own room, or ‘Berth’. Recent refurbishment resulted in all Berth’s being fitted with their own bathroom facilities, alongside a bedroom and small area in which to relax (Wynn & Wynn, 2017). Refurbishments over time have reduced the capacity of the Royal Hospital from 476 residents in 1692, to approximately 300 today (Wynn & Wynn, 2017).

Long Wards are divided into four Company's (namely, 1, 2, 3, and 4 Company) which are akin to the hierarchical Army structure and defined as 'smaller sub-units' (Army, 2022). Each Company is supported by a Captain, whose historical title is 'Captain of Invalids' in reference to their role being related to the Royal Corps of Invalids, to which In-Pensioners belonged in the past (Wynn & Wynn, 2017). Captains are responsible for *"the overall welfare, conduct and behaviour of the Chelsea Pensioners within their Company."* (RHC, 2022c, para.2). Several other job roles within the Royal Hospital adopt military-style titles, and are staffed by former Army personnel, including Regimental Sergeant Major, Company Sergeant Major, Chief Clerk, and Quartermaster, however the workforce does include staff without prior military experience (RHC, 2022c).

The Royal Hospital is governed by a Board of Commissioners who are nominated by the UK Government's Secretary of State for Defence and appointed by the Monarch following a recruitment process. A role of Governor, also appointed by the Monarch, is occupied by a former senior officer of the British Army holding the rank of 3 or 4 star General, who chairs the Board of Commissioners and oversees the running of the Royal Hospital (RHC, 2022d). Further, the Royal Hospital receives an annual financial contribution known as the 'Grant in Aid' from the Ministry of Defence (MoD) to aid the care delivered to the In-Pensioners (RHC, 2022d).

A GP led medical practice, embedded within the fabric of the Royal Hospital and staffed by Royal Hospital Chelsea employees, offers unprecedented access to healthcare support allowing staff to identify and address In-Pensioner health concerns at the earliest opportunity (RHC, 2022e). Additionally, the MTI has a capacity of 68 beds and offers nursing care for In-Pensioners who become less independent and require additional care (RHC, 2022f).

Facilities within the Royal Hospital include the Great Hall which provides a communal dining area for In-Pensioners who receive three meals each day and has the capacity to accommodate all residents simultaneously (Pailthorpe & Nuttall, 2003; Wynn & Wynn, 2017). Furthermore, the Royal Hospital has its own chapel, consecrated in 1691, with an original mandatory attendance of twice a day reduced now to voluntary attendance on Sunday mornings and regular In-Pensioner parades (Pailthorpe & Nuttall, 2003). In-Pensioners also have access to their own social club, café, and shop,

all of which are situated within the grounds of the Royal Hospital (Wynn & Wynn, 2017).

1.5 Rationale for the Project

As discussed earlier (1.2), the older UK population includes military veterans (MoD, 2019a), some of whom are afforded the option of living in supported housing establishments like the Royal Hospital Chelsea (1.3).

Despite delivering care to veterans for over 300 years, the lack of outcomes evidence and the desire to support current and future In-Pensioners, motivated the Royal Hospital Chelsea to co-fund this PhD study alongside the Northern Hub for Veteran and Military Families Research at Northumbria University, with the aim of exploring the Royal Hospital's current service provision, the impact its model of care has on its residents, and to inform future direction by contributing new evidence to address the hiatus of evidence-based research at Royal Hospital Chelsea. This approach to obtaining new evidence on a particular subject is referred to as applied research and defined as *"…. original investigation undertaken in order to acquire new knowledge […] directed primarily towards a specific practical aim or objective."* (OECD, 2015, p.45).

This project had two main aims, the first of which was to gain an understanding of the current Royal Hospital Chelsea model of care by evidencing the influence this has on In-Pensioner health and social care outcomes, and the contribution the environment has on the In-Pensioner experience and their quality of life.

Second, the project aimed to inform the future provision of the Royal Hospital by exploring current services the future need and sustainability of the model of care, projecting findings to inform the growth of existing services, including its outreach programme, for current and future generations of ageing veterans.

Organisations are often evaluated by the quality of their service provision rather than the impact their services have on those in receipt of their services (Cooney et al., 2009). This project sought to identify the 'human', rather than economic, value of Royal Hospital Chelsea interventions, with findings of the overall project informing the

strategic direction of the Royal Hospital, and potentially contribute towards national health and social care policy for the ageing population.

This project commenced in March 2020 and was carried out during the global Covid-19 pandemic. Steps taken to mitigate the impact of the pandemic on the project are discussed in the Method chapter. The impact of Covid-19 on this study, and on the model of care delivered by the Royal Hospital Chelsea, is discussed throughout this thesis.

1.6 Outline of Thesis

Chapter 1 introduces this PhD, outlining the background of the research and contextualising the subject being explored. This chapter also provides the rationale for the research, an overview of the thesis, and contributions made.

Chapter 2 presents the literature review which explored theories relevant to ageing and a separate systematic narrative review, which was carried out to identify existing empirical and grey-literature evidence of global veteran-specific residential care in a non-hospitalised setting for those over 65 years of age. Evidence of health and social care outcomes as a result of living in these settings is also presented within this chapter. Findings from the whole literature review supported the rationale for the research.

Chapter 3 outlines the methodological considerations of the project including the research paradigm and Pragmatism, and the research design. The chapter also details the steps taken to demonstrate researcher rigor and reflections. All elements of these methodological considerations shape the way the research and analytical process was carried out.

Chapter 4 details the methods applied across all stages of the project, outlining the design, participant cohorts, recruitment and materials used. It further details the data collection and analytical process implemented and the ethical considerations of the project.

Chapter 5 reports on the quantitative and qualitative findings from the four primary data collection components, Parts A, B, C, and D. It discusses the findings from the

quality-of-life questionnaires and the themes identified from the semi-structured interview analysis.

Chapter 6 provides a detailed discussion of the results from the literature review and Parts A, B, C, and D, referencing empirical evidence and the relevant theories used to critically evaluate the overall findings. This chapter also discusses the strengths and limitations of the project, researcher reflections, and outlines the original contribution to knowledge. Finally, this chapter presents the overall conclusions and future research implications of this thesis.

1.7 Contributions

Throughout the duration of this project, I have carried out Professional Development training (Appendix A), and I have engaged in oral and poster presentations to share my ongoing findings with multiple stakeholders at conferences throughout the UK (see Appendices B and C). Engagements have been in-person and via online digital platforms.

1.7.1 Invited Presentations

Care of the ageing veteran population: Developing an evidence base for the Royal Hospital Chelsea model of care. Presented at:

King Edward VII Hospital Ethics Committee (May 2022, oral presentation)

Royal Hospital Chelsea Research Oversight Committee, (October 2020, oral presentation, online)

Royal Hospital Chelsea Research Oversight Committee, (April 2021, oral presentation, online)

Royal Hospital Chelsea Research Oversight Committee,
(October 2021, oral presentation, online)

Royal Hospital Chelsea Research Oversight Committee,
(March 2022, oral presentation, online)

Royal Hospital Chelsea Public Engagement Team,
(August 2022, oral presentation, online)

Royal Hospital Chelsea Research Oversight Committee,
(September 2022, oral presentation, online)

Royal Hospital Chelsea Health & Wellbeing Oversight Committee,
(April 2023, presentation)

1.7.2 Peer-reviewed Conferences

A global review of residential care models for the ageing military veteran population: What is available and what evidence exists to demonstrate their impact on health and social care outcomes? Presented at:
British Society of Gerontology Annual Conference,
(July 2021, oral presentation, online)

Care of the ageing veteran population: Developing an evidence base for the Royal Hospital Chelsea model of care. Presented at:
Forces in Mind Trust Research Conference,
(March 2022, poster presentation)

Care of the ageing veteran population: Developing an evidence base for the Royal Hospital Chelsea model of care. PhD: Preliminary Findings. Presented at:

British Society of Gerontology Annual Conference,

(July 2022, oral presentation, online)

The impact of life in a veteran-specific residential setting: Living at, and representing, the Royal Hospital Chelsea reinvigorates identity, sense of purpose and belonging, and enhances quality of life. Presented at:

British Society of Gerontology Annual Conference,

(July 2023, oral presentation)

1.7.3 Internal Peer-Reviewed Conferences

What residential models of care exist for ageing military veterans, what are their characteristics, and what evidence exists to demonstrate their impact on health and social care outcomes? A Systematic Narrative Review. Presented at:

Health and Life Sciences Early Career Researcher

(Conference, June 2021, online)

1.7.4 Publications

Cullen, H. & Wilson-Menzfeld, G. (2022). *International Residential care models for the ageing military veteran population: A Systematic Narrative Literature Review.* Manuscript in preparation.

1.8 Chapter Summary

The place in which older people live can influence opportunities to age ‘well’. Challenges to provide suitable accommodation for the ageing population has prominence on the UK Government’s agenda. Several accommodation options exist to facilitate positive outcomes, however some are reluctant to move, preferring to live within a familiar environment, irrespective of suitability.

The Royal Hospital Chelsea provides the opportunity for older Army veterans to live in a communal setting akin to that experienced during military service, however the clear lack of outcomes evidence presents the opportunity to explore the In-Pensioner experience to identify the personal impact of residing an establishment that is tailored to meet their needs.

This chapter introduced the project, its aims and rationale for conducting the research. It contextualised the project by introducing the Royal Hospital Chelsea, its residents and presented an overview of a globally ageing population that includes military veterans who have access to residential accommodation that caters for this specific employment group. It further outlined the residential landscape for those over 65 years of age and the interest in exploring the health and social care outcomes for those who reside within these establishments. Finally, this chapter presented an outline of the overall thesis and the contributions to date.

CHAPTER TWO

LITERATURE REVIEW

2.1 Overview

Chapter two has two main aims. Firstly, to provide an overview of theories that relate to ageing, with a focus on the theories of ‘Successful Ageing’ and ‘Ageing in Place’, both of which have several corresponding theory titles, which are subsequently discussed. Secondly, to outline the findings of a systematic narrative review of existing literature relating to non-hospitalised residential care provision specifically for military veterans over 65 years of age and identify evidence relating to the impact these settings have on their health and social care outcomes.

2.2 Theories of Ageing

As the ageing population increases, understanding factors that influence ageing are important to enable service providers, policy makers and other stakeholders ensure the older person has their needs met as they age (Bowling, 1993; Bowling & Dieppe, 2005).

This project will consider ageing theories whilst analysing what factors relating to ageing ‘well’ are present in the resident population of the Royal Hospital Chelsea. In addition to an individual’s ability to age ‘well’, the influence of the location in which individuals reside as they age is also considered, with ‘ageing in place’ and ‘ageing in the right place’ theories explored to identify what impact the environment has on an individual’s ageing process and quality of life.

The project will also consider additional theories, including social cohesion, military cohesion, institution, and community theories to inform the discussion and provide broader evidence of the influence the environment has on the overall life experience of In-Pensioners.

2.2.1 Ageing Well

The theory of ageing ‘successfully’ followed what are considered two of the most significant theories relating to ageing in the early part of the last century, namely ‘activity theory’ and ‘disengagement theory’, bringing an additional dimension to evidencing contributors that influence the ageing process (Ballesteros, 2019).

Activity theory posits the importance of engaging in pursuits that generate feelings of usefulness, being needed and contributing to society, which result in an increase in life satisfaction (Knapp, 1977; Tavel, 2008). Self-worth is found to increase by the degree of engagement, with higher frequency resulting in enhanced self-worth (Knapp, 1977). The value of being socially active is of equal significance whether an individual is in mid or later life, which can be impacted by life events such as bereavement, physical decline, or retirement from work, causing alternative activities to be identified to maintain social engagement (Knapp, 1977). In contrast, Disengagement theory concerns the intentional retreat from engaging in society, relationships, and responsibilities such as employment, notwithstanding retirement, as individuals prepare for the ensuing decline in age and advancing mortality, however the choice to disengage is not an indicator of an inability to engage, rather a conscious decision which is said to bring individuals increased fulfilment as they reprioritise their later lives (Tavel, 2008). However, Tavel (2008), suggests caution when applying Disengagement theory to the current population as the positioning of individuals at the time of the conception of the theory, in the mid twentieth century, may be less relevant than it is today.

Neither Activity nor Disengagement theories are intended as direct comparisons to each other as *“the opposite of disengagement is engagement, a concept different from, though related to, the concept of activity”* (Cumming, 1963, as cited in Knapp, 1977, p.554), suggesting the decision not to engage in activity is not an indicator of disengagement.

The theory of ageing ‘successfully’ was conceptualised by Rowe and Khan (1987) who differentiated the ‘normal’, or non-pathological, process of ageing, where there is a natural decline in bodily functions such as a deterioration in sight, hearing, or memory capacity, and the pathological, where there is a presence of disease. However, they acknowledged the risk of this separation and potential disregard of the

heterogeneousness of individuals in the ‘normal’ group, alongside the possibility that such individuals may be considered free of the risk of disease. A further risk of categorisation is an assumption that ‘normal’ ageing is absolved from intervention to improve any identified decline. To mitigate the potential risks of separating the non-pathological and pathological processes of ageing, Rowe & Khan (1987) further distilled ‘normal’ ageing into two categories, namely ‘usual’ and ‘successful’. ‘Usual ageing’ encapsulates expected age-related decline whereas ‘successful’ ageing concerns those who demonstrate fewer, or less, age-related deterioration and disease, than the ‘usual’ classification, which may also be influenced by protective factors such as lifestyle and social support.

Developing ‘successful ageing’ further, Rowe & Khan (1997, p.433) suggested three components, namely, *“low probability of disease and disease-related disability; high cognitive and physical function capacity; and active engagement with life”,* all of which are interconnected and contain sub-components including risk of disease or disease-related disability occurring, feasible engagement in cognitive and physical activities, and social engagement and meaningful activity, respectively. However, Hill (2010) suggests research exploring ‘successful’ ageing has focused on participants who are either non-diseased or may have a propensity to be resilient against factors that influence not ageing ‘successfully’, therefore research may have an imbalance as a result of this participant selection. Additionally, Bowling (1993) suggests that the ability to age ‘successfully’ may be impacted by circumstances beyond the influence of the person concerned and may be defined by some as a reflection of economic status or social positioning, therefore doesn’t consider social-cultural or micro, meso, or macro factors impacting ageing. Instead, this theory is self-blaming, perhaps pointing to an individual’s own capacity, or in some cases failure, to age ‘successfully’, or indeed ‘unsuccessfully’.

However, despite substantial research on ‘successful’ ageing, there continues to be an absence of a clear definition which may explain the numerous phrases used to explore the subject, including ‘positive’, ‘healthy’, ‘productive’, ‘active’ and ‘well’ (Corr & Tarou, 2006; Glicken, 2009; Annele et al., 2019; Ballesteros, 2019; Moghimi et al., 2019). Additional challenges to the definition are the subjective nature of the interpretation of ‘successful’, as individuals may consider themselves to be ageing

‘successfully’ with or without the presence of disease and may have accepted their health or life circumstances and be satisfied with their position.

Ballesteros (2019) reviewed the interpretations and categorisations of the term ‘successful ageing’, and those connected to the theory, across 17 peer-reviewed papers, identifying Biomedical (concerning the medical condition and physical functioning), Psychological (mental wellbeing, values, life satisfaction, and resilience), and Social outcomes (engagement opportunities and feelings of safety), and corresponding influencing factors (Table 2).

Table 2. Summary of successful ageing (and related terms) outcomes and predictors or determinants (modified from Fernandez-Ballesteros, 2008). (Ballesteros, 2019)

Component	Outcomes	Predictors or determinants
Biomedical	✓ Longevity ✓ Biological Health ✓ Cardiovascular and pulmonary function ✓ Mental health ✓ Functional abilities ✓ Physical strength ✓ Vital capacity ✓ Absence of disability ✓ Autonomy	✓ Long-life ancestors ✓ Maximizing health across ✓ life span ✓ Socioeconomic conditions ✓ Social/health services ✓ Environmental conditions
Psychological	✓ Subjective health ✓ Activity ✓ Competence (motor and cognitive) ✓ Mental and physical positive functioning ✓ Life and social engagement ✓ Behave according to own values and beliefs ✓ Coping ✓ Purpose in life ✓ Personal growth ✓ Psychological well-being ✓ Life satisfaction ✓ Perceived quality of life ✓ Adaptation capabilities ✓ Mature defence mechanism ✓ Family relationships ✓ Affective states ✓ Meaning in life ✓ Maintenance of valued activities and relationships	✓ Selective Optimisation with Compensation (SOC) ✓ Development and maintenance of primary control ✓ Socio-emotional selectivity ✓ Adaptive process developing capacities for solving difficulties and minimising the effects of deficits ✓ Coping strategies across life ✓ cycle ✓ Behavioural lifestyles
Social	✓ Social productivity ✓ Social networks ✓ Material security ✓ Environmental mastery	✓ Optimising opportunities for security ✓ Education

Ballesteros (2019) further synthesised the multiple definitions and components of ‘successful’ ageing, creating four areas, or ‘Domains’ to demonstrate the correlation between definition and outcome under the over-arching construct of ‘ageing well’ (Figure 4).

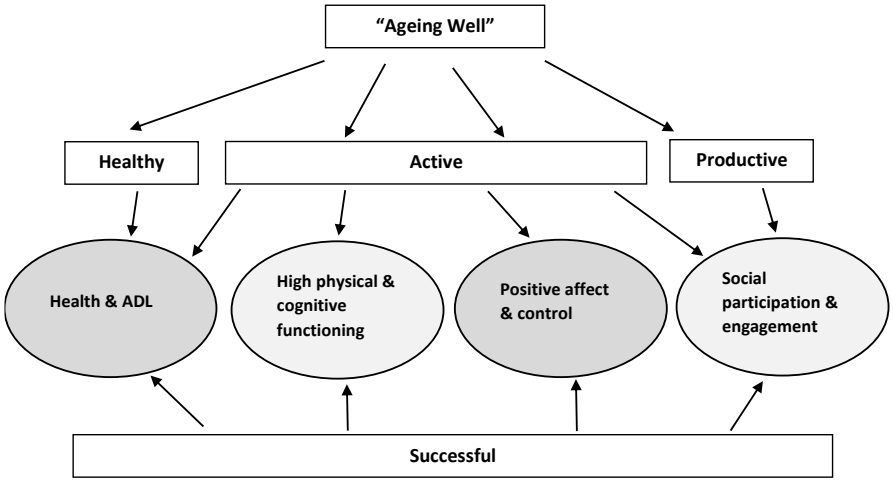


Figure 4. Four Domains model of ageing well

Modified from Fernandez-Ballesteros (2008) and Fernandez-Ballesteros et al. (2013) (Ballesteros, 2019)

Ballesteros (2019) tested the validity of his synthesis of 'successful' ageing, initially using ATLAS.ti software to produce a 'word cloud' of the most frequently used terms relating to the person and ageing process. Further testing, using Confirmatory Factor Analysis and Structural Equation Modelling, confirmed the validity of the four Domains (Ballesteros, 2019). However, Ballesteros (2019) acknowledged that terms including 'security' or 'spirituality' were not included in the testing process and are therefore omitted from the four Domains.

As discussed, Ballesteros (2019) highlights the challenge of identifying a generic term that concisely demonstrates an individuals' ageing status, which risks the exclusion of ageing 'indicators' that may contribute towards the body of evidence. Using the four Domains detailed in Figure 4 above, Successful [ageing], and Active [ageing] concepts are each associated with all four Domains, namely Health & ADL, High physical & cognitive functioning, Positive affect & control, and Social participation & engagement. However, the Healthy [ageing] and Productive [ageing] concepts are singularly associated to the Health & ADL, and Social participation & engagement Domains respectively, indicating that not all concepts have a multi-dimensional status across the areas that influence an individual's 'ageing well' status.

This project upholds the concept of ‘successful’ ageing, whilst acknowledging its disadvantages, by using the term ‘ageing well’ and the four Domains as summarised above.

2.2.2 Ageing in Place

The concept of ‘Ageing in Place’ enables people to age within a place they call home, whilst having access to appropriate support services, and is widely recognised and implemented (Kaul et al., 2020; Rogers et al., 2020; Sixsmith & Sixsmith, 2008). Ageing in place is an important consideration of this project as the population group, namely In-Pensioners, move into the Royal Hospital Chelsea with the intention of remaining there for the rest of their lives, therefore ageing in place.

Similar to defining ageing ‘successfully’, identifying a consistent meaning of the term ‘ageing in place’ appears equally challenging (Rogers et al., 2020; Sixsmith & Sixsmith, 2008), however the World Health Organisation (2004, p.9) define this concept as

> *“Meeting the desire and ability of people, through the provision of appropriate services and assistance, to remain living relatively independently in the community in his or her current home or an appropriate level of housing. Ageing in place is designed to prevent or delay more traumatic moves to a dependent facility, such as a nursing home.”*

Critics of the phrase ‘ageing in place’ believe it to be outdated and potentially ageist as enabling people to *“live in homes that are right for them – meeting their needs and attending to their preferences”* should apply to everyone irrespective of their age (Kagan, 2023, p.2). Similarly, Rogers et al. (2020, p.9) recognise the progression of the concept to include the option to live in the place of one’s choosing, suggesting a more relevant description of ageing in place to be *“one’s journey to maintain independence in one’s place of residence as well as to participate in one’s community”* with ‘journey’ recognising the flexibility of the physical location as individuals age.

Enabling people to age in place, or ‘the right’ place, is prompting residential care providers to consider settings where this can be facilitated, tailoring the surroundings

to the needs of the resident in contrast to moving them as their needs increase (Iecovich, 2014).

The desire for older people to remain in their own homes increases as they age, with resistance to relocate similarly increasing, and making decisions to move later in life potentially having a detrimental impact on health and wellbeing outcomes (Severinsen et al., 2016). One reason for this is the attachment people have to the place in which they live as it is seen as an extension of their identity and personal history, with some choosing to remain in their home regardless of access to the support available (Severinsen et al., 2016).

Financial implications can have a direct impact on ageing in place. The cost of moving may be one consideration for individuals to remain in their own home, particularly for those who are homeowners (Kaul et al., 2020). However, the cost of remaining in place may be prohibitive if homes require adaptations or high levels of maintenance resulting in financial expenditure that may be beyond the affordability of some (Kaul et al., 2020; Sixsmith et al., 2017). Additional challenges include the unsuitability of the homes in which individuals live which may be because of the condition of the accommodation or the location, with rural locations potentially having reduced access to the services required to support ageing in place, including suitable transport options (Kaul et al., 2020; Severinsen et al., 2016).

Supporting individuals to age in place is believed to be an economically viable option for state finances as receiving support at home is considered less expensive than placing individuals in residential or nursing homes (Severinsen et al., 2016; Sixsmith & Sixsmith, 2008; Sixsmith et al., 2017), however there are wider implications to society as ageing in place becomes an established concept. One such implication is the reduction of available housing options as a direct result of the older generations remaining in place (Kaul et al., 2020; Severinsen et al., 2016).

Despite the debate about the language used in this space, ageing in your own home (or not) has multiple implications on both health and wellbeing outcomes.

Receiving support in the home is found to empower independence and enable individuals to remain connected to the familiar surroundings of their home, in whatever format that presents, and within an environment they are used to (Sixsmith et al., 2017). It also facilitates continued engagement with relationships such as friends or

family and a community in which they are established, however it is acknowledged that not everyone has such a network of support available (Kaul et al., 2020; Sixsmith et al., 2017). Living in familiar surroundings and maintaining engagement with established networks has been found to increase wellbeing, quality of life, and contribute towards a positive ageing experience (Severinsen et al., 2016; Sixsmith et al., 2017). These outcomes support the theory of ageing in place. However, older people may be reluctant to admit needing assistance as it may be considered a challenge to their independence (Sixsmith et al., 2017). This absence of support may impact on their ability to socialise, particularly for those with decreased mobility levels, subsequently resulting in increased loneliness and isolation (Kaul et al., 2020; Sixsmith et al., 2017). The opportunity to age in place is facilitated by home adaptations to create a safe environment for people to live in, accompanied by support from health and social services to provide a package to meet individual needs (Sixsmith & Sixsmith, 2008)

The theoretical framework of ageing 'well', and concept of ageing in place, will be considered throughout this project as it seeks to address the research aims and identifies the impact on In-Pensioners as a result of living at the Royal Hospital Chelsea.

2.3 Systematic Narrative Review

In addition to the general UK residential care options available to the wider population and military veterans as outlined earlier (1.3), a systematic narrative review was conducted as part of this project to gain detailed knowledge of veteran-specific residential establishments, in a non-hospitalised setting, available to those aged 65 years and older to understand the global landscape of provision. This systematic narrative review aimed to identify extant service provision for veterans and the impact living in these establishments had on health and social care outcomes.

Systematic Narrative Reviews enable the collection and analysis of multiple types of data, including peer-reviewed and non-peer reviewed literature, and are often used when there is a lack of empirical evidence to answer phenomena (Popay et al., 2006; Snilstveit et al., 2012; Steven et al., 2020). Conducting systematic narrative analysis alleviates the challenges of 'narrative review' as the systematic approach requires the

application of a methodical and clearly defined process, including a rigorous and reproducible systematic, search of extant literature, an exacting inclusion criterion, and thorough assessment of selected studies or results (Snilstveit et al., 2012). Non-peer reviewed, or unpublished, data can be referred to as grey literature, grey data, or grey information and can comprise of data obtained from multiple sources including digital platforms, email communication, organisational and academic reports (Adams et al., 2016; Benzies et al., 2006).

The lack of empirical evidence relating to ageing veterans' residential care meant a Systematic Narrative Review approach was the most appropriate methodology to apply to the literature review to ensure qualitative, quantitative, mixed-methods, non-peer reviewed studies and wider grey literature (or grey 'information') could be included. This helped ensure a broad spectrum of valid information was captured to enable to review question to be answered comprehensively (Popay et al., 2006).

2.3.1 Search Strategy

Nine databases were searched (Table 3). The rationale for using these specific databases was to generate results from a broad field with a focus on health and social care outcomes. Therefore, databases that held social science, life-science and healthcare policy results were sourced. It was anticipated that using veteran-specific terminology in the search strategy would narrow the field to identify relevant papers for review, however as the aim of the review was to determine which establishments specifically included veterans, this targeted approach was considered appropriate. Furthermore, excluding the term 'veteran' generated residential care results that were too numerous and generic and subsequently impractical for the review aims.

The definition of the term 'veteran' varies across the world with the UK applying veteran status to anyone who has served at least one day in the armed forces. However, other countries apply different criterion including the requirement to have served overseas or completed minimal lengths of military service (Gribble et al., 2019), therefore it was important to include both the term 'veteran' and 'ex-servicem?n' in the literature search to ensure this population group was identified. Furthermore, the wide-ranging terminology used to categorise residential living options, as identified in Table 1, required multiple search terms to be used to maximise the search results, including

the term assisted living, to accommodate international phrases for residential options. This supported the identification of global studies to support the review aims.

The term ‘children’ was applied as an exclusion criterion as the project aims were to explore residential options for adults over 65 years of age, therefore literature relating to children was not relevant. Similarly, excluding literature specifically relating to the homeless population limited the identification of temporary residential accommodation options as these were not relevant to the review question. Applying the term ‘dementia’ as an exclusion criterion aimed to minimise literature that identified specialised residential establishments offering high levels of care, or nursing care, as these did not align with the aims of the review.

Applying a wildcard technique, in this case using ‘?’ in ex-servicem?n, broadened the search to accommodate alternative spellings, and the use of phrase searching, by applying quotation marks around specific words, i.e., “care home”, limited the search results to ensure these words were identified together to indicate a residential option.

Table 3. Database Search

Database Search and Screening Results				
Search Terms Used* (excluding ZETOC):	**(veteran OR ex-servicem?n) AND ("residential care" OR "care home" OR "assisted living") NOT dementia NOT homeless NOT children**			
***ZETOC Database Search Terms**	**(a) veteran AND "residential care" (b) veteran AND "care home" (c) veteran AND "assisted living"**			
Database	**Results**	**Date of Search**	**For Full-Text Screening**	**Final for Inclusion in Review**
ASSIA & MEDLINE (via ProQuest)	**n=289**	24-Jun-20	**n=16**	**n=3**
CINAHL with Full Text	**n=130**	22-Jun-20	**n=14**	**n=5**
Cochrane Library	**n=19**	19-Jun-20	**n=0**	**n=0**
Google Scholar	**n=718**	23-Jun-20	**n=11**	**n=1**
PubMed	**n=111**	26-Jun-20	**n=7**	**n=1**
Science Direct	**n=484**	25-Jun-20	**n=11**	**n=1**
Scopus	**n=216**	25-Jun-20	**n=6**	**n=2**
Web of Science (excluding Medline database)	**n=55**	25-Jun-20	**n=0**	**n=0**
Zetoc (British Library)	**n=7**	18-Jun-20	**n=1**	**n=0**
Totals before Reference Searches:	**n=2029**		**n=66**	**n=13**
Reference Searches (from those papers selected to include in the review)	**n=31**		**n=1**	**n=1**
Totals:	**n=2060**		**n=67**	**n=14**

Google Scholar was also utilised to help identify potential empirical evidence that may fall outside of the databases searched. Military specific journals were not used as the review demographic focuses on veterans aged 65 and over therefore the author considered it unlikely that these journals would elicit results not already identified using the selected databases and search engines.

Studies were only excluded through design purposes if they were literature reviews or theses. International studies were included in the search, and no studies were excluded based on publication date. All empirical papers published prior to June 2020 were included in the search. This ensured retrieval of maximum relevant results. Whilst all languages were included in the search criteria, the results did not identify any non-English Language papers.

2.3.2 Study Selection

Empirical Studies

The screening process is detailed in the PRISMA flow diagram (Moher et al., 2009), (Figure 5).

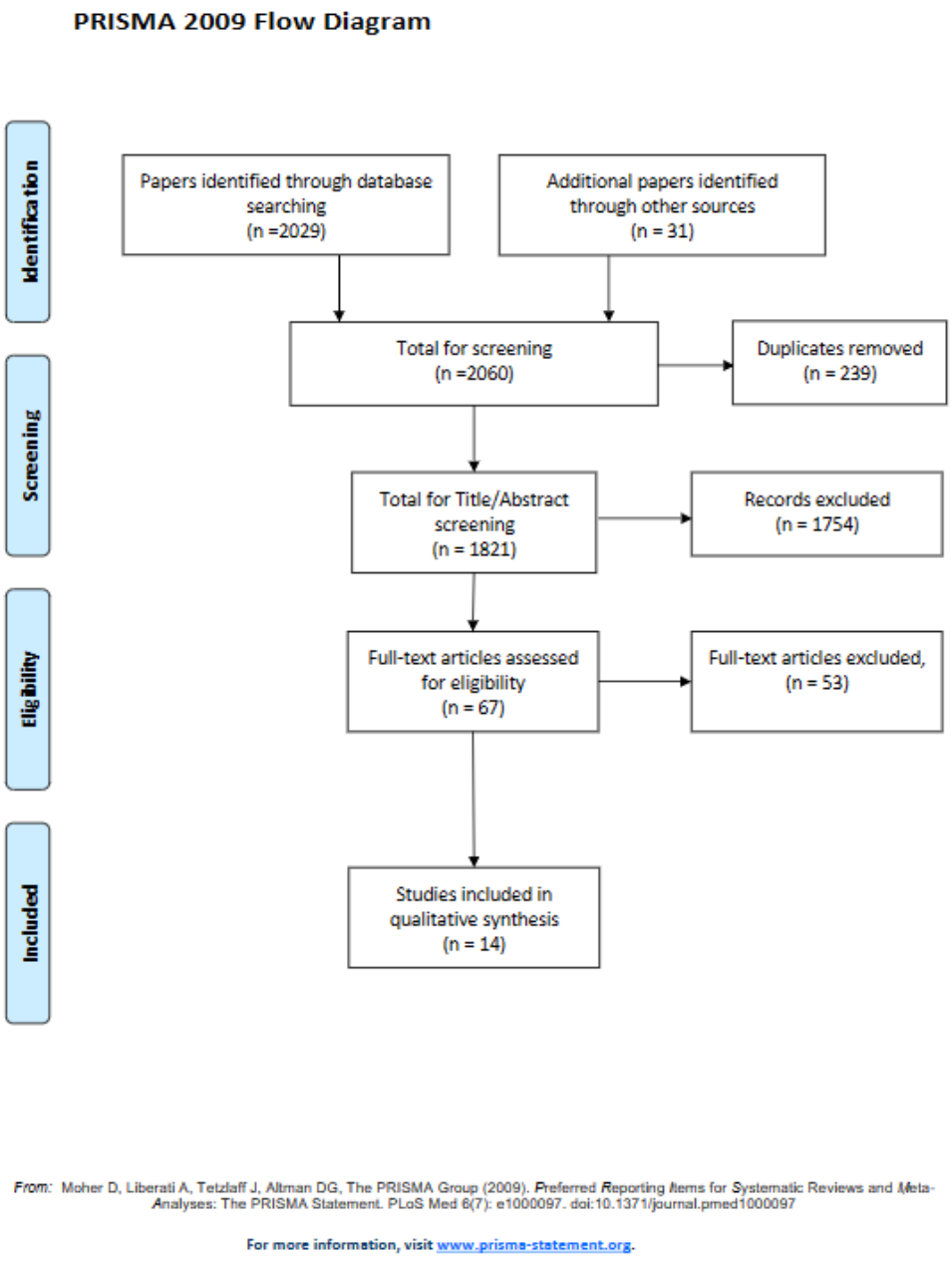


Figure 5. Prisma Flow Diagram

The screening search identified 2029 papers. An additional 31 papers were identified as a result of a hand search of reference lists. Of the 2060 considered relevant for title and abstract screening, 239 duplicates were removed and a further 1754 were excluded leaving 67 papers for full-text screening.

Full-text screening took place using a PICO format screening tool which included inclusion and exclusion criterion (Appendix D). Of the 67 papers considered relevant for full-text screening, 53 were excluded following further investigation as they did not meet the necessary criteria to inform the aims and objectives of the review. A total of 14 papers were identified for full review (Appendix E).

2.3.3 Empirical Study Selection Analysis

Studies were reviewed individually, and collectively, and subsequently analysed using inductive thematic analysis to identify recurring characteristics within the data alongside any individual points of note that were considered relevant for further exploration (Braun & Clarke, 2006). Areas of interest were then appraised against the review question to ensure the most salient points were included in the results.

2.3.4 Grey Information Data

Grey Information data was searched using internet search engines, email, and direct in-person communication. The inclusion of Grey Information provided evidence of the current residential options available to veterans to inform the overall review. In retrospect, the decision to include Grey Information was justified as it identified well-known international veteran-specific residential establishments such as the Royal Home for Retired Military Veterans and Museum Bronbeek, and the Royal Hospital Chelsea, which were not evidenced empirically, but were relevant to the review.

Direct contact was made with 76 organisations across 66 countries (Appendix F). Responses were received from 24 countries with a total of 10 confirming residential care facilities for veterans over 65 years of age. (Table 4). The search identified the World Veterans Federation Directory (2021) which became a key source in identifying

organisations to contact. Of the 10 countries identified via direct contact, additional grey information was found for seven of these countries.

Table 4. Grey Information Country Search Results

Grey Information Country Search Results	
Total number of countries contacted[1]	66
Total number of responses received[1]	24
Of the responses received (24) how many confirmed provision	10
Of the 10 countries identified as having provision - how many were identified as a result of direct contact[2]	3
Countries (from the 10 countries identified) with additional data sourced from internet searches	7

[1] Includes the n=10 countries identified to have provision
[2] Poland; Jordan; Czech Republic

To promote consistency, grey information search terms were closely matched to the empirical search terms (Table 5) and results were synthesised using the inclusion/exclusion criteria as set out in the empirical research strategy (Appendix D). Residential options that included the non-veteran population were included in the review on the condition that they made specific reference to accommodating veterans.

Table 5. Grey Information Search Terms

Grey Information Search Terms
Military Veterans care homes; residential homes; ?assisted living
Military Veterans care homes; residential homes; ?assisted living in [country]

Data from the selected empirical studies and grey information results were extracted using a single data extraction tool (Appendix D).

2.3.5 Study Quality Assessment

As the review used empirical and grey information data it was not possible to use a single quality assessment tool applicable to both search methods, however, to ensure a degree of quality, 10% of the selected papers were randomly chosen and quality checked by the author's academic supervisor, Dr Gemma Wilson-Menzfeld. All grey information included within the review was obtained from officially recognised websites or via bona-fide email communication.

2.4 Results

2.4.1 Overview

Empirical evidence was identified in three countries, namely the USA, China, and Taiwan. Data extracted from empirical studies covered three areas, namely participant characteristics which included gender, participant numbers, client groups, and participant age (Appendix G); residency characteristics including population group, residency type and size, room type, organisation type and funding method (Appendix H); and Outcomes including Quality of Life (QoL); longevity; physical health; social care engagement; environment; pastoral care and reason for leaving residence (Appendix I).

2.4.2 Study Characteristics

Consolidation of the characteristics identified above led to four prominent areas of interest; Service Provision; Participant Demographics; Barriers; and Outcomes (Table 6). Data on service development, funding, and admission criteria were identified, however the findings did not contribute to the review question and were therefore excluded.

Table 6. Study Characteristics

Empirical Study Characteristics				
Study	**Service Provision**	**Participant Demographics**	**Barriers**	**Outcomes**
Chapko et al. (2009)		✓		✓
Chen et al. (2010)	✓	✓		✓
Gilman et al. (2018)	✓		✓	✓
Guihan et al. (2009)	✓		✓	✓
Haverhals et al. (2016)	✓			✓
Hedrick et al. (2007)	✓	✓	✓	✓
Hedrick et al. (2009)		✓		✓
Kenter (1980)	✓			✓
Kheirbek et al. (2018)	✓	✓		✓
Lemke & Moos. (1989)	✓	✓		✓
Leung (2010)	✓			
Levy et al. (2013)	✓		✓	✓
Montross et al. (2006)		✓		✓
Wu (2002)	✓			✓

Where available, data extracted from grey information results matched the characteristics of the selected studies (Appendices J, K).

2.4.3 Empirical Study Results

2.4.3.1 Service Provision

Seven studies refer to two USA residential programmes, namely the Assisted Living Pilot Program (ALPP) (Chapko et al., 2009; Guihan et al., 2009; Hedrick et al., 2007; Hedrick, et al., 2009) and the Medical Foster Home (MFH) (Gilman et al., 2018; Haverhals et al., 2016; Levy et al., 2013). For ease of reference, the findings for these programmes will be presented under sub-headings throughout the empirical findings.

2.4.3.1.1 Assisted Living Pilot Program

Chapko et al. (2009), Guihan et al. (2009), Hedrick et al. (2007) and Hedrick et al. (2009) present findings on the Assisted Living Pilot Program (ALPP), a US Veterans Affairs (VA) led initiative that funds a veteran's stay in a VA contracted residential

facility for a maximum of two months with the primary outcome being to provide a cost-effective transitional model of residential support for eligible USA military veterans.

Collectively, the studies looked to inform the development of a long-term residential model of care that gives eligible individuals options of care that best suit their needs within limited financial means (Guihan et al., 2009).

The ALPP included three residency types, namely the Adult Family Home (AFH), Residential Care Facility (RCF), and Assisted Living Facility (ALF). All residency types differed in capacity and living arrangements. An AFH offers an individual their own room within a family home supporting a maximum of six residents. The RCF is larger, and a resident is more likely to live in a shared room. Finally, the ALF is a self-contained living space (Guihan et al., 2009; Hedrick et al., 2007). All residency types were authorised to support individuals with daily tasks (Hedrick et al., 2007), using the 'Instrumental Activities of Daily Living' (IADL) assessment tool to identify an individuals' ability to function independently (AssistedLiving.org, 2021).

As discussed earlier, three studies (Chapko et al., 2009; Guihan et al., 2009; and Hedrick et al., 2009), presented findings on the ALPP examining the same cohort of individuals engaged in the programme (n=393) who were followed for a period of one year following their residency start date. Hedrick et al. (2007) presented findings on 743 ALPP residents who consented to have their data reviewed for the purposes of their paper, therefore, the findings from Hedrick et al. (2007) are not comparable with other ALPP studies however they do refer to the same dataset. Each study presented findings on different programme elements, namely usage and cost (Chapko et al., 2009); background and facility features (Guihan et al., 2009); resident and service provider attributes (Hedrick et al., 2007); and health outcomes (Hedrick et al., 2009), with each being relevant for inclusion in the systematic review.

Most providers engaged in the ALPP were in the private sector (92.5%) with ALF and RCF establishments linked to for-profit organisations, 76.6% and 62.8% respectively (Guihan et al., 2009). Of the three facility types the RCF reported the majority of not-for-profit providers (11.5%) with AFH and ALF reporting 4.4% and 5.6% respectively (Guihan et al., 2009).

The smallest facility type (AFH) accepted residents with the highest needs, provided a homely setting and had the least amount of skilled healthcare professionals

delivering care, however the size of facility did not impact on resident outcomes (Hedrick et al., 2007; 2009). Hedrick et al. (2007) found little difference in the delivery of the key elements of provision across all three facility types engaged in the ALPP.

The ALPP programme took place in the North-West region of the USA with service providers who are considered leaders in long-term residential care (Guihan et al., 2009), therefore the transferability of the findings to service providers with less expertise may not result in comparable outcomes. However, it could be argued that findings from service providers who are leaders in their field may encourage other service providers to implement the programme.

2.4.3.1.2 Medical Foster Home

Implemented by the US Veterans Health Administration (VHA) in 2008, the Medical Foster Home (MFH) is a residential care model for eligible veterans who lack familial support or whose increasing care needs necessitate a change in their current living situation. The MFH offers a different choice of continuing care to veterans who qualify for state funded healthcare support but are reluctant to consider care in a more formal nursing home environment, preferring to receive 24-hour support in a more homely non-nursing environment (Gilman et al., 2018). The MFH provides an opportunity for the veteran to remain in residence for the rest of their life (Haverhals et al., 2016). The veteran self-funds their accommodation, food, and associated expenses, and receives health-related support from the VHA Home Based Primary Care (HBPC) team, comprising of healthcare professionals managed by the VHA, who work holistically with the care provider to manage and improve the health needs of the veteran resident (Gilman et al., 2018; Haverhals et al., 2016).

In early 2016, almost 1000 (n=992) veterans were being cared for in approximately 700 (n=693) MFH across 117 programmes in the USA (US Department of Veterans Affairs, Medical Foster Home Program, 2016, as cited in Haverhals et al., 2016, p.442). The MFH model enabled service-provider flexibility, so providers were able to offer a service to the veteran resident whilst managing their own life-commitments (Haverhals et al., 2016).

In contrast to the four studies relating to the ALPP, which presented findings on the same programme and dataset, the selected MFH studies present findings on different perspectives of the model of care using different establishments, participant groups and methods. Gilman et al. (2018) explored service user and family members experiences, Haverhals et al. (2016) presented service provider findings, and finally, Levy et al. (2013) evaluates the model of care incorporating service provider, service user, and family experiences. All studies contributed different elements relating to the same model of care which supports the aim of the literature review.

Haverhals et al. (2016), Levy et al. (2013) and Gilman et al. (2018) highlighted the multi-disciplinary support received by veterans residing in a MFH facility from the HBPC unit. This support facilitated the maintenance of an individual's personal capability, reduced institutional dependence (Levy et al., 2013) and enabled the care provider to communicate with the HBPC team to inform them of any relevant changes to a veterans' health condition and enabled the care provider to be guided by the HBPC team to offer the veteran appropriate care and support (Haverhals et al., 2016).

Levy et al. (2013) qualitatively reviewed one MFH, carrying out semi-structured interviews with service providers, service users, and their families alongside two focus groups and found successful engagement between the MFH service provider and the HBPC team was key to providing an effective service with veteran family members. The association between themselves and the care provider was observed as a collaborative effort to ensure the veteran received the necessary support. However, the number of service users engaged in the study was small with only two veterans and three caregivers participating, alongside seven family members of veterans who had either chosen to, or refused, a MFH placement, compared to 23 service providers, (Levy et al., 2013) which may have resulted in an imbalance of the findings.

Some families focussed on the daily living support as a key element of life in a MFH and some recognised wider outcomes, namely the care provider's ability to provide a homely living environment and create a feeling of attachment to the place in which the residents lived (Levy et al., 2013).

In contrast to Levy et al. (2013), Gilman et al. (2018) focussed on the experiences of the veteran and their families (or guardians), carrying out semi-structured interviews across six MFH establishments and found veterans were drawn to the MFH model of

care at a time when either their own ability, or that of their families, to maintain the level of care required was diminished. The offer of around-the-clock support and the tailored care package was a determining element of the decision to reside in an MFH and reinforced the model as an exclusive continuing care choice for veterans who qualified for state funded care but were seeking 24-hour individualised care in a home setting.

2.4.3.1.3 Alternative Provision

Lemke and Moos (1989) found residential facilities studied were equal in capacity and operational need and offered comparable service provision and degrees of resident independence, however not-for-profit establishments demonstrated access to more healthcare provision and greater staff retention levels beyond 12 months in contrast with the for-profit establishments (66.0% and 55.0% respectively). Comparing these findings to more recent studies may be problematic as the composition of establishments and the service provider landscape today is anticipated to be different to the time of the study, therefore caution should be applied when considering the transferability of results.

Wrap-around services were examined in other included evidence. Kheirbek et al. (2018) retrospectively examined a holistic approach tailored to veterans over 100 years old, identifying eight individuals who lived within the medical facility between 2005 and 2015. Each individual patient's complex needs were considered, by engaging with an interdisciplinary team of healthcare professionals who delivered appropriate care to address individual health needs, including drugs management, which reduced any deterioration in health, kept patients safe and promoted longevity irrespective of their advanced age. Further, engaging with individuals to discuss their healthcare plans was found to contribute towards positive life satisfaction outcomes enabling them to maintain levels of social engagement whilst factoring in their health conditions (Kheirbek et al., 2018).

Kenter (1980) focussed specifically on a 'foster home' model of care which supported veterans who were without their own accommodation and required some form of physical or mental health support at a level not requiring hospitalisation or full nursing care. The age of this article makes it challenging to correlate findings to current models

of care, however it does offer an insight into USA veteran-specific provision pre-MFH implementation.

Taiwan's Veteran Affairs Commission (Chen et al., 2010) offered continued care placements in which accommodation was similar to the USA 'Assisted Living' model of care. However, residents were expected to be independent and require minimal levels of supervision, with those experiencing deteriorating health being relocated to establishments more able to support their healthcare needs (Chen et al., 2010).

Lemke and Moos (1989) noted distinctions in the residences themselves which may influence service provision, including the effect the service provider type had on the standard of the facilities on offer, with evidence on quality being varied. The variances in state, profit and not-for-profit owned establishments make it challenging to evaluate the services delivered by different suppliers (Lemke & Moos 1989).

2.4.3.2 Participant Demographics

Unsurprisingly veteran specific establishments were predominantly occupied by males (Chapko et al., 2009; Chen et al., 2010; Hedrick et al., 2007; Hedrick et al., 2009; Kenter, 1980; Kheirbek et al., 2018; Lemke & Moos, 1989) which may align with findings that the Armed Forces are male dominated (Gustavsen, 2013). In contrast, non-veteran specific establishments were found to have predominantly female occupancy (Lemke & Moos, 1989; Montross et al., 2006).

Chapko et al. (2009), and Hedrick et al. (2009) found residents engaged in the ALPP programme were predominantly male (95.2% vs 4.8%) with an average age of nearly 70 years (72 years of age - Hedrick et al., 2007) and low educational attainment (Hedrick et al., 2007). Lemke and Moos (1989) studied a total of 132 facilities with veteran establishments drawn from 36 USA States with predominantly male occupancy, whereas non-veteran facilities were predominantly home to females. Veteran residents were found to be typically younger than the wider non-veteran group evaluated. Whereas, opposingly, Montross et al. (2006) found that of 205 participants engaged in the study, over half were women (60%) almost all were white (96%) with an average age of 80 years. Kheirbek et al. (2018) analysed the historical medical data of all veterans (n=8) aged over 100 years of age who lived, and died, in the

Washington DC Veterans Health Medical centre between 2005 and 2015. All veterans studied had been involved in the Second World War and were mostly combatant males (n=6) with females (n=2) engaged in support roles.

Prior to joining the ALPP, the majority of participants lived alone (46.3%) and in their own accommodation (70.0%), however 13.5% were homeless and/or living in homeless shelters (Hedrick et al., 2009) (11.0% - Hedrick et al., 2007). Over half (57.0%) of participants had no care support in place before residing in an ALPP facility and required some form of assistance device to support their physical health (64.4%) (Chapko et al., 2009).

Divorced or single veteran numbers were almost double that of the non-veteran resident population studied ((23% -v- 5%-10%) and (26% -v- 15%) respectively), with 28% of veteran residents being married and the comparative number of widowed residents found to be less than in non-veteran facilities (Lemke & Moos, 1989). Further, Chen et al. (2010) found almost one-fifth of Taiwanese veterans living in residential care facilities to be single with limited or no relatives.

Irrespective of ownership type, Lemke and Moos (1989) found little difference in resident demographics, security, or opportunities to engage in various in-house or external social activities, which may be due to the similar residency size and the equal numbers of residency types included in the study. However, not-for-profit residents were more likely to be females from more advantaged backgrounds, which was found to be due to this demographic having sufficient funds to self-finance their choice of residence.

2.4.3.3 Barriers to engagement in service provision

2.4.3.3.1 ALPP

Of those service providers who declined to take part in the ALPP, almost all (97.6%) identified the lack of veteran numbers as a barrier to engaging (Guihan et al., 2009). Further, the provision of a secure establishment and the requirement for any professional healthcare intervention was found to be a barrier to admitting potential residents across all facility types within the programme (Hedrick et al., 2007).

2.4.3.3.2 MFH

Levy et al. (2013) found that only 10% of veterans offered MFH placement accepted, with approximately 50% of service providers securing placements for less than 10 veterans over a 12-month period. Barriers to veterans engaging in the MFH programme included lack of awareness of the programme and confusion over the terminology and purpose of the MFH with some believing the MFH was aimed towards the more traditional foster home for children, and some participants indicating that service providers were engaged in the programme primarily for financial gain.

Geographical location was found to have an impact on whether a MFH was a suitable option (Gilman et al., 2018; Levy et al., 2013), however one participant found the proximity of the MFH to their former Armed Forces unit was a positive outcome irrespective of the distance from their familial home (Levy et al., 2013). Some veterans were less concerned about distance than their relatives who considered a driving duration of around 30 minutes was agreeable (Gilman et al., 2018).

In addition to location Gilman et al. (2018) found a further three primary reasons for rejecting MFH placement, namely costs considered to be too high, inappropriate timing for the transition to MFH care and concerns that adequate support would be given to the veteran to ensure they were well looked after. Some veteran participants indicated a reluctance to live in a nursing home environment as a result of previous experience, however they were receptive to a MFH residence (Gilman et al., 2018).

2.4.3.3.3 Alternative Provision

Of the remaining papers, Leung (2010) identified a resistance by the ageing population of China to consider living in older persons residences, which he believed was as a result of cultural influences. However, priorities of those who did choose to live in a residential establishment preferred the accommodation to be close to their offspring, have good amenities and be in a nice location (Leung, 2010).

2.4.3.4 Outcomes

2.4.3.4.1 ALPP

All ALPP residents completed an adapted version of the Resident Assessment Instrument for Assisted Living within two-weeks of their arrival, repeated within one year of residency (Hedrick et al., 2009). All residents demonstrated the need for assistance in areas such as cooking, household chores, self-medication, and personal hygiene tasks (Hedrick et al., 2007). Results indicated a non-statistically significant improvement on ADL scores for residents in AFH's when compared against ALF's, however there was an overall improvement in ADL scores across all facility types, from 4.1 at initial assessment to 3.8 at follow-up, with the higher score indicating increased level of need (Hedrick et al., 2009).

Following the end of VA funding, almost a third (27.5%) of short-stay residents remained at the relevant facility, with 26.7% still in residence at the end of the 12-month engagement timeframe. Over half (59.7%) of all other resident types remained after VA funding ended, with 55.6% still in residence at the end of the 12-month engagement timeframe. Combining both categories, almost half (49.8%) remained in an ALPP facility at the end of the 12-month engagement timeframe (Chapko et al., 2009).

The ALF delivered the highest number of activities, with the RCF and AFH following second and third respectively (Guihan et al., 2009). Across all facility types several activities were more prevalent than others, namely *'games (80%), exercise (56%), excursions (44%), arts and crafts (35%), movies/television (31%), and music (30%)'* (Guihan et al., 2009 p.182).

Further, access to television, seen as an enhancement to quality of life, was generally available at RCF and AFH facilities, however ALF residents were likely to be asked to supply their own room fixtures (Guihan et al., 2009).

2.4.3.4.2 MFH

Six areas engendered a positive MFH model, namely caregiver engagement with the VHA team; treating the veteran as a family member; managing the veteran's healthcare needs; supporting an individual's 'end-of-life' journey; administering the

financial element of care provision directly with the veteran and arranging caregiver relief when necessary (Haverhals et al., 2016).

The involvement of the VHA was of importance to some participants (Gilman et al., 2018) with effective engagement between the veteran, care provider and the veterans' relatives resulting in the development of a strong connection and appropriate placement for the veteran (Levy et al., 2013).

Veterans who were engaged in the study indicated a preference to the MFH model of care rather than the support they had received in previous care establishments with several veterans indicating that the small-scale size of the MFH was preferable (Gilman et al., 2018). Further, a home-like setting in the correct residential area were deciding factors when considering the MFH as a preferred care option and were key elements of positive and effective resident and provider outcomes (Gilman et al., 2018; Levy et al., 2013)

The MFH model of care offered the veteran resident personalised care by providers who considered them as family members which resulted in positive outcomes for residents (Gilman et al., 2018; Haverhals et al., 2016) with care provider dedication found to be critical to positive outcomes (Levy et al., 2013).

Those delivering care gave precedence to making residents feel at home and enhancing life satisfaction which was found to be a deciding factor for potential residents when considering their preferred option of care (Gilman et al., 2018) and an essential element of resident satisfaction (Gilman et al., 2018; Levy et al., 2013). In addition, the ability for an individual to retain their identity and receive one-to-one care equal to that received in the family home contributed to resident satisfaction when living in a MFH (Gilman et al., 2018).

2.4.3.4.3 Alternative Provision

Healthcare goals and enhanced patient results were achieved by adopting a holistic approach to managing the care of veterans over 100 years of age. Engagement by healthcare professionals, family members and the individual themselves contributed to positive health and life satisfaction outcomes and a reduction in the impact of any

ailments through social interaction and assistance with mental health wellbeing (Kheirbek et al., 2018).

Further, all veterans took part in regular activities, including church attendance, off-site outings, academic engagement, and demonstrated a wish to be independent to maintain a good quality of life (Kheirbek et al., 2018).

A review of health records indicated that all participants were found to be independent as they entered their 9th decade of life, all were over 90 years of age at the time of their admission and demonstrated a deferral in the decline of physical performance and long-term health conditions (Kheirbek et al., 2018).

Montross et al. (2006) found participants attributed regular activities such as reading, listening to the radio, watching television, spending time with family members, having several good friends and an improved general health and quality of life to their self-reported successful ageing however it was not associated with how old an individual was, their gender, culture, marital, financial, or schooling status. Further, variation in residential demographics did not evidence any significant difference in an individual's potential to age positively (Montross et al., 2006).

Lemke and Moos (1989) found not-for-profit residential facilities can offer a broader affinity, or sense of belonging, to residents where a connection to the provider exists with both residents and staff believing not-for-profit providers championed resident autonomy and engagement in service delivery. Not-for-profit establishments were found to offer more in areas where provision is not governed by operational regulations, for example an enhanced living space (Lemke & Moos, 1989).

Irrespective of the connection military veterans may have with not-for-profit establishments, and the access to more amenities and tailored provision, Lemke and Moos (1989) found both state-funded and not-for-profit veteran specific establishments were found to lack a sense of belonging or community ethos with both adopting a more regimented environment. However, it was noted veterans may be more amenable to living in a veteran specific residential setting as there may be a perception that this is seen as an extension to military life rather than dependency on support from external sources (Lemke & Moos, 1989).

The ability for ageing veterans to care for themselves was dictated by their physical health and conditions affecting mental capacity rather than age with a decline in health impacting on the ability to live independently (Wu, 2002).

Resident engagement in a home-like setting, receiving more one-to-one support and the ability to engage with their own social and familial network was found to increase the length of residence, with the positive impact of residential placement being observed by the caregiver and care professionals (Kenter, 1980). However, Kenter (1980), referenced a report (no date) that found those who resided in larger establishments were more likely to remain there for longer with 70% of those who returned to a clinical setting within 1 year doing so from a smaller residence.

2.4.3.5 Summary – Empirical Studies

2.4.3.5.1 ALPP

ALPP provision was dominated by commercial organisations with little difference identified in the key elements of provision or outcomes irrespective of the residency type or capacity, however residents with the highest level of need were supported in smaller establishments by the least qualified workforce.

ALPP occupancy was predominantly male, seventy years old and less educated with many individuals lacking care packages before joining the programme. Further, approximately half (46.3%) lived alone and over one tenth (13.5%) were found to have no fixed address prior to engaging in the ALPP.

Limited availability of veterans was cited by almost all potential providers as a reason not to engage in the ALPP. Conversely, some potential providers were considered unsuitable as they were unable to provide sufficient security, or care for ALPP residents.

Following the conclusion of the ALPP almost half of veterans made the decision to continue with their residency.

2.4.3.5.2 MFH

The MFH facilitates flexibility by enabling the host to deliver support and care whilst managing their own personal obligations. The holistic approach of provider, HBPC team, veteran, and their family all contribute towards positive resident and provider outcomes, however, veterans were found to be wary of a potential lack of support, and the motive towards monetary reward being a concern.

Potential veterans and providers lacked knowledge and understanding of the MFH programme which contributed to a low engagement rate. In addition, prohibitive prices, the locations of the MFH residences and veterans not being ready for this level of care were contributing factors towards the non-engagement of veterans.

A veteran 'foster home' programme in the USA has been in existence since 1951 (Lemke & Moos, 1989) and may have been a pre-cursor to the current MFH model of care however there is a lack of evidence to support this assumption.

2.4.3.5.3 Alternative Provision

The remaining studies found minimal variance in the care delivered across organisations delivering services however it was noted that due to a lack of provider competition, state financed residences potentially delivered a reduced standard of service provision. Individual residences were found to influence the standard of the facilities available however the challenge when comparing service provider types was acknowledged.

Non-veteran establishments were primarily occupied by white females with not-for-profit establishments occupied by females considered to be from more advantaged backgrounds. However veteran residents were younger and almost twice as likely to be divorced than non-veteran residents with almost one-fifth of Taiwanese veterans being single with little or no family.

Non-commercial establishments engendered a 'sense of belonging', promoted independence and invited contribution towards the way the service was delivered, however veteran specific establishments were found to lack this 'sense of belonging' or shared culture and adopted a regimented approach which may be seen as a reflection of their military service. Further, non-commercial establishments were found

to have the flexibility to provide a better living experience by offering improved furnishings.

Engagement in social events was found to contribute to an individual's perception of successful ageing, better life quality and generalised healthiness. An individual's capacity to be independent was found to be governed by their physical and psychological capability as opposed to how old they were.

Residents' demographics did not impact on an individuals' perception of how well they were ageing however the duration of residence was influenced by the environment, alongside a resident's ability to involve family members in their lives and the level of care received, with those residing in larger establishments more likely to maintain a lengthier residency.

Data was collected across several studies to indicate, for example, levels of resident need, engagement in activities, length of stay within residences and resident demographics, however this data was not used to evidence the direct impact living within the residence has on an individual's health and social care outcomes.

2.4.4 Grey Information Results

Ten countries confirmed residential care provision for veterans over 65 years of age via direct email or online communication methods. Of these, additional grey information was identified in seven countries. The results are presented under the separate headings of UK Provision, Rest of the World Provision and Outcomes to mirror empirical results.

2.4.4.1 UK Provision

The review identified 11 service providers offering 25 veteran residential establishments across England and Scotland with all provision in Scotland being delivered by one provider (Table 7). The review did not identify any veteran-specific provision in Wales or Northern Ireland.

Table 7. Summary of UK Provision

Grey Information: Summary of UK Provision					
Service Provider	**Number of Residential Care Properties**	**Location**	**Accommodation Type**	**Authority Registered[(1)]**	**Over 65 yrs. Only**
Blind Veterans UK	n=1	England	Care Home	Yes	No
Broughton House	n=1	England	Care Home	Yes	Yes
Defence Business Services, Veterans UK	n=1	England	Residential Care Home	Yes	Yes
Erskine Hospital	n=4	Scotland	Care Home	Yes	No
Royal British Legion	n=6	England	Care Home	Yes	n/s
Royal British Legion Industries (RBLI)	n=3	England	Care Home	Yes	No
Royal Hospital Chelsea	n=1	England	Sheltered Housing & Care Home	Yes[(2)]	Yes
The Royal Alfred Seafarers Society	n=2	England	Sheltered Housing & Care Home	Yes[(2)]	n/s
The Royal Cambridge Home	n=1	England	Care Home	Yes	Yes
Royal Naval Benevolent Trust	n=2	England	Care Home	Yes	Yes
Royal Star and Garter	n=3	England	Nursing Home	Yes	No

[(1)] Care Quality Commission (CQC) (England); Care Inspectorate (Scotland)
[(2)] Care Home provision only

Several providers offered multiple care packages within their residence (Appendix J). All UK residential care establishments are required to register with the relevant regulatory body, namely the CQC (England) (CQC, 2023) and Care Inspectorate (Scotland) (2022).

Except for the Defence Business Services, Veterans UK, all care providers hold charitable status and are registered with the Charities Commission (England) (2022) or OSCR Scottish Charities Regulator (2022) and indicate that funding of residential care is met either by self-funding or State/Local Authority contribution subject to an individual's financial status.

The residency population group varied across service providers with three offering a veteran only residential setting. Other providers extended the residential care offer to members of the veteran's family including spouse, widow, partner and/or dependents. Only the Royal Cambridge Home had a mixed non-veteran population, having been originally established in 1851 to provide a home for the widows of soldiers (2021).

Royal Hospital Chelsea had the largest resident capacity with 300 beds providing accommodation specifically for British Army veterans. The Royal Naval Benevolent Trust supports Royal Navy and Royal Marine veterans, their wives, and widows. The Royal Alfred Seafarers Society accommodates individuals with a specific seafaring history with the Defence Business Services, Veterans UK, residence providing accommodation for veterans, their spouse, widow, or partner of the Polish Armed Forces who fought during World War II. The remaining service providers offer accommodation to all British Armed Forces veterans, and wider population groups where indicated, irrespective of which service they served in (Appendix K).

2.4.4.2 Rest of the World Provision

Of the remaining nine countries found to offer residential care for ageing veterans, the majority of provision was identified in Australia, Canada, Poland and the USA (Table 8). An overview of residence characteristics can be found at (Appendix K).

Table 8. Grey Information Summary of Rest of the World Provision

Grey Information: Summary of Rest of the World Provision				
Country of Residence	**Service Provider**	**Number of Residential Care Properties**	**Accommodation Type**	**Over 65 yrs. Only**
Australia	Private Service Providers	n=32	Residential Care Home	n/s
Canada	State and Private Providers	n=17	Long-term Care Home	n/s
Czech Republic	Ministry of Defence of the Czech Republic	n=2	Residential Care Home	n/s
France	State and Private Providers	n=3	Residential Care Home	No
Jordan	State Provider	n/s	Residential (Nursing) Care	Yes
Poland	State Provider	n=23	Residential Care Home	Yes
the Netherlands	Dutch Ministry of Defence	n=1	Residential Care Home	Yes
New Zealand	Private and Charity Providers	n=5	Rest Home Care & Residential Care Home(s) with Nursing Care	No
USA	US Veterans Affairs	multiple	State Veterans Home	n/s
	US Veterans Affairs	multiple	Assisted Living	No
	Private Service Providers	multiple	Adult Foster Home	No
	State and Private Providers	multiple	Medical Foster Home	No
	US Veterans Affairs	multiple	Community Living Center	n/s
	Private Service Providers	multiple	Community Nursing Home	n/s
	Private Service Providers	multiple	Community Residential Care	n/s

The USA was identified as offering the greatest state managed care provision with seven models of care accessible to eligible military veterans irrespective of their age. A total of 32 residential facilities were identified in Australia delivered by four service providers. Veteran only residences were identified in seven countries, namely Canada, the Czech Republic, France, Jordan, the Netherlands, Poland, and the USA. Australia offered one veteran specific establishment however this is excluded from the review as it offered residential village accommodation for those able to live independently (Appendix K).

Most residences were accessible to a mixed population of veteran and non-veteran, however Canada and New Zealand offered residences that accepted

wives/spouse/partner(s), with one residence in the USA indicating that they accepted dependents (Appendix K).

With the exception of the USA, most residential facilities identified were either care homes or care homes with a nursing care option available where required. The seven care-models in the USA are managed by the US VHA. It is not within the scope of this review to cover all USA care provision in detail however an overview can be found in (Appendix K).

Funding options for eligible veterans across all countries was identified as a mix of state funding, or a combination of personal contribution and state funding (Appendix K).

Provision specifically for veterans aged 65 years and older was identified in Canada, Jordan, Poland and the Netherlands. Poland offers 23 residential care homes for veterans over the age of 65 years specifically for those who fought for the independence of Poland 1914-1956. France and the USA specified provision for veterans under 65 years of age with the remaining countries not indicating age eligibility criterion.

Most of the service provision in Australia was delivered by for-profit organisations (n=25) with Australia, Canada, France and New Zealand indicating some service provision delivered by not-for-profit organisations (n=13). Of the USA models of care, State Veterans Homes and the Assisted Living Facility were state funded, with the Adult Foster Home and Medical Foster Home models of care delivered by for-profit providers. The review was unable to identify the organisation types for all models of care in the USA due to the multiple care delivery options across the country (Appendix K).

Facility sizes varied across all countries. Some 3924 beds were available across 32 facilities in Australia indicating the largest bed capacity of all countries identified, however given the nationwide care delivery in Canada and the USA these countries may exceed this capacity. Individual establishment capacity ranged from a maximum of three veterans in the Medical Foster Home (USA) to 450 at the Perley & Rideu Veterans Health Centre in Ontario, Canada (not shown).

2.4.4.3 Outcomes

The review of grey information did not identify any outcomes evidence. Seven care provider reports were examined for evidence however these generally focussed on the support or care delivered by the service provider rather than the actual impact this provision has on its residents. One report included data on a client survey however this referenced a programme supporting the wider community and not their residential establishments (Presbyterian Support Central, 2020).

2.4.4.4 Summary – Grey Information

Veteran-specific options were found in 10 countries, with four of these indicating provision for eligible members of the veteran's family. Most of the provision available was found to accommodate a mix of veterans and the general population, however many residences did not specify a minimum age criterion.

The UK offers provision in two of its four nations, namely England and Scotland, and has the largest military charity led provision globally. All UK providers are registered charities except for one residence which is operated by a government agency. Further, all providers are registered with an appropriate authority to oversee the quality of care delivered.

Providers are a blend of government funded, commercial and not-for-profit organisations, with the USA identified as providing the most government agency led options with a total of seven residential choices to veterans who meet the necessary criteria.

Most of the provision is in the form of care homes with some including access to higher levels of nursing care if necessary. Australia indicates the largest volume of provision however capacity in Canada and the USA may be greater due to the dispersal of the veteran population and the number of veteran specific models of care available in the USA.

Residential care across all countries is financed in several ways including self-pay, self-pay with financial contribution from the state. Full government funded residential care was identified in Jordan, Poland, the Netherlands, and the USA. All financial contributions from the state are subject to an individual's eligibility.

There was an absence of evidence on an individual's health and social care outcomes within the grey information findings.

2.5 Summary

This systematic narrative review sought to identify global residential options for veterans over 65 years of age, identify their characteristics and evidence the impact living in this environment has on an individual's health and social care outcomes.

Considering the global growth of the ageing population (WHO, 2021; Fan et al., 2019), it was anticipated the review would have delivered greater results.

This review suggested that the USA offers the greatest options of state supported residential care for eligible veterans with seven programmes accessible across the USA (US VA, 2021), and indicated that most of the evidence in this field is specific to the USA.

Multiple programmes are offered, each with their own service provision, barriers, and outcomes. Despite this, the demographics of individuals within veteran-specific residential care is similar across services. Veterans were found more likely to be single or divorced and younger (Chen et al., 2010; Lemke & Moos, 1989), have lower educational standards (Hedrick et al., 2007) with fewer relatives than the non-veteran populations studied (Chen et al., 2010). However, levels of independence, or dependence, varied across the studies with resident needs found to be commensurate with the ageing veteran population living in similar establishments (Hedrick et al., 2009).

It was not within the scope of the review to explore funding options in detail, however in brief, the review found residential options for veterans are delivered by State, for-profit and not-for-profit organisations with the majority being for-profit. There appears to be little impact on the care delivered irrespective of service provider type, however there are complexities when evaluating services across different service provider categories (Lemke & Moos, 1989).

Despite the advantages of these residential programmes, there were barriers. A lack of veteran numbers for both programmes being an issue (Guihan et al., 2009; Levy et al., 2013) as well as residential location (Gilman et al., 2018; Levy et al., 2013).

Potential ALPP service providers were considered unsuitable if they were unable to provide secure establishments alongside the delivery of professional healthcare required to meet the programme criteria (Hedrick et al., 2007). Although potential residents were concerned that the level of care available within an MFH may be inadequate (Gilman et al., 2018), Pracht et al. (2016) found that residing in an MFH may be a protective factor with the holistic approach to care provision resulting in the improved the quality of care received and a reduction in resident admissions to hospital. Thirteen empirical studies included health and/or social care indicators within their evidence, however there was a paucity of evidence relating to the impact of health and social care outcomes on ageing veterans as a result of living in a residential establishment. Nevertheless, the review did identify some outcomes that are worthy of note.

A holistic approach between care provider and resident was found to result in positive outcomes for residents (Gilman et al., 2018; Haverhals et al., 2016; Kenter, 1980; Kheirbek et al., 2018; Levy et al., 2013). Not-for-profit providers were found to offer enhanced surroundings and engender a sense of belonging (Gilman et al., 2018; Lemke & Moos, 1989) however some not-for-profit veteran specific establishments indicated a lack of sense of belonging (Lemke & Moos, 1989).

Interestingly, despite the time lapse in studies between Kenter (1980), and both Levy et al. (2013) and Gilman et al. (2018), all found a homely environment and receiving one-to-one support resulted in positive resident outcomes for those living in a foster home setting.

Nearly half of residents engaged in the ALPP made the decision to remain in their chosen facility at the end of the pilot, which the study authors believe may indicate a level of resident satisfaction and programme success (Chapko et al., 2009).

Grey information results did not provide any evidence on health and social care outcomes, however all establishments identified via internet searches detailed the facilities and activities available which the author suggests may be a promotion tool to attract prospective residents rather than an indicator of health and social care impact. Access to resident satisfaction surveys may have contributed to the findings however these were unavailable. The author suggests that these findings contribute towards the review question by highlighting this absence.

2.6 Strengths and Limitations

2.6.1 Retrieved Evidence

All empirical studies were peer-reviewed, however the study types varied with five qualitative descriptive pieces, one report and one article (Appendix E). Half of the included studies related to two USA residential models, namely the ALPP (n=4) and the MFH (n=3). The ALPP studies used the same population sample data with each study reporting on separate topics. All seven studies met the inclusion criteria and were therefore included. This may result in potential reporting bias as just two residential options were reviewed however, due to the paucity of available evidence, the inclusion of these studies was not at the expense of other eligible studies.

Where indicated, veteran-specific studies had predominantly male participants (Chapko et al., 2009; Chen et al., 2010; Guihan et al., 2009; Hedrick et al., 2007; Hedrick et al., 2009; Kheirbek et al., 2018; Wu, 2002) which may present a data bias. However, it could be argued, as military Armed Forces are traditionally male dominated (Gustavsen, 2013) this limitation is unlikely to impact on overall findings or in answering the review question. Four studies reported on mixed population groups therefore findings from this review may be relatable to non-military residential care however caution should be applied if doing so as the variance in levels of provision, ownership type, establishment size, geographical location and funding may make it difficult to draw generalised comparisons.

The residential search terms, as outlined in Table 3, may not have international transferability, which may be a limitation of the review, however as all papers identified in the review were non-UK, it is suggested that this limitation had minimal impact on the search results.

This review included empirical evidence and grey literature data from across the globe. Due to the geographical demographics of the USA and Canada, it was not within the scope of the review to explore all options in detail, therefore a summary of evidence is included. It is acknowledged that provision will be available that is not identified within this review.

2.6.2 Review Process

A comprehensive search strategy was carried out (Table 3). The search strategies for both empirical and grey information evidence were transparent and systematic. If repeated empirically, the search strategies applied would elicit the same results, however it is recognised that the fluid nature of obtaining grey information may present challenges in replicating the same results (Adams et al., 2016; Benzies et al., 2006) and may result in the emergence of new data not captured within this review.

The review was strengthened by the search strategy which included non-English language papers and grey information search results. There were no empirical non-English language papers identified and grey information data when translated was not relevant to the review and therefore excluded. However, the inclusion of grey information data identified provision in countries where empirical research appears to be absent, namely the Czech Republic, Jordan and Poland

Whilst grey information data is subject to updates and failed to identify any outcome measures, the results of the grey information search contributed towards answering the review question and were therefore considered appropriate to include.

The inclusion of this evidence provided an overview of real-time residential provision, correct at the time of publishing, to inform the review. Further, grey information data evidenced in the review was obtained from trusted sources including service provider websites and defence organisations.

As discussed earlier, 10% of the empirical studies were independently selected and assessed by the authors academic supervisor. This quality check looked to add rigour to the selection process and limit potential researcher bias. Further, adhering to the search strategy and screening selection tool minimised any bias across both search strategies.

Finally, the age of some studies (i.e., Kenter, 1980; Lemke & Moos, 1989) may be considered a limitation of the review however the paucity of available evidence supported the decision to include these studies.

2.7 Conclusion

The ability to age ‘well’ depends on a number of factors including an individual’s health, engaging in measures to support healthy lifestyle choices, physical and mental activity levels, and social engagement. An important contributor towards ageing ‘well’ is the opportunity to age ‘in place’, or put simply, grow older in an environment an individual considers to be ‘home’.

The systematic narrative review had two main aims, namely, to examine residential care provision for military veterans over 65 years of age living in a non-hospitalised setting, and to identify evidence on the impact these settings had on the health and social care outcomes of residents.

Review findings identified a gap in evidenced-based, and grey information data, knowledge on the impact residing in such establishments has on an individual's health and social care outcomes. Broadly speaking data is available on quality of life, opportunities to, and availability of, facilities and engagement levels however there is minimal evidence on what impact this engagement has on an individual’s life satisfaction.

Of the evidence that was identified, the holistic approach of the MFH, and living in a homely environment was found to contribute towards resident satisfaction. Additionally, engagement in social events contributes towards an individual’s perception of successful ageing, however the ability to engage in activities is dictated by physical and mental capabilities rather than age.

Empirical findings were dominated by the ALPP trial residential programme and the MFH model of care, both located in the USA. The search strategy did not evidence similar models of care in any other country however these residential options are worthy of further investigation to explore the viability of implementation in other countries. Grey information identified veteran-specific residential options in several countries, indicating the presence of accommodation tailored towards veterans however there was an absence of any outcomes evidence to enable individuals to make an informed decision on these options.

It is reasonable to assume that there are military veterans living in non-veteran specific residences worldwide. Unless a declaration of veteran status is a requirement of the

admission process it is possible that the veteran population will remain hidden. Identifying veterans may present an opportunity to inform individuals on veteran-specific residences, which may be more appropriate for their needs, although it is recognised that some veterans may prefer to withhold their veteran status.

Research exploring the health and social care impact on ageing military veterans who live in non-hospitalised veteran-specific residential establishments, and any correlation between this impact and their shared military experiences, may identify best practice and potential areas of service development and enable the comparison of resident outcomes with similar establishments which may inform health and social care policy for veterans, other unique employment groups and the wider ageing population who reside in similar establishments.

The lack of available evidence of the impact on health and social care outcomes as a result of living in a veteran-specific establishment support the wider project aims of exploring these areas at the Royal Hospital Chelsea.

2.8 Chapter Summary

The theories of ageing ‘well’, and ageing in [the right] place, are outlined with each considered relevant to this project as both theories have the potential to influence an individuals’ life experience. This chapter also presented the aims, method, and findings of a Systematic Narrative Review. This review explored accommodation options for military veterans, over 65 years of age, living in a non-hospitalised residential setting. The review findings indicate a gap in outcomes evidence for older veterans living in residential establishments.

CHAPTER THREE

METHODOLOGICAL CONSIDERATIONS

3.1 Overview

This chapter will outline and explore the study's philosophical roots, including the research paradigm, Pragmatism, and the research design. It will also describe the processes implemented to demonstrate rigor and will consider researcher reflections as part of methodological reflections.

3.2 Philosophical Roots

3.2.1 Ontology and Epistemology

Two key philosophical assumptions for any research concern ontology and epistemology (Ladyman, 2012). Ontology is described as relating to "*the nature of reality and what there is to know about the world*" (Ritchie et al., 2013, p.4), or "*the study of being*" (Crotty, 1998, p.10). Two primary ontological stances within social sciences research are that there is an exterior reality that is detached from our own views of the subject (*"realism"*), and an opposing stance that there is no exterior reality (*"idealism"*) (Ritchie et al., 2013, p.5).

Epistemology concerns the way in which we know and develop knowledge of a subject, or *"how we gain knowledge of what we know"* and the association between the researcher and the subject being researched (Creswell & Clark, 2017, p.37), with the way in which we explore this knowledge, being dependent on which philosophical stance we approach the phenomenon as each has its own positioning (Guba & Lincoln, 1994). Mixing quantitative and qualitative research methods poses philosophical challenges due to differing epistemological stances (Shan, 2022), with the former holding traditionally Postpositivist and the latter traditionally Constructivist worldviews (Bishop, 2015).

Creswell and Clark (2017) refer to four philosophical positionings they consider suitable for mixed methods research, namely: Postpositivist, Constructivist, Transformative, and Pragmatist, with each having distinct approaches that are often

considered incompatible. Pragmatism is considered the most commonly used approach in mixed methods research, although it is not exclusive to this paradigm, nor is it the only one used in this approach to answering phenomena (Hall, 2013). Pragmatists recognise and acknowledge these positionings however they are not seen as barriers to taking an alternative approach to research and *"advocate a shared aim for all research – to produce positive change in the world"* (Bishop, 2015, p.7). Pragmatism contradicts the postpositivist and constructivist positionings on ontology and epistemology believing that the understanding of reality and truth are achieved through experience of the world (Rorty, 1999) and as such reject metaphysical concepts of truth and reality. Further, Rorty (1999, p.xxv) argues that *"Pragmatists cannot make sense of the idea that we should pursue truth for its own sake"* but rather *"the purpose of inquiry is to achieve agreement among human beings about what to do […] to make life better"*. This project uses Pragmatism due to its fit with mixed methods research, and 'real world' applied research.

Pragmatism supports the use of both qualitative and quantitative research approaches and arguably addresses the challenges of using multiple philosophical positionings to answer phenomena by facilitating the flexibility required when applying mixed methods research (Hall, 2013). However, Shan (2022) argues that Pragmatism has a weak philosophical positioning as it simply demonstrates that the Pragmatist approach is well-suited to mixed methods research however it does not offer direction or instruction on how best to apply its positioning to address the phenomena in question.

In addition to ontology and epistemology, a further philosophical consideration is axiology, or research values. In this regard, postpositivism adopts neutrality, constructivism assumes subjectivity and Pragmatism applies both positions when considering values, which include ethics and researcher reflexivity (Creswell & Clark, 2017). However, debate exists in relation to how Pragmatists demonstrate values within mixed methods research with some believing adopting the 'what works' approach to Pragmatism enables the exclusion of axiological considerations (Biddle & Schafft, 2015).

It is suggested that the transformative philosophical position on axiology, that of *"honoring the life experience of participants"* (Biddle & Schafft, 2015, p.329), may offer Pragmatists a remedy to the void said to exist in its positioning on axiology (Biddle &

Schafft, 2015). Notwithstanding that the transformative positioning is primarily engaged in human rights and social justice research, this project observes the importance the transformative positioning places on participant opinion and adopts this as a Pragmatist axiology.

3.2.2 Pragmatism

Pragmaticus and Pragmatikos are the Latin and Greek words for Pragmatism respectively and defined as *"a pragmatic attitude or procedure"* (Ormerod, 2006, p.894). It is the work of Charles Saunders Peirce that links Pragmatism to the principle of philosophy, believing that Pragmatism concerns the interpretation of ideas, views or beliefs linked to first-hand human experiences and their perceptible origins (Ormerod, 2006).

Creswell and Clark (2017) reference the five factors Tashakkori and Teddlie (2003a) consider important when combining Pragmatism with mixed method enquiry:

1. *Both quantitative and qualitative research methods may be used in a single study*
2. *The research question should be of primary importance – more important than either the method or philosophical worldview that underlies the method*
3. *The forced-choice dichotomy between Postpositivism and Constructivism should be abandoned*
4. *The use of metaphysical concepts, such as truth and reality, should also be abandoned*
5. *A practical and applied research philosophy should guide methodological choices*

These factors will be discussed further to demonstrate the justification for selecting Pragmatism as the mixed-methods paradigm for this project.

Quantitative and qualitative measures are considered tools with which to facilitate empirical enquiry in combination, rather than used as separate entities (Ritchie et al., 2013). It was important to have the flexibility to use more than one method of data collection for this project as not all participant groups were engaged in all data collection methods.

Pragmatism in mixed methods research enables the selection of the most effective method by which to answer a research question which has greater importance than the requirement to affiliate with one specific world view (Ritchie et al., 2013). For this project, the selection of a singular philosophical positioning, would have resulted in the revision of the project aims, as each was engaged in one or both data collection methods. Therefore, the research question had greater weighting than the predetermined selection of a specific worldview.

The engagement of three participant groups and mixed methods data collection made a Pragmatist approach the most appropriate philosophical positioning to address the phenomenon. Some argue that adopting a Pragmatist approach to research misinterprets flexibility with some using the approach to satisfy funders and others adopting an 'anything goes' approach thus ignoring any paradigmatical positioning (Hall, 2013), however Ritchie et al. (2013) counter this with a belief that adopting a Pragmatic approach requires those undertaking the research to be vigilant and aware of the steps taken when conducting their research.

3.2.3 Research Paradigm

It can be argued that quantitative research, in isolation, fails to capture the depth of the participant 'voice' with results unable to articulate the context, or circumstances, in which the quantitative data is collected (Creswell & Clark, 2017) and that qualitative research alone is unable to produce 'generalised' or statistically significant data (Ritchie et al., 2013) due to an absence of quantitative data collection measures, statistical analysis strategies, and smaller participant numbers. The mixed methods approach brings both disciplines together and offers the researcher the opportunity to use multiple data collection tools, including philosophical positionings, or worldviews, alongside the opportunity to utilise both inductive ('bottom up') and deductive ('top down') skills enabling researchers to move across all datasets to interpret findings in the most effective way to answer research questions (Creswell & Clark, 2017).

The opportunity to collect and analyse both quantitative and qualitive data to answer the same phenomenon in the form of mixed methods research seeks to address methodological challenges of qualitative or quantitative research when used alone

producing new knowledge through triangulation (Creswell & Clark, 2017). In other words, as cited by Creswell and Clark, (2017, p.13) *"as Fetters and Freshwater (2015) suggested, mixed methods provides the research equivalent of the equation 1+1=3*", creating an additional dimension to the data captured and subsequently analysed.

Mixed methods research can be considered more challenging than a single research approach (Creswell & Clark, 2017), for example, the researcher's skills and experience of using quantitative and qualitative methods within one project being an important factor, combined with the ability to complete the research within project deadlines as arguably more data is collected and therefore requires more time to analyse and interpret than using single research methods (Creswell & Clark, 2017). However, there is acknowledgement that contributions from multiple analytical approaches have a place in answering complex, applied research questions (Creswell & Clark, 2017).

A mixed methods approach was adopted for this project as it was critical to integrate qualitative and quantitative methods to answer the project aims. As discussed earlier (see 1.5), this research project sought to address research aims developed in collaboration with the Royal Hospital Chelsea that directly relate to their resident population, therefore these specifications were key considerations when assessing the most effective research methodology to adopt. The combination of mixed methods, and Pragmatism facilitates the collection and interpretation of 'real world' data using more than one data collection source and appropriate philosophical positioning to answer the research aims using the most effective methods (Pelto, 2015). Qualitative data collection, which in the context of this project comprised of semi-structured interviews, facilitates the capture of information broader than that which is possible using quantitative measures alone as it gives participants the flexibility to reveal data outside of the scope of targeted quantitative data collection, adding to the wider knowledge base to inform the research aims. Therefore, both methods of data collection were considered important for this project.

Thematic Analysis, more specifically, Reflexive Thematic Analysis (Braun & Clarke, 2022a), was the most appropriate qualitative methodology for this project, as applying a pragmatic positioning, and a subjective approach, to the data were important considerations. The term 'thematic analysis' is a broad phrase for analytical processes that identify relationships within data (Braun & Clarke, 2021). However, within this

generalised terminology there are several approaches, which Braun and Clarke (2021; 2022b) summarise as ‘coding reliability’, ‘codebook’, and ‘reflexive’, with each having different methodological approaches. Reflexive Thematic Analysis differs from the aforementioned approaches in that the development of themes occurs following researcher immersion in the data, rather than via a more pre-determined coding method (Braun & Clarke, 2021). Furthermore, researcher subjectivity is key when exploring and adding meaning to the data, rather than being disadvantageous to the process (Braun & Clarke, 2021; 2022b).

As discussed earlier, inductive, or deductive, analysis is used to identify patterns in data that lead to the development of themes (Braun & Clarke, 2006). Inductive analysis focuses on the data itself, allowing themes to develop out of the data, in contrast to using the data to fit within a pre-determined coding framework, or by using a theoretical (deductive) approach to analyse the data (Braun & Clarke, 2006). A further consideration in thematic analysis is whether themes are identified semantically or latently, with the former identifying the ‘surface meaning’ of the data, and the latter analysing at a deeper level to explore what lies beneath the ‘surface meaning’ of the data presented (Braun & Clarke, 2006; 2022a).

Reflexive Thematic Analysis affords the researcher theoretical ‘freedom’ in-so-far as the research methodology is not committed to one specific theory (Braun & Clarke, 2021). However, throughout the reflexive analytical process the researcher is required to demonstrate awareness of philosophical positioning and theoretical assumptions, and ensure that these are *“consistently, coherently, and transparently enacted throughout the analytic process and reporting of the research”* (Braun & Clarke, 2019, p.594). The researcher is required to systematically reflect on their decision-making processes and beliefs, which includes their own personal positioning, by recognising and accepting the influence personal beliefs and standpoints have on their research. A reflexive journal was maintained throughout the project to provide a tool to support researcher reflection and demonstrate transparency. Researcher awareness of subjectivity was acknowledged throughout the project with thoughts and processes discussed in more detail within the reflexive summary (see 6.8).

Quantitative data facilitates the capture and measurement of specific wellbeing constructs relating to participant perceptions of their quality-of-life experiences via

targeted questions, the results of which may be used comparatively against population groups in similar establishments or against individual participants themselves in the form of repeating the questionnaire process at different intervals to compare responses, thus establishing a database of wellbeing evidence.

A non-experimental survey design was used for quantitative data collection. As Kerlinger (1986, as cited in Johnson, 2001, p.3) noted, *"most social scientific and educational research problems do not lend themselves to experimentation, although many of them do lend themselves to controlled inquiry of the nonexperimental kind".* A non-experimental survey design facilitates the collection of data from a specific, or pre-determined, group of individuals (Coughlan et al., 2009), where data may be collected from participants through the completion of questionnaires or engagement in controlled interviews, where questions are fixed (Johnson, 2001). However, a limitation of these data collection methods can be low response rates to questionnaires, and lack of researcher clarity on the questions asked in controlled interviews, which may result in challenges when generalising the findings (Johnson, 2001). The project explored one variable, namely the quality-of-life of In-Pensioner residents, therefore a non-experimental survey design was an appropriate methodology to use.

Two approaches to quantitative data collection within a non-experimental survey design are longitudinal and cross-sectional research. Longitudinal research enables information to be obtained from the same participant group across multiple data collection periods, whereas cross-sectional research supports data collection within a single timeframe (Johnson, 2001). Both data collection methods were important considerations for this project as the data collection criteria across the participant groups varied. A further consideration is the instruments used to collect data. Developing a bespoke survey to answer the research phenomenon can be both costly, and time, prohibitive (Coughlan et al., 2009). The use of extant quantitative data collection tools can ensure validity and reliability of the information collected and mitigate the risk of ambiguity or erroneous questions that fail to address the research question (Coughlan et al., 2009). This project used longitudinal research for In-Pensioners who were new to the Royal Hospital Chelsea, with data collected across two timeframes. Cross-sectional research was used for In-Pensioners who were already established at the Royal Hospital Chelsea, with data collected at a single point

in time. Therefore, the single variable and multiple data collection methods of the non-experimental survey design were considered the most suitable approach for this project.

Often when using mixed methods research, one data collection method typically has a greater significance over the other, with precedence determined by the research aims, the process by which the multiple data results are analysed, and the priority each dataset holds within the overall research aims (Östlund et al., 2011). For this project, qualitative data assumed this position as the semi-structured interviews contributed more data than quantitative data which had a relatively small sample size as, in line with the project aims, Key Staff were not included in the quantitative data collection and New In-Pensioners were not included in the qualitative data collection.

Mixed methods was preferred over multiple methods as it was considered important to integrate (triangulate) the qualitative and quantitative findings to address the project aims, rather than the contrasting multiple methods approach where each element of data collection has its own research question, and are therefore considered as separate entities, with data that are amassed rather than synthesised, in the way mixed methods data are integrated and considered holistically (Morse & Cheek, 2014).

From its inception this project intended to use mixed methods to address the phenomena and was therefore a *"fixed mixed methods design"* (Creswell & Clark, 2017, p.52). The use of quantitative data supported the interpretation of the qualitative findings whilst also contributing data that is comparable to similar population groups as the data collection used empirically recognised quality of life measures (Appendix L). Further, qualitative data collection in the form of semi-structured interviews enabled the capture of the lived experiences of In-Pensioners and Key Staff. As a result of these requirements a mixed methods design was adopted to answer the project aims.

3.3 Research Design

This project followed a non-traditional Convergent design, to explore the research phenomenon, which enabled the simultaneous collection, and independent analysis, of qualitative and quantitative data within one phase (Creswell & Clark, 2017; Egilsdottir et al., 2022, Fetters et al., 2013). In contrast to collecting data sequentially,

the opportunity to collect data simultaneously and analyse it separately, using the convergent design, facilitated the efficient use of time (Creswell & Clark, 2017), which was a key consideration due to the limited timeframe of the project.

A non-traditional convergent mixed methods approach was used for this project as, following the independent analysis of the qualitative and quantitative data, the results were not integrated ahead of triangulating the findings. In further divergence from a typical convergent design, the qualitative and quantitative data did not hold equal positioning. Qualitative data held primacy to address the project aims as it was intended to capture in-depth evidence of the overall experience of In-Pensioner life at the Royal Hospital. In this project, qualitative data was more dominant than quantitative data for several reasons. Firstly, as captured in the literature review, this is the first piece of research to be conducted with the Royal Hospital Chelsea to evidence its model of care, therefore it was felt that an explorative, broad qualitative approach should be dominant within the research design. Secondly, the participant sample was small and contextually unique. It was not the intention of the project to generalise findings from this cohort across other cohorts, and therefore qualitative data took dominance. However, quantitative data was still important.

Quantitative data, in the form of quality-of-life questionnaires, provided evidence of In-Pensioner and New In-Pensioner thoughts and feelings covering a short time span and whilst this is undeniably valuable data, the inclusion of qualitative data provided greater depth to the findings. The decision to use recognised extant quality-of-life measures saved time, which was important as discussed. Furthermore, it was deemed appropriate to select existing and recognised measures to meet the project aim of demonstrating transferrable evidence from the quantitative findings, which it is argued, also contributed towards the validity and rigor of the data.

Quantitative findings from the New In-Pensioner cohort served two purposes, namely, to contribute towards the broader project findings but moreover to specifically establish an evidence baseline of quality-of-life data from which the Royal Hospital could build upon. This baseline evidence was not relevant to established In-Pensioners due to their length of residence however obtaining quality-of-life information from this cohort was considered beneficial to the overall representation of the In-Pensioner experience of life at the Royal Hospital, therefore the collection of this data was justified.

Qualitative methods were dominant throughout this project in that they were used with both In-Pensioners and Key Staff. The qualitative data was analysed before the quantitative data, with the quantitative data used to support, or contradict, the main qualitative findings through triangulation. Therefore, the quantitative data was not intended to be generalised to other cohorts or used on its own. Furthermore, the quantitative data supported the development of the conceptual model (see 6.1) however this model was primarily developed through data collected as part of the semi-structured interviews. This approach to qualitative and quantitative data is compatible with a non-traditional convergent design and is illustrated in this project as the qualitative data is reported ahead of the quantitative data.

The use of the non-traditional convergent design reflects the philosophical positioning of Pragmatism as it demonstrates the flexibility to select of the most appropriate design to address the project aims. Further, this approach facilitates the collection and separate analysis of two types of data, namely, qualitative, and quantitative, to explore the same phenomena with the interpretation of both data sets triangulated within the discussion (Creswell & Clark, 2017; Dawadi et al., 2021).

3.4 Methodological Reflections

Demonstrating rigor in research practice is important as it contributes towards the validity and credibility of the data, the research process, and the researcher. However, to do so in mixed methods research is challenging due to an absence of a recognised evaluation tool that supports both qualitative and quantitative research within a single study (Eckhardt & DeVon, 2017; Harrison et al., 2020). Furthermore, it is important to ensure that the conclusions drawn from the analysis of mixed methods research are '*reliable, valid, and trustworthy'* (Eckhardt & DeVon, 2017, p.2).

Research to establish an appropriate quality evaluation tool for mixed methods is ongoing (Eckhardt & DeVon, 2017; Leech et al., 2010). O'Cathain et al. (2008) devised an evaluation framework for mixed methods research conducted within health, social, and educational research referred to as GRAMMS (Good Reporting of a Mixed Methods Study), however the framework is considered lengthy and designed as a supportive aid rather than a directive. Creswell and Clark (2017, p.282) outline four areas they consider as the 'minimum criteria' with which mixed methods research

should be evaluated to identify ‘good quality’ study. It is within these four criteria that this project demonstrates rigor (Table 9):

Table 9. Minimum criteria for evaluating mixed methods research (Creswell & Clark, 2017)

Criteria for evaluating mixed methods research:
Collects and analyses both qualitative and quantitative data rigorously in response to research questions and hypotheses
Intentionally integrates (or mixes or combines) the two forms of data and their results
Organises these procedures into specific research designs that provide the logic for conducting the study, *and*
Frames these procedures within theory and philosophy

Pragmatism was utilised to frame this mixed methods project (see 3.2.2), collecting and analysing both qualitative and quantitative data separately to address the research question. The most suitable methods for each of these data collection types were used. Qualitative and quantitative data was then triangulated and is deliberated within the discussion.

Researcher influence is deemed to be present in all research as it is thought a completely unbiased approach is not possible, however acknowledging this enables an alternative way to demonstrate that consistency and thoroughness was implemented (Ritchie et al., 2013). Throughout the project the researcher consistently maintained awareness of potential bias as a result of their own military experience, balancing this with the requirement to apply subjectivity throughout the reflexive thematic analysis of the data.

The application of ‘bracketing’, or the process of suspending researcher subjectivity from the item being researched or analysed, thus applying objectivity, is considered as one way to demonstrate rigor however this is disputed as the ability to completely remove existential thoughts is believed not possible (LeVasseur, 2003). Contrary to researcher subjectivity being an issue, Braun and Clarke (2022a) emphasise its importance, highlighting that without it, thematic analysis would not be possible.

Therefore, as researcher subjectivity, through the use of reflexive thematic analysis, is inextricably linked to the interpretation of data, researchers are required to be aware of, and consider, any potential biases when analysing and presenting findings (Connelley, 2010).

As an applied 'real world' research project, an effective alliance between the researcher, the Northern Hub for Veterans and Military Families Research at Northumbria University, and the Royal Hospital Chelsea was an integral element of the project. Discussions with the Royal Hospital were key to identifying their requirements and objectives ahead of project commencement. These requirements enabled informed decisions to be made to support the project design ensuring the Royal Hospital were in agreement with the project design whilst ensuring researcher impartiality was maintained throughout the duration of the project.

As discussed earlier (see 3.2.3) a reflexive journal was populated during the project. It is important to acknowledge within this chapter that perhaps the most significant consideration regarding subjectivity and potential researcher bias is the researchers own experience and knowledge of supporting military veterans and of having served in the Royal Air Force (RAF) which offered valuable insight and understanding throughout the project however this experience, knowledge and subjectivity was consistently challenged by the researcher themselves to ensure a level of 'sense-checking' was applied to minimise disproportionate bias.

An 'insider/outsider' element was present due to the researchers RAF service, however, the Royal Hospital Chelsea is an establishment specifically for Army veterans. Whilst as a veteran a number of similar experiences are shared, for example, completing initial military training and subsequent 'job' training and, it could be argued, similar traits, all branches of the Armed Forces have unique characteristics therefore there is a distinct separation which reduced the opportunity for disproportionate bias.

For this project the researcher interviewed In-Pensioners in person at the Royal Hospital and was therefore exposed to the surroundings in which they lived which served to raise researcher awareness of their environment however this was not the case for the majority of Key Staff who were interviewed using online digital platforms and the New In-Pensioner cohort were not interviewed. Reflexivity and abductive analysis are important elements of ethnography (Reeves et al., 2008) and were also

key to this project, however the requirement for ethnographers to spend significant amounts of time embedded in their surroundings to carry out the research made this approach unrealistic due to project time constraints.

3.5 Chapter Summary

This chapter presents the methodological considerations and approach used within this study. Justifications for using qualitative and quantitative methods together (mixed methods) and the Pragmatist philosophical positioning as the most appropriate methodological approach to meet the requirements of the phenomenon have been outlined.

The philosophical foundations of Pragmatism were considered the most appropriate foundations on which to base this project to explore the phenomenon, and reflect the researchers own positioning.

A non-traditional convergent design was applied to facilitate qualitative and quantitative data collection and analysis of three participant groups, namely Key Staff (Data Collection Part A), In-Pensioners (Data Collection Part B & Part C), and New In-Pensioners (Data Collection Part D).

The practice of researcher reflection was discussed to demonstrate researcher thoughts and processes throughout this project and to provide the reader with an insight into the researcher rationale for these processes.

Finally, this chapter discussed the rigor applied throughout the project to maintain the validity of the research and the credibility of the processes applied.

CHAPTER FOUR

METHOD

4.1 Overview

Chapter 4 details the method applied for all elements of the project, namely: Part A (Key Staff Qualitative Data Collection); Part B (In-Pensioner Qualitative Data Collection); Part C (In-Pensioner Quantitative Data Collection); and Part D (New In-Pensioner Quantitative Data Collection). The Systematic Narrative Review is not discussed in this chapter, as this method is presented earlier in this thesis (Chapter 2).

This chapter will discuss the design, participant recruitment, participant materials, procedure, data analysis and ethical considerations for each phase. This chapter will also outline the justification of analysis method for each element. Finally, the impact of the Covid-19 pandemic is discussed within this chapter.

4.2 Design

4.2.1 Overview

As discussed in detail within the Methodological Considerations chapter (3.3) this project used a non-traditional Convergent mixed-methods design, for participant data collection, analysis, and interpretation. This was carried out over one phase comprising of four data collection parts as described below and summarised in Figure 6.

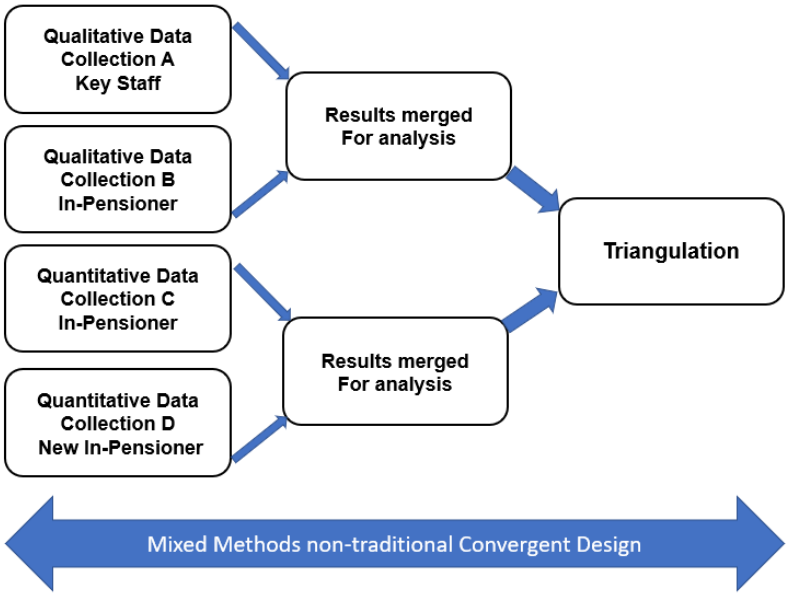


Figure 6. Project Design

4.2.2 Primary Data Collection

Primary data collection comprised of three participant focussed elements. Part A collected qualitative data from Key Staff, identified by their job role (see 4.5.1, Table 10), to record their opinion of, and contribution to, the In-Pensioner experience. Further details of the Key Staff participation process are detailed within this chapter (see 4.5.1). Part B included qualitative data collected from In-Pensioners already resident at the Royal Hospital, with Parts C and D including quantitative data from both established In-Pensioners (Part C), and New In-Pensioners (Part D) who arrived during a 12-month period (May 2021 – May 2022). The recruitment process and procedures for the In-Pensioner and New In-Pensioner participant groups are discussed further in this chapter (4.5.2 and 4.5.3).

Qualitative data collection assumed dominance as the project was explorative due to the lack of available evidence relating to the Royal Hospital Chelsea model of care. However, quantitative data was also required to evidence any impact on In-Pensioner and New In-Pensioner quality of life and provide a different perspective from that of the qualitative data.

4.2.3 Triangulation

Triangulating the data was important to ensure the qualitative and quantitative findings comprehensively addressed the research aims.

Both qualitative and quantitative data sets were analysed separately prior to triangulation. Immersion in the findings and consistent cross-checking of the analysis from both qualitative and quantitative data sets took place, enabling collective interpretation of the findings. The data were not intended to challenge each other, but to facilitate a greater understanding of the project phenomenon. Triangulating the data added strength to the findings which either complemented or contradicted each other, or equally, generated new knowledge.

4.3 Royal Hospital Chelsea Research Oversight Committee

As a direct result of this project taking place, the Royal Hospital established a Research Oversight Committee to ensure regular progress updates were presented to the committee. It was also an opportunity to answer any questions and obtain feedback. The committee, chaired by a Royal Hospital Commissioner, meet twice yearly usually in April and October. Project updates were given via online digital platforms, initially on 14 October 2020, with further updates in April and October 2021 and 2022. The final meeting to present the project findings to the Research Oversight Committee and the Health and Wellbeing Oversight Committee was on-person at the Royal Hospital and held in April 2023.

4.4 Project Steering Group

Following recommendation from the Research Ethics Committee (Appendix M), a Project Steering Group was established to facilitate engagement between the researcher and representatives from the participant groups to ensure their views were heard and considered. The primary role of the steering group was to *'provide advice, input, and direction on the project by discussing their thoughts and opinions but will not be a decision-making body',* as detailed in the Terms of Reference (Appendix N). The group comprised of six members including the researcher and were scheduled to meet on four occasions during the lifetime of the project. The group met in March 2021

and May 2022 and received a project update communication in November 2022. A final meeting was due to take place in April 2023 after the project findings had been presented to the Research Oversight Committee, however this did not happen due to the unavailability of some steering group members. A final meeting will go ahead over the summer to discuss the final study outcomes and conclude steering group meetings.

The Project Steering Group gave access to the thoughts of staff and In-Pensioners in an open forum which would have been otherwise inaccessible. The opportunity to receive feedback from a small number of people who lived and worked at the Royal Hospital gave valuable insight into the Royal Hospital and was beneficial in the development of the participant interviews and recruitment process.

For example, an In-Pensioner practice interview took place with a steering group staff member which helped identify the benefit of producing a summary of topics to be discussed at In-Pensioner interviews to give them an opportunity to consider their responses ahead of the interview taking place.

4.5 Participant Recruitment

4.5.1 Key Staff Participant Group (Part A)

Key Staff (Part A) were identified as a result of their specific job role. Discussions took place with the Director of Health & Wellbeing to identify specific Key Staff roles considered appropriate for inclusion in the project and were selected to ensure a balanced cross-section of those employed in governance, strategic, management and operational roles. Staff were grouped into three areas namely, Board of Commissioners and Executive Board, Heads of Care, and Care Delivery as detailed below (Table 10).

Table 10. Key Staff Participant Roles

Board of Commissioners & Executive Board	**Heads of Care**	**Care Delivery**
Governor	Head of Medical Services	Regimental Sergeant Major
Commissioners (n=4)	MTI Matron	Captain of Invalids (n=2)
Chief Executive	Social Care Manager	Rehabilitation Team Lead
Quartermaster	Chaplain	Domiciliary Care Team Lead
Director of Health & Wellbeing		Practice Nurse
		Admissions Officer

In line with ethics approval, all participants in Part A were employed by the Royal Hospital therefore all non-Royal Hospital Chelsea employed staff and NHS staff were excluded. This decision did not impact the job roles deemed necessary to inform the research aims.

The Medical Centre holds a unique position in that it is a GP-led practice located within the Royal Hospital specifically to provide medical services to In-Pensioners. The practice follows NHS guidelines however staff are Royal Hospital Chelsea employees.

Key Staff received an email (Appendix O) from the Interim Director of Health and Wellbeing to raise awareness of the project and advise that the project researcher would be contacting them to invite them to participate in the project.

An introductory letter (Appendix O) gave more information about the project, and processes, and was accompanied by the Participant Information Sheet and initially emailed to staff. This was also included as a paper copy in the Key Staff Information Packs which were distributed via the internal mail system at the Royal Hospital.

Of the 25 Key Staff roles invited to take part, one role within the Heads of Care declined and four roles within Care Delivery did not respond to invitation. It was also intended to interview two members of the rehabilitation team however it became apparent that the team were contracted staff and not directly employed by Royal Hospital Chelsea, therefore a decision was made to interview only the team lead who was an employee of Royal Hospital Chelsea. A total of 19 Key Staff took part in the project.

4.5.2 In-Pensioner Participant Group (Part B, Part C, and Part D)

The In-Pensioner (Part B & Part C) and New In-Pensioner (Part D) cohorts represented In-Pensioners living independently within the Royal Hospital, who share key characteristics in that they have all served in the British Army and all are 65 years of age or older. Established In-Pensioner participants were selected based on the Company in which they lived, duration of residence and Army Regiment in which they served.

In-Pensioners living in the nursing home section of the MTI were excluded from the project as they were not included in the ethical approval process, however the Long Wards within the MTI that are for those able to live independently, but with decreased mobility, were included in the recruitment.

The decision to exclude In-Pensioners living within the MTI and receiving nursing care was made for several reasons including the MTI being monitored by the CQC (CQC, 2022), therefore, to include this group of In-Pensioners would have required a full National Health Service (NHS) ethical approval process which may have delayed the project considerably. Further, all participants engaged in the project did so voluntarily and anonymously. Including In-Pensioners receiving nursing care may have raised questions around the capacity to consent and as the project committed to maintain anonymity there would have been a conflict to discuss potential participants with staff. There were no other exclusion criteria considered.

The recruitment period for In-Pensioners was June to August 2021, with interviews expected to take place from July 2021 to February 2022. It was intended to hold a recruitment coffee morning at the Royal Hospital however the ongoing impact of Covid-19 and potential risk of infection to In-Pensioners meant this event did not take place. Therefore, all In-Pensioners living independently at the Royal Hospital were invited to participate in the project and received an information flyer via the Royal Hospital internal postal system.

A one-page Recruitment flyer (Appendix O) provided a brief overview of the project and was delivered by the Royal Hospital's internal postal system to approximately 200 In-Pensioners who lived independently in the Long Wards, asking them to consider

taking part. The researchers contact details were included and In-Pensioners were asked to make direct contact if they wished to take part. In-Pensioners who lived within the nursing care area of the MTI were not part of the project and therefore did not receive the recruitment flyer.

The response following receipt of the recruitment flyer was remarkable. By the end of the first day, a total of 16 In-Pensioners had registered their interest in taking part. By day seven 33 had contacted the researcher. This allowed for a purposive recruitment strategy based on individual characteristics.

A Register of Interest form (Appendix P) captured participant name, date of birth, date moving into Royal Hospital Chelsea, Regiment in which they served including date of enlistment and date of discharge, and finally which Company, Long Ward and Berth they lived in. This information helped inform which In-Pensioners were selected to take part in the project.

It was important to establish a balanced representation of In-Pensioner's to minimise any selection bias. Consequently, the selection criteria focussed on the Company an In-Pensioner lived in, how long they had been resident at the Royal Hospital and which Army Regiment they had served in. In-Pensioner age and length of military service were not considered pertinent to the selection criteria as neither variable influenced their placement within each Company or Long Ward, or their length of time in residence at the Royal Hospital Chelsea. However, this data was captured at the point an In-Pensioner registered their interest to take part in the project and is outlined in Table 11.

Furthermore, the project explored the model of care holistically to include the social care and peer-support contribution, therefore the current health status of the In-Pensioner and New In-Pensioner cohorts was not captured.

Table 11. In-Pensioner Participant Demographics

Age[1]				**Length of Military Service**				**Gender**	
65-75 years	76-85 years	85+ years	Average Age (years)	Up to 10 years	11-20 years	21+ years	Average Length of service (years)	Male	Female
8	11	6	79.64 years	6	4	15	19 Years	24	1

(1) In-Pensioner admissions to the Royal Hospital Chelsea permitted from age 65 at time of project.

Gender was recorded as it was hoped female In-Pensioners would participate in the project, however gender was not an exclusion criterion (Table 11). The aim was to recruit a total of 25 In-Pensioner participants for the project. A summary of the In-Pensioner recruitment response can be found below (Table 12).

Table 12. In-Pensioner Recruitment Selection Summary

In-Pensioner Participant Recruitment Summary								
Company	**Years at Royal Hospital Chelsea**							**Comments**
Recruitment Response:	**0-23 months**	**2-4 years**	**5-7 years**	**8-9 years**	**10-12 years**	**13+ years**	**Total**	
1 Company	2	2	**6**	1	0	1	**n=12**	
2 Company	0	4	0	1	2	0	**n=7**	
3 Company	1	**3**	**2**	1	**2**	**3**	**n=12**	
4 Company	0	1	0	0	1	0	**n=2**	
Totals	**3**	**10**	**8**	**3**	**5**	**4**	**n=33**	
Final Selection:	**0-23 months**	**2-4 years**	**5-7 years**	**8-9 years**	**10-12 years**	**13+ years**	**Total**	**Comments**
1 Company	**2**	2	**2**	1	0	1	**n=8**	Reduction of n=4
2 Company	0	4	0	1	2	0	**n=7**	See note 4
3 Company	1	**2**	**1**	1	**1**	**2**	**n=8**	Reduction of n=4
4 Company	0	1	0	0	1	0	**n=2**	See note 5
Totals	**3**	**9**	**3**	**3**	**4**	**3**	**n=25**	

METHODOLOGY:

1. Summary of responses per Company
2. Breakdown of duration living at RHC
3. Filter to ensure fair balance across the Companies
4. All of 2 Company included as numbers were relatively low at n=7 and duration living at RHC was relatively balanced (apart from 2-4 years however to reduce this would result in an imbalance across the companies as a whole)
5. All of 4 Company included as a) numbers were small and b) this is a Long Ward within the MTI
6. Final filtering consideration was based on a 'last in first out' process whereby those who registered their interest to take part earlier were included
7. Individuals not selected were placed on a 'reserve' list for contact should any participant withdraw

In-Pensioners not selected for inclusion were notified and asked if they would like to be included on a reserve list should any selected In-Pensioners withdraw their participation. All In-Pensioners agreed to join the reserve list. Over the duration of the project three participants withdrew with replacements identified from the reserve list.

In addition to the initial eight participants placed on the reserve list a further four participants contacted the researcher after the selection process had been completed and were subsequently added to the reserve list.

The initial recruitment responses did not include any female In-Pensioners. As a result, two female residents were approached by the researcher during the on-site interviews to raise awareness of the project and invite them to consider taking part. One female In-Pensioner agreed to take part and was subsequently interviewed. This brought the total number of participants to 26, however one participant subsequently withdrew before interview due to declining health, returning the total participant number to 25.

4.5.3 New In-Pensioner Participant Group (Part D)

All new residents who joined the Royal Hospital over a one-year timescale, May 2021 to May 2022, were automatically invited to take part in the project, therefore a specific selection process was not required. New In-Pensioners willing to take part agreed to complete two Quality-of-Life questionnaires on arrival at the Royal Hospital and again six months later to create an evidence baseline for residents' quality of life.

As part of their admissions process, New In-Pensioners received a Participant Information Pack (4.7.3) from the Quality Assurance and Clinical Compliance Officer. A one-page recruitment information sheet was included in their Participant Information Pack to raise awareness of the project and invite them to consider taking part (Appendix Q).

No direct contact was made by the researcher until a consent form had been received. The Quality Assurance and Clinical Compliance Officer had been given 30 sets of Information Packs and a pre-prepared spreadsheet containing 30 Unique Identifying Numbers (UIN) which they were asked to populate as each pack was handed out.

Following the relaxation of Covid-19 restrictions and the recommencement of admissions to the Royal Hospital a further 10 packs and 10 UIN's were sent to the Royal Hospital to ensure all new residents within the stated timeframe were given an opportunity to take part in the project.

The data collection period ran from May 2021 to November 2022 to allow for those New In-Pensioners who arrived towards the end of the twelve-month period to submit their second Quality-of-Life questionnaire.

A total of 40 Participant Information Packs were distributed with responses received from 23 New In-Pensioners. Of these, 17 completed consent forms and both questionnaires and were therefore fully engaged in the project. To maintain anonymity the questionnaires were annotated with the UIN but not an individual's name therefore when the first questionnaires were received without a consent form the Quality Assurance and Clinical Compliance Officer was contacted to obtain the name of the participant who was then contacted by letter prompting them to return a signed consent form.

The criteria outlined for all participant groups are considered compatible with purposive sampling (Campbell et al. 2014). As In-Pensioners all live in the same residence and are therefore not representative of a wider population group, random sampling was not a relevant approach to participant recruitment (Sharma, 2017).

Copies of all recruitment documents are available (Appendix O).

4.6 Materials

4.6.1 Participant Information Pack(s)

The distribution of Participant Information Packs varied across all three cohorts. Key Staff were automatically sent a Participant Information Pack as they had been identified by their job role. In-Pensioners identified following the selection process, were sent a Participant Information Pack to help inform their decision to engage and New In-Pensioners received their first information pack as part of their admissions process. A summary of the documents distributed to each participant group can be found below (Table 13). Copies of all documents are available for review (Appendix Q).

Table 13**.** Summary of Participant Information Pack(s) documents

Participant Information Pack Contents	**Key Staff**	**In-Pensioner**	**New In-Pensioner***
Coversheet	X	X	X
Participant Information Sheet	X	X	X
Consent Form	X	X	X
Stamped Addressed Envelope(s) (SAE) (Addressed to Researcher)	X	X	X**
Participant Recruitment Flyer – In-Pensioner		X	
Participant Recruitment Information Sheet – New In-Pensioner			X
Quality of Life Questionnaire			X
Coversheet (pack 2)			X
Quality of Life Questionnaire (pack 2)			X
Stamped Addressed Envelope (Addressed to Researcher) (pack 2)			X
Received n=2 information packs (one on arrival at RHC and one six months later)** * n=1 SAE for Consent form; n=1 SAE for questionnaire**			

4.6.1.1 Coversheet

The Coversheet (Appendix Q) outlined the contents on the information pack and gave contact details for the researcher, project supervisor (Dr Gemma Wilson-Menzfeld (nee Wilson)) and Northumbria University's Departmental Research & Innovation Lead (Professor Tracy Finch).

An additional Coversheet was included in the second New In-Pensioner information pack, distributed six months after arrival at the Royal Hospital. This acted as a reminder of the participant's engagement in the project and gave instructions for completing the second Quality-of-Life Questionnaire along with researcher contact details to support participants with any questions they may have had.

4.6.1.2 Participant Information Sheet

The Participant Information Sheet (Appendix Q) provided a comprehensive overview of the project and why it was being carried out. It included information to explain why the participant(s) were being invited to take part in the project, emphasised that participation was voluntary, and that participants could withdraw from the project at any time without giving a reason and without implication to the individual.

Details on the processing of participant information and data protection guidelines, in line with General Data Protection Regulations (GDPR), were provided alongside information regarding the interview process (where applicable) and steps to mitigate the impact of Covid-19. Details on where to access support and what will happen to the results of the project were also outlined.

4.6.1.3 Consent Form

The consent process is discussed in detail in section (4.9.2). All participants were required to complete a Consent Form (Appendix Q) before being accepted onto the project. There were some variations in the Consent Form in that Key Staff did not complete the Quality-of-Life questionnaire and New In-Pensioners were not interviewed therefore their consent forms reflected these differences.

Key Staff who agreed to participate in the project were sent a consent form via email and also received a paper copy within their Participant Information Pack. Several staff returned their signed consent forms via email with the remaining participants returning paper copies to the researcher.

Both In-Pensioner cohorts who agreed to take part in the project received their consent form as part of their Participant Information Pack and returned a signed copy to the researcher in the envelope provided.

All consent forms were signed by the researcher and returned to participants with a copy retained on the project file.

4.6.1.4 Quality-of-Life Questionnaires

Two Quality-of-Life questionnaires (Appendix L) were used to capture both In-Pensioner participant groups' feedback on their quality-of-life experience. The measures used were the ICECAP-A (ICEpop CAPability Adult) (Flynn et al., 2015) and the WHOQOL-BREF (World Health Organisation Quality of Life BREF) (WHO, 1996).

The ICECAP-A questionnaire explores an individual's capability by asking respondents to select one answer from four options that best reflect how they are feeling across five areas namely: stability; attachment; autonomy; achievement; and

enjoyment (Flynn et al., 2015). Responses are scored numerically from best (score 4) to worst (score 1) (Figure 7). The ICECAP-A questionnaire was selected as it supports economic evaluations (Flynn et al., 2015), which was a relevant consideration at the time of developing the design of the project.

This consideration changed during the project however, as data collection had commenced prior this change in project design and as the questionnaire provides an additional measure in the form of a short summary of quality of life, a decision was made to continue to collect this data as it was still relevant to the project aims.

1. Feeling settled and secure	✓	
I am able to feel settled and secure in all areas of my life		4
I am able to feel settled and secure in many areas of my life		3
I am able to feel settled and secure in a few areas of my life		2
I am unable to feel settled and secure in any areas of my life		1

Figure 7. ICECAP-A example of Question 1

The ICECAP-A questionnaire was selected in preference to the ICECAP-O (ICEpop CAPability Older people) questionnaire as it presented opportunities to capture data on achievement, which was relevant to the project, specifically relating to the representational role of In-Pensioners.

The ICECAP-A is designed to capture quality-of-life data on adults up to 65 years of age, or in summary, those considered to be of working age (Baji et al., 2021). The minimum age of admission to the Royal Hospital was 65 years of age at the start of the project, therefore at the upper age limit of the ICECAP-A, so it could be argued that the ICECAP-O may have been a more appropriate measure for this population group. However, the requirement for In-Pensioners to commit to represent the Royal Hospital as Chelsea Pensioners for a minimum of two years, wherever possible, and irrespective of their age at the point of becoming a Royal Hospital resident, resulted in the decision to use the ICECAP-A in preference to the ICECAP-O measure. Furthermore, both measures are considered comparable (Baji et al., 2021), therefore

it is argued that the selection of the ICECAP-A measure did not negatively influence the findings.

The WHOQOL-BREF questionnaire is a brief version of the WHOQOL-100 comprising of 26 questions across four areas namely: physical health; psychology; social relations; and environment, giving an opportunity to gather data that encompasses broad quality-of-life experience, and is found to be a cross-culturally reliable measure (Kalfoss et al., 2008; Skevington et al., 2004). The Field Trial Version, December 1996, formatting and scoring matrix (WHO, 1996) was used for this project.

Participants were asked to answer each question by selecting the most appropriate response across a choice of five which were numbered from one to five, for example (Figure 8):

		Very Poor	Poor	Neither poor nor good	Good	Very good
1	How would you rate your quality of life?	1	2	3	4	5

Figure 8. WHOQOL-BREF example of Question 1

Questions 3, 4 and 26 were negatively framed, therefore these questions were transformed ahead of the analysis in accordance with the WHOQOL-26 scoring guidelines (WHO, 1996, p.10). Further, and in accordance with the scoring guidelines, missing scores were averaged within the relevant domain to facilitate calculating collective mean scores across all domains, however all other data analysis recognised the missing scores and was calculated accordingly.

The ICECAP-A questionnaire captured participants' feelings on the date of completion with the WHOQOL-BREF capturing how an individual has been feeling over the preceding two weeks.

New In-Pensioners were asked to complete both questionnaires at two points in time, once at the point of admission to RHC and the second six months later, to help create an evidence baseline for the Royal Hospital.

The In-Pensioner cohort were also asked to complete the same questionnaires following completion of their interviews. Questionnaires were completed in their own time and returned to the researcher in a pre-prepared envelope.

The In-Pensioner data was supplementary to the baseline evidence obtained from the New In-Pensioner cohort and was not intended to be used as a comparator as the length of residence of the In-Pensioner cohort inevitably influenced responses. However, it was considered that the data would contribute towards the wider knowledge of quality-of-life experience of In-Pensioners and therefore useful to the overall project aims.

Key Staff were not asked to complete a quality-of-life questionnaire as this was not relevant to the project aims.

4.6.2 Semi-Structured Interview Schedule

Interviews were carried out using a semi-structured approach. Semi-structured interviews provide a pre-determined schedule of interview questions but offer flexibility for both researcher and participant, as supplementary questions can be asked to explore participant responses further (Kallio et al., 2016). In contrast, open interviews deliver variable results as the participant directs the conversation pathway with minimal intervention by the interviewer (Alsaawi, 2014; Creswell & Clark, 2017). Furthermore, and in contrast to the flexible nature of open and semi-structured interviews, closed questions, used in quantitative data collection, remove the opportunity for participant narrative by offering specific responses to questions which may range from ‘strongly agree’ to ‘strongly disagree’, or ‘often’ to ‘never’, where the participant selects what they consider to be the most appropriate answer (Creswell & Clark, 2017).

The use of semi-structured interviews provides an element of consistency across the topics discussed ensuring all participants were given the opportunity to answer the same questions (Alsaawi, 2014). However, simultaneously, semi-structured interviewing gives participants an opportunity to actively engage in the topics discussed by having the flexibility to provide responses as detailed or limited as they wish (Galletta, 2013; Kallio et al., 2016). The semi-structured interview was considered

the most effective approach for this project as it enables a collaboration between the participant, who has the flexibility to share their thoughts and introduce other points they wish to discuss, and the interviewer, who guides the interview process by interjecting the discussion with the topics required to address the project aims.

Interview question content was developed by considering the aims and objectives of the research project, providing a framework on which to build the interview questions. Further, knowledge gained from the systematic narrative review gave insight into existing residential care options, the facilities available and opportunities for its residents which contributed to the development of the interview questions. The structure of the interview questions was loosely based on those found in a peer-reviewed paper included in the Systematic Narrative Review (Levy et al., 2013).

The interview questions (Appendix S) sought to elicit feedback on life at the Royal Hospital including opportunities to, and the impact of, accessing healthcare support, the social care provision including engaging in activities, the commitment of In-Pensioners to represent the Royal Hospital and the impact of living and working in a historical environment alongside barriers and challenges to service delivery.

Questions concerning Covid-19 were included in the interview as the pandemic was present throughout the duration of the project and inevitably had an impact on staff, In-Pensioners, and service delivery.

Areas for discussion were primarily the same for both Key Staff and In-Pensioner cohorts which enabled responses to be considered together to provide an overall picture of the Royal Hospital Chelsea experience.

There were a few differences in the questions asked, as the Board of Commissioners and Executive Management were asked about their contribution towards the strategic direction of the Royal Hospital, whereas other Key Staff and In-Pensioners were asked whether they felt able to share their thoughts with management and have input into the strategic direction.

The development of the interview questions was an iterative process with Key Staff responses during their interviews taken into consideration when formulating the remaining Key Staff, and subsequent In-Pensioner interview questions.

For instance, feedback from one Key Staff participant included the suggestion of an area for discussion concerning the impact on the In-Pensioner experience to live within the Royal Hospital for the duration of their lifespan, without the requirement to be transferred to an external establishment as they aged, or their health deteriorated. In essence, the ability to 'age in place' even though, in reality, In-Pensioners physically move from the Long Wards (independent living) to the MTI (nursing home) located within the grounds of the Royal Hospital but a separate building. As a result of this feedback, this topic was included in all future interviews for both cohorts.

4.6.3 Supplementary Participant Documentation

Several documents were used to communicate with participants during their engagement with the project.

In-Pensioners who were not selected to take part in the project received a personalised letter (Appendix O) thanking them for their interest in the project and advised that they would be retained on a reserve list should a space become available.

Following a practise In-Pensioner interview with a member of the Project Steering Group, a Topic Summary document was created to highlight the areas that would be discussed during the interview *(*Appendix T). This gave In-Pensioners an opportunity to consider their responses in advance to ensure they got the most out of the interview and chance to share their views. The Topic Summary was sent to In-Pensioners with their interview confirmation letter as discussed in (4.6.3), however this document was not available for Key Staff as it was created after completion of their interviews.

On conclusion of each interview, and for the New In-Pensioner cohort, following completion of each set of Quality-of-Life questionnaires, all participants received a letter thanking them for their participation (Appendix O). This information was either sent via email, handed out following face-to-face interview, or via post.

At the end of their engagement all participants were sent a personalised letter (Appendix O) thanking them for taking part in the project and advising that their engagement was now complete. The letter advised that participants would receive a copy of the final report at the conclusion of the project.

4.7 Procedure

4.7.1 Key Staff

As outlined earlier (4.5.1), an email from the Interim Director of Health and Wellbeing was sent to Key Staff raising awareness of the project. The researcher then contacted each staff member individually via email attaching copies of an introductory letter, Participant Information Sheet, and Consent Form. The email invited them to take part in the project and advised that a full Participant Information Pack would be sent (Appendix Q).

Participant Information Packs for each member of staff were sent to the Royal Hospital for internal distribution. This enabled participants to have paper copies of documents previously emailed to them including the consent form which they could sign and return to me in a provided envelope.

Following receipt of a signed Consent Form, each form was countersigned and returned to each participant for their records with a copy retained on the project files. Included with the consent form was a next steps letter which advised participants that an interview would be arranged within a Covid-safe environment and signposted them back to the information pack for any further information. Participants were given the opportunity to contact the researcher at all stages of the process.

Sixteen interviews took place using online methods such as Zoom or Teams, depending on participant preference, and three interviews took place in person at Royal Hospital Chelsea. These interviews took place in a confidential space where only the researcher and participant were present. All participants consented to have their interviews recorded which took place using an external recording device and the Microsoft Voice Recorder function within the researcher's laptop. Obtaining two recordings mitigated against either method experiencing a technical failure and potential loss of data. All interviews were scheduled using a Microsoft Outlook calendar meeting invitation. It was anticipated that interviews would last approximately 60 minutes however some took considerably longer, with one lasting 120 minutes. It was felt important not to hasten the end of any interview as to do so may have resulted in the loss of important feedback. Participants were given options to pause the interview for comfort breaks or reschedule if they became fatigued. As discussed

above (4.6.3), participants received an information sheet at the end of their interview (Appendix O).

Participant recruitment took place from May to August 2021 with interviews taking place from June to September 2021.

Following the interview, a thank you, or 'end of engagement', letter was sent informing Key Staff that their part in the project was complete. This letter advised they would receive a copy of the final project report when available. Copies of all documents are available for review (Appendix O)

4.7.2 In-Pensioners

Following the selection process, all In-Pensioner participants were sent a Participant Information Pack, contents as detailed in Table 13. As participation was confidential the information packs were sent direct to the In-Pensioners.

Participants were asked to return their signed consent form to the researcher which was then countersigned and returned to the In-Pensioner with a 'next steps' letter advising that an interview would be scheduled at the Royal Hospital in due course, within a Covid-19 safe environment. In-Pensioners were given the opportunity to contact the researcher at any time should they have any questions. As mentioned above, a copy of the consent form was retained on the project file.

With the support of Royal Hospital Chelsea, meeting rooms suitable for the interviews were identified and secured for all dates. In-Pensioners were contacted by telephone to schedule an interview time that suited them and subsequently sent confirmation of their interview date, time, and place (Appendix O) which gave further reassurance that the interviews would take place in a Covid-safe environment. As mentioned above (4.6.3), In-Pensioners also received a copy of the Topic Summary document which highlighted the areas to be discussed in the interview.

Twenty-two interviews took place face-to-face at the Royal Hospital in August and September 2021 with the final two interviews taking place in May 2022. These interviews took place in a confidential space where only the participant and researcher were present. One interview took place online, via Zoom, in October 2021 as the participant was comfortable with using digital technology. In-Pensioners were each

allocated 90 minutes for interview to allow for any comfort breaks or pauses to reduce participant fatigue. A minority took longer than the allocated 90 minutes (up to two hours including breaks) but it was felt inappropriate to hasten the end of any interview as to do so may have lost valuable feedback. Participants were given the opportunity to schedule a second interview if they deemed it necessary, however all interviews were completed in one session.

Three interviews were rescheduled following notification from one In-Pensioner that, after being interviewed, they had tested positive for Covid-19. The participant had taken a Covid-19 test the day before their interview and received notification after the interview had taken place.

Following interview, In-Pensioner participants were handed an information sheet (Appendix O) thanking them for taking part in the interview. They were also given the Quality-of-Life Questionnaires and asked to complete them in their own time and return them to the researcher in the pre-paid return envelope supplied.

Nine questionnaires were received with questions unanswered. Where it was considered likely to be an oversight, rather than a deliberate omission, the questionnaire was returned to the individual to give them the opportunity to complete the questionnaire in full. Three questionnaires were returned to In-Pensioners for completion.

Where it was believed individual questions had been unanswered intentionally, this was recorded appropriately on the spreadsheet to indicate a non-response. A total of six questionnaires recorded missing data.

An ‘end of engagement’ letter was sent informing In-Pensioners that their part in the project was complete. This letter advised they would receive a copy of the final project report when available. Copies of all documents are available for review (Appendix O)

4.7.3 New In-Pensioners

The researcher worked with the Royal Hospital Chelsea’s Quality Assurance and Clinical Compliance Officer to engage with the New In-Pensioner cohort following their arrival at the Royal Hospital as part of their arrivals process with the officer agreeing to distribute the information packs using the internal postal system.

A spreadsheet containing a list of pre-allocated Unique Identifying Numbers (UIN) corresponding with each set of Information Packs was shared with the Quality Assurance and Clinical Compliance Officer for them to populate as the packs were handed out. This created a distribution record that was retained by the Royal Hospital. The Researcher became aware of a participant name only after receiving a signed Consent Form. This protected the identity of those new In-Pensioners who joined the Royal Hospital but did not wish to engage in the project. All New In-Pensioners were included in the invitation to participate as they would be living independently at the Royal Hospital and therefore had capacity to consent.

New In-Pensioners were given the first Participant Information Pack containing the Quality-of-Life questionnaires within the first few weeks of moving into the Royal Hospital and the second six months later.

As with other participant cohorts, following receipt of a signed Consent Form it was countersigned and returned to the participant with a copy retained on the project file. To maintain anonymity two envelopes were provided for participants to return the consent form and first Quality of Life questionnaire separately.

Two Quality of Life questionnaires received ahead of a signed Consent Form were not recorded on the data spreadsheet until the Consent Form arrived. Engagement with the Royal Hospital Chelsea's Quality Assurance and Clinical Compliance Officer enabled the researcher to establish the identity of these individuals by referencing the UIN to facilitate direct contact between the researcher and the New In-Pensioner to prompt the return of their consent form.

Six second sets of questionnaires distributed six months after New In-Pensioner arrival were received, however the first questionnaire had not been completed, nor a signed Consent Form received. It is considered likely that the first Participant Information Pack was inadvertently overlooked by the New In-Pensioner during their first few weeks of moving into the Royal Hospital, however they responded after receiving the second information pack and returned the questionnaire. As the aim of the New In-Pensioner cohort is to capture their Quality-of-Life responses on arrival at the Royal Hospital and six months later, it was not possible to include them in the data collection.

One participant consented to take part in the project and completed the first set of questionnaires however the second set were not received, therefore this participants data could not be included in the project.

In line with In-Pensioner data collection procedures and to maintain consistency, New In-Pensioner questionnaires received with unanswered questions were either returned to participants for completion, or questions were annotated as unanswered. As a result, eight questionnaires were received with questions unanswered. Of these, two questionnaires were returned to In-Pensioners for completion and six questionnaires recorded data as missing.

New In-Pensioners received an acknowledgement letter thanking them for returning their consent form and first questionnaires. This letter reminded participants that they would receive the second questionnaires in six months' time and referred them to the Participant Information Sheet should they have any questions regarding the project. Participants were also given the opportunity to contact the researcher at any point during the project.

As for all participants, a thank you, or 'end of engagement', letter was sent informing New In-Pensioners that their part in the project was complete. This letter advised they would receive a copy of the final project report when available. Copies of all documents are available for review (Appendix O).

4.7.4 Participant Deaths

Over the duration of the project four In-Pensioners and two New In-Pensioner's sadly died. All had completed their engagement in the project. Advice was sought from the university ethics department (May 2022) as to the best way to approach retaining the data within the project. Discussions also took place with the Research Oversight Committee and project supervisors.

It was agreed that the next of kin be contacted via letter informing them of their family member's engagement in the project and the offer to withdraw their data from the project if they wished.

As next of kin details were not obtained as part of the project, the letters were sent to the Quality Assurance and Clinical Compliance Officer for onward transmission to the

next of kin. A copy of the letter templates can be found at (Appendix U). A date for response was included on the letter with an understanding that no response indicated the families wish for the participants data to remain within the project. This decision was made primarily to avoid placing a responsibility for the family to respond at a time when they are grieving the loss of their family member. One response was received via email with confirmation that they were happy for their family members data to remain in the project.

The Participant Information Sheets for all participants included the following text: *"Consent given prior to death, is believed to extend beyond death (HRA, 2019). Therefore, if a participant dies after participating in an interview their information will remain as part of the project, unless a family member wishes this is be withdrawn. The family members will be given this opportunity, and if they wish to remove it, information will be removed from the project and destroyed."* Copies of the Participant Information Sheets were also sent to the next of kin for information.

Notification of the death of one New In-Pensioner participant was received in January 2023, after data analysis had taken place. Following a discussion with the project supervisors and considering the proximity to the project end date, the next of kin were not contacted as it was believed they would have received project details (i.e., Participant Information Sheet; consent form) within the personal possessions of the deceased, and therefore, had the opportunity to contact the researcher to withdraw the participant from the project if they chose to do so.

All project records were updated to indicate that the participants had died.

4.8 Data Analysis

4.8.1 Qualitative Data

As discussed earlier (see 3.2.3), this project used a Reflexive Thematic Analysis methodology, which relies on researcher subjectivity throughout the coding process and development of themes, and requires researcher reflexivity on how their beliefs, norms, and personal positioning, influences the data analysis (Braun & Clarke, 2022a). Researcher reflexivity is discussed in detail within the 'Phase 6: 'writing up'' narrative below.

This project analysed the data using an inductive approach, allowing the data to drive the theme development, rather than applying a 'targeted' approach to identify data that corresponded to a pre-determined coding framework. Data were analysed at a semantic level, considering what participants said, rather than exploring a deeper, or 'hidden' meaning.

Interviews were transcribed verbatim, checked for accuracy then uploaded into NVIVO ahead of data analysis.

Data analysis followed the Braun and Clarke six phases of Reflexive Thematic Analysis (2022a) (Figure 9). These phases are outlined below and are followed by researcher justification of this choice of analysis.

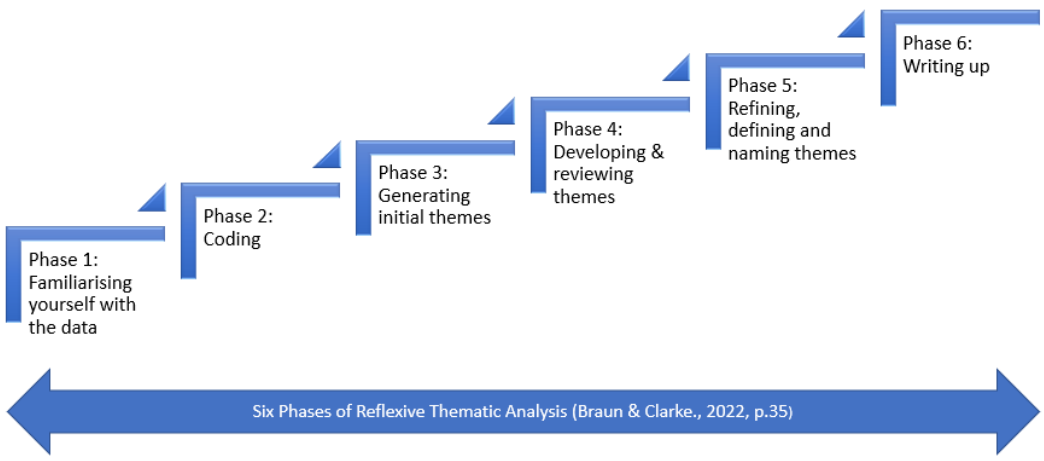


Figure 9. The Six Phases of Reflexive Thematic Analysis

"Phase 1: familiarising yourself with the data"

Data analysis began with an initial reading of all interview transcriptions, followed by an in-depth accuracy check which involved listening to each interview recording whilst re-reviewing the typed transcription. This was important as interview recordings were transcribed by a university approved third party unfamiliar with military terminology and 'jargon'. The transcriber was given a list of words that were likely to be repeated frequently however an accuracy check was considered essential.

This process of accuracy checking helped with the refamiliarisation of the data, following a time lapse between the interviews taking place, transcription and start of data analysis. Furthermore, the familiarisation and immersion in the dataset ensured full control of, and engagement with, the data was maintained by the researcher throughout the analysis process.

During the refamiliarisation process, inductive analysis commenced as any information considered potentially useful was highlighted and notes made to assist with the coding stage of the analysis. Further, listening to the interviews again helped recall the context of the discussion and the 'personality' behind the narrative and helped clarify any discussion points that may be misinterpreted by simply reading text.

"Phase 2: coding"

Following detailed accuracy checking, using the interview recording against the transcription, all transcriptions were uploaded onto the NVIVO-12 database ahead of the coding process. Each transcription was colour-coded to reflect Key Staff or In-Pensioner which helped to keep a record of the coding progress for each cohort. As mentioned above, the dataset for both participant groups were combined for analysis.

Participant transcriptions were not pre-selected ahead of coding as neither the level of seniority of Key Staff nor In-Pensioner positioning, for example duration of residence or which Company they lived in, were considerations during the process, therefore transcriptions were randomly selected and coded in small Key Staff or In-Pensioner groups of two or three at a time, which enabled momentum to be maintained throughout the coding process. Furthermore, this facilitated researcher familiarity and continuity with the flow of the semi-structured questions which varied slightly between participant cohorts (see Appendix S), enabling immersion in the dataset and consistency of the coding procedure for each participant group. This process also ensured that a balanced mix of both participant groups were coded throughout this phase of data analysis.

The knowledge gained from conducting, and subsequently accuracy checking the interviews raised an awareness of broad areas where 'codes' were likely to occur. Using this knowledge, and the areas discussed during the interviews, a number of headings, for example 'admissions process', 'In-Pensioner characteristics', and 'Outreach', were created in NVIVO-12 to provide an initial structure for the coding

process. It is important to note that these headings were not intended as predefined or assumed codes but considered as a starting point from which to populate the database and start the coding process. Many new areas were added as the coding process progressed.

Using an inductive process, each transcription was systematically reviewed, following a line-by-line coding process involving the review of each line of each transcription, identifying data that may be relevant to informing the review question, and coding accordingly. Each transcription was reviewed with equal levels of attention to ensure consistency and maximise the opportunity to identify data of interest. Data considered potentially useful was allocated a code (or 'label') by which it could be identified, and by which other closely matched data could sit within. To ensure data was not analysed out of context, relevant information surrounding the area of interest was included within that code. This line-by-line coding method created a library of qualitative data to facilitate answering the project aims.

A total of 44 transcriptions required coding. Of these, 32 transcriptions underwent full line-by-line coding, where all potentially valuable data was coded with the coding not strictly limited to the aims of the project, but creating a wider dataset, which supports the reflexive thematic analysis approach. Further, it was thought that this extensive data coding would support any future research of the dataset. So whilst a time-consuming process, this approach ensured potential areas of interest were not overlooked, and captured data that could be analysed at a future date using a different research question.

However, the comprehensive line-by-line coding of all data for the 32 transcriptions resulted in project time constraints, therefore it was not possible to carry out the same depth of coding on the remaining 12 transcriptions, which comprised of five Key Staff and seven In-Pensioner transcriptions (see Table 14). Following a discussion with the researcher's supervisors and recognising that the proportion of transcriptions for both Key Staff and In-Pensioner participants already coded was not disproportionately balanced, it was agreed that a more focussed approach to coding the remaining transcriptions could take place. As outlined in Table 14, a total of 32 transcriptions underwent full line-by-line coding within NVIVO-12. As data 'saturation' is incompatible with Reflexive Thematic Analysis (Braun & Clarke, 2022a), the knowledge already

gained during the coding process of the 32 transcriptions, was utilised to code the remaining 12 transcriptions. Data from the 12 transcriptions that contributed towards the most prevalent codes already created were appropriately coded and added to the dataset within NVIVO-12. This focussed approach to the data within the 12 transcriptions added weight to the extant codes. Furthermore, any new data considered to be of relevance was identified and captured, with new codes generated and the data added to NVIVO-12 for inclusion in the analytical process. This decision did not impact negatively on the overall data capture as the researcher was fully immersed in the overall dataset, which ensured all data relevant to the research aims were captured. Furthermore, the philosophical positioning of pragmatism enabled a pragmatic approach to be applied to the remaining 12 transcriptions. For completeness, all 12 transcriptions were fully coded within NVIVO-12, to capture additional data that may be relevant for future research, before project completion.

Table 14. Qualitative Data Coding Participant Summary

Participant Group	**Coding process**		**Total(s)**
	Full line-by-line coding	**Focussed Coding**	
Key Staff	14	5	19
In-Pensioner	18	7	25
Total(s)	32	12	44

By working methodically and reviewing each code, a process of synthesising took place to merge codes that were similar or duplicated. This involved using NVIVO-12 to cross-reference the narrative (or ‘quote’) behind each code to ensure codes weren’t merged inappropriately. This process facilitated a constant knowledge refresh of the data and the generation of deeper awareness of the data.

A substantial number of codes were created with over 800 generated at one stage during the coding process. Following synthesis of codes and development of themes this was reduced to 346 appropriate codes for analysis within the themes. The number

of codes created is a reflection of the coding taking place across the whole dataset and not being limited to coding only areas considered to meet the aims of the project.

"Phase 3: generating initial themes"

Following completion of the coding process, codes were systematically reviewed to identify which codes were represented most frequently by the number of participant quotes or those that held particular significance to support the project aims. This in-depth analysis, following a data-led inductive process, helped to identify potential patterns of the data which began the process of establishing areas of interest, or themes.

Codes were analysed using the concept of "what is the data telling me", to facilitate theme development. This involved reviewing the codes with an open-minded approach, thus avoiding any preconceptions of what the data 'should' be saying rather than what it was actually revealing.

This iterative process resulted in ten initial areas of interest being identified from the codes, with recognition that this was too many. Further synthesis subsequently reduced the potential themes to seven.

"Phase 4: developing and reviewing themes"

Following the initial identification of the seven themes, a duplicate database within NVIVO-12 was created to facilitate the division of selected codes into the relevant themes. This maintained the integrity of the original database and allowed the flexibility to move codes within themes as the analysis continued.

Codes were then exported from NVIVO-12 into an Excel spreadsheet and subsequently separated out into individual spreadsheets for each theme for ease of reference to start the development of the themes. As further inductive synthesis took place, codes considered relevant were transferred onto hand-written 'mind-maps' to further develop areas of interest giving the flexibility to allocate and reallocate codes as the themes progressed. An example of a mind map is available (Appendix V).

As each mind-map developed it gave a visual overview of the codes as they were placed into sections that would shape the narrative of the theme. This enabled the

researcher to establish whether the most appropriate codes selected supported the concept of the theme in question.

"Phase 5: refining, defining and naming themes"

The above process of developing mind-maps continued across all themes with codes separated out within each theme to establish a coherent narrative and further synthesis by removing codes that became less relevant as the theme narrative developed.

Each code was numbered according to the provisional format of the theme narrative, or section, within each theme. Codes were then arranged within each Excel spreadsheet in number order. The quotes behind each code were then printed to establish a paper copy of each theme, creating a 'running order' of the theme story to support the write-up (Phase 6). This process enabled a review of the data to ensure that, at this stage in the analysis process, the overall theme contained the appropriate narrative to support the theme concept.

Each theme was given a 'working title' during Phase 4, and subsequently refined during Phase 5 alongside the development of a theme concept. As an example, the opportunity for In-Pensioners to access healthcare was given the working title of 'Access….to Healthcare package'. This later became 'From 'Enlistment' to Last Posting: wrap around healthcare promotes positive life satisfaction', with the concept:

> *"Unprecedented access to embedded, wrap around, healthcare provision enables In-Pensioners to live healthy, potentially prolonged, lives. This promotes reassurance and health surety in a safe, secure environment where the raison d'être of the establishment is supporting the In-Pensioners themselves.*
>
> *Despite the resistance to accept age decline and potential infirmity, the existence of the MTI offers further reassurance that In-Pensioners can live the rest of their lives in a familiar environment amongst friends and staff who are known to them."*

Throughout the analysis process, the data behind the codes were consistently reviewed to maintain familiarity of the context of the codes, ensuring continuity of an inductive approach, and developing an ongoing depth of knowledge within each theme.

The process of refining the data resulted in three themes that best articulate the qualitative findings.

"Phase 6: writing up"

Write-up of each theme began with a focussed review of the quotes behind each code to identify the most pertinent data for interpretation. This involved recognising where data had been repeated across the codes and ensuring it was not duplicated during the write-up, and equally was not overlooked and excluded from a following area within the theme.

During the write-up of each theme, a process of revision and refinement took place, with areas that became less relevant to the overall story being removed to maintain coherent narrative. Further, the aims of the project were consistently reviewed to ensure the narrative for each theme remained relevant and didn't deviate from the key areas identified.

This refinement included the removal of two themes as the points within the theme were considered important to the Royal Hospital in the wider sense, however, they were not as aligned to the project aims as they needed to be. Whilst the decision to remove these themes was challenging, it was believed to be a correct one.

It was important to ensure that each theme was able to be read in isolation but equally formed part of an overall story that addressed the aims of the project. This also involved placing the themes in a way that guided the reader through a coherent story pathway. To achieve this, further refinement included the collation of several themes into more succinct super-ordinate themes.

As described above, qualitative data was analysed using a Reflexive Thematic Analysis methodology. At project initiation, a framework analysis approach was considered as it supports the data management and analysis of large volumes of qualitative data (Kiernan & Hill, 2018) however following completion of the semi-structured interviews it became evident that a flexible approach to the analysis would

be more appropriate to allow both inductive and deductive analysis of the data to take place which is compatible with Reflexive Thematic Analysis, and Pragmatism, rather than using framework analysis, which approaches the data with a preconceived idea of interpretation and intentionally searches for data to furnish these ideas.

Reflexive Thematic Analysis allowed a subjective approach to be applied to the data and required the researcher to consistently question their thoughts around the analysis, the process and development of their findings and recognise their positioning as a researcher and how that influences the findings. (Braun & Clarke, 2022a)

My positioning as a researcher is that of a military veteran with knowledge and experience that undoubtedly influences my interpretation of data when researching military subjects, therefore I believed it more appropriate to approach the analysis through this lens rather than attempt to exclude this knowledge and experience and adopt an objective approach. Reflexive Thematic Analysis enabled me to utilise my positioning and enabled an effective approach to analysing the qualitative data. Braun and Clarke (2022a, p.13) state *"within a qualitative paradigm, researcher subjectivity – who we are, and what we bring to the research, ranging from our personal identities and values, through to our disciplinary perspectives – is an integral part of the analysis".*

Further, my knowledge and experience extend beyond my own military experience as I am engaged with a number of military charities in the roles of volunteer welfare representative and wellbeing support. Academically, I hold an MSc in Military Veterans and Families Studies therefore my experience is broad and contributes towards my interpretation of military issues.

The NVIVO-12 software database was used to support the data analysis process. NVIVO-12 is a software package recognised as supporting the analysis of mixed-methodology research and provides a repository for interview transcripts to be stored and subsequently analysed and allows flexibility to export the data into other formats, such as Microsoft Excel. (NVivo, 2022).

4.8.2 Quantitative Data

The process followed for the receipt and recording of New In-Pensioner consent forms and quality-of-life questionnaires is described in (4.7.3).

Questionnaire responses were recorded on an Excel spreadsheet to using the participant UIN only to avoid identification by name. Entries into the spreadsheet were cross-checked twice to ensure accuracy. Data was not entered onto the spreadsheet until the researcher had a complete set of questionnaires from each participant. For example, if the ICECAP-A had not been completed, the WHOQOL-BREF data was not entered until the ICECAP-A had been returned complete.

A separate Excel spreadsheet was created to record the In-Pensioner cohort quality of life data. To ensure consistency the process for checking and recording responses was the same as that for New In-Pensioners as outlined above.

Collecting data on an Excel spreadsheet facilitated the recording and monitoring of outstanding questionnaires across the data collection period. When data collection was complete, all information was uploaded onto the IBM® SPSS® statistical analysis software platform. Created in 1968 and acquired by IBM in 2009, SPSS is recognised as an effective database to support the statistical analysis of social sciences data and was therefore considered the most appropriate software package to use for this project (IBM, 2022).

Templates were created within IBM® SPSS® to reflect the quality-of-life questionnaires and response options and were then populated with the participant answers.

The aims of the quantitative data were to enable the comparison of New In-Pensioner responses from their two datasets to identify any noticeable differences in their responses from their initial arrival at the Royal Hospital and again six months later, indicating any improvement or decline in their quality of life. This data established a baseline of quality-of-life evidence for this group of In-Pensioners in line with the project aims.

The In-Pensioner cohort dataset offered evidence into the quality of life for those who were established at the Royal Hospital and offered a comparator to the second set of data from the New In-Pensioner cohort.

The complete datasets offered a different perspective of quality of life for both participant groups. Further analysis enabled the identification of specific questions within the questionnaires which linked to the project aims to enable a more targeted approach to the data. For example, questions from the WHOQOL-BREF include:

> *Q.14 To what extent do you have the opportunity for leisure activities?*
> *Q.23 How satisfied are you with the conditions of your living place?*
>
> *Q.24 How satisfied are you with your access to health services?*

Using Levene's test, the homogeneity of variances was assessed before carrying out ANOVAs and post hoc tests on all quantitative data. A Levene's test across all questions on ICECAP-A, found only question five violated the assumption of homogeneity of variance. Subsequent statistical analysis utilised a one-way ANOVA, applying the Welch test for this question. A one-way ANOVA test was carried out on all other ICECAP-A questions which did not violate the assumption of homogeneity of variances (Appendix W).

For WHOQOL-BREF, homogeneity of variances was considered across Domains. The assumption was violated for Domain 3 only. Tukey post hoc tests were carried out for Domains 1, 2, and 4, and Games-Howell post hoc test for Domain 3 only (Appendix X). Unanswered questions were processed in accordance with the WHOQOL-BREF scoring guidelines (WHO, 1996, p.10).

Results from the quantitative data were then used in the Discussion chapter (Chapter 6) to critique the qualitative findings.

4.8.3 Transparency

During data analysis, engagement took place with the Royal Hospital Research Oversight Committee to keep them appraised of progress and potential themes being identified. Additionally, monthly updates were sent to the Director of Health and Wellbeing.

The data analysis process across both qualitative and quantitative datasets was documented using version control measures on all documentation as analysis progressed. The use of Excel spreadsheets and ‘mind-maps’ captured the progress from initial qualitative data coding to the development of themes.

Further, a reflexive diary, and regular discussions with my supervision team during data analysis, ensured the transparency of the process. This engagement took place throughout data analysis and enabled me to share preliminary thoughts on data synthesis as areas of interest and patterns of data were being identified.

This combination of measures facilitated transparency throughout the data analysis process.

4.9 Ethical Considerations

4.9.1 Ethical Approval

The project was approved through Northumbria University’s Ethical Approval System (16 October 2020) (Ref: 24587) and the London Camberwell St Giles Research Ethics Committee (REC) (18 February 2021) (REC Ref: 21/LO/0058; IRAS Ref: 288952) (Appendix M).

Social Care ethics approval, using the Integrated Research Application System (IRAS) system, was sought due to the complex nature of the Royal Hospital establishment and mix of ‘sheltered accommodation’, care home and NHS Medical Centre provision. This decision demonstrated rigour and gave assurance that the project has engaged in a robust ethical process.

The Social Care ethics application was submitted on 11 December 2020 with notification that a panel meeting with the London Camberwell St Giles REC was confirmed for 15 January 2021. The application was subject to a documentation check by the Health Research Authority approvals officer ahead of the panel date which resulted in a number of additional documents being submitted via the IRAS system ahead of the panel meeting.

Following the REC panel meeting attended by myself and my supervisor, Dr Gemma Wilson-Menzfeld, a number of recommendations were suggested and actioned. The

ethics application was resubmitted on 17 February 2021 with final REC ethics approval granted on 18 February 2021 (Appendix M).

As a PhD student not employed within the NHS or Health and Social Care sector the project supervisor, Dr Gemma Wilson-Menzfeld (nee Wilson) was required to be registered as Chief Investigator for the purposes of the IRAS ethics submission.

Due to the military connection of the Royal Hospital, the requirement for ethics approval from the Ministry of Defence (MoD) was investigated however as none of the participant groups were employed by the MoD there was no requirement to obtain MoD ethical approval (MoD, 2020).

4.9.2 Consent

All participants were required to give informed consent in the form of a signed consent form before being accepted onto the project. Two different consent forms were used. The Key Staff and In-Pensioner consent forms covered an agreement to be interviewed, however New In-Pensioners were not interviewed but asked to complete two Quality of Life questionnaires only and therefore their consent form reflected this.

The Consent Form required signatures in two places, once to confirm consent to participate and then again to acknowledge the 'Statement of confirmation' in which participants signed to agree the procedure used by Northumbria University to hold and process their data. Finally, to complete the consent process the researcher countersigned the consent form.

The In-Pensioner consent form did not explicitly detail the Quality-of-Life questionnaire, but it is covered in the Participant Information Sheet.

4.9.2.1 Capacity to Consent

All participants were required to have capacity to consent to take part in the project. The Mental Capacity Act (NHS Research Health Authority, 2021, para.6) states a core principle is *"a person must be assumed to have capacity unless established otherwise."* Key staff, as employees of the Royal Hospital, are assumed to have the capacity to consent. Both In-Pensioner cohorts were living independently at the Royal Hospital at the time of engaging in the project and as participation was voluntary, contact was initiated by the In-Pensioner in the first instance, indicating a level of

capacity to consent. The researcher set a response timeframe of a minimum of seven and a maximum of 30 days for participants to return their consent form.

Further, In-Pensioners without the capacity to consent would be resident in the nursing care section of the MTI which is not included in the project therefore the risk of participant engagement by an individual without the capacity to consent was considered very low.

4.9.3 Participant Anonymity and Confidentiality

4.9.3.1 Participant Unique Identifying Numbers (UIN)

All participants were allocated a randomly assigned Unique Identifying Number (UIN) to prevent identification. To maintain the random allocation, numbers 1 to 80 were drawn from a bag individually and added to a spreadsheet containing a list of Key Staff roles (n=25); In-Pensioners (n=25) and New In-Pensioners (n=30) removing any researcher bias towards number allocation and the potential to identify individuals by their number, for example an assumption that the Royal Hospital Chelsea Governor could be identified by the UIN NURHC-001.

Due to an increase in admissions to the Royal Hospital a further 10 UIN's were created for New In-Pensioners.

Except for the New In-Pensioner cohort, only the researcher had knowledge of who had been allocated which UIN. As discussed in 4.5.3 the Quality Assurance and Clinical Compliance Officer allocated the New In-Pensioner UIN as they were given their Participant Information Pack as part of their arrivals process.

4.9.3.2 Key Staff

The inclusion of specific job roles increased the risk of individual staff identification, particularly when only one member of staff was employed in that position, for example, the Chief Executive role. Extra vigilance by the researcher alongside the ability to refer to these staff within the groups allocated, namely Board of Commissioners and Executive Board; Heads of Care; and Care Delivery, enabled participant anonymity when reporting on findings.

4.9.3.3 In-Pensioners

All In-Pensioners living independently were invited to take part in the project. To facilitate open discussion, it was important that In-Pensioner participation remained confidential. The nature of the establishment and the fact that several staff from governing, executive management and operational levels were engaged in the project it was important that In-Pensioners felt reassured they could speak openly without fear of implications on their care and support. To maintain confidentiality the researcher did not share In-Pensioner details with any member of staff or other In-Pensioner participants. All engagement and correspondence took place directly with In-Pensioners themselves.

There were some challenges as several In-Pensioner participants were happy to inform staff members and other In-Pensioners that they were taking part in the project. At the time of interview several participants transited through the administration offices to the interview room, however this was by choice and not influenced by, and beyond the control of, the researcher.

As Royal Hospital Chelsea is a predominantly male occupied establishment, particular attention was taken to ensure any female participants would not be identified in the findings. As for all In-Pensioners taking part, reference to regiment(s) served or an individual's hometown was omitted as this may potentially enable a participant to be identified, particularly among the Royal Hospital residents and staff. This was to protect In-Pensioner identity and not to anonymise the male to female ratio of the cohort.

4.9.3.4 New In-Pensioners

The recruitment of New In-Pensioners relied on support from the Royal Hospital's Quality Assurance and Clinical Compliance Officer as they agreed to distribute Participant Information Packs as part of the arrivals process with the first pack issued initially and the second six months later. This resulted in the Quality Assurance and Clinical Compliance Officer having knowledge of the UIN allocation for this group, however the risk of participant identification was considered minimal due to a requirement for all staff to maintain In-Pensioner confidentiality as part of their role.

Following distribution of the first information pack, and on receipt of a Consent Form, all future engagement in the project was directly between the New In-Pensioner and the researcher thereby reducing the risk of a confidentiality breach.

Participants were provided with two self-addressed envelopes to ensure the consent form and first Quality of Life questionnaire were returned directly to the researcher separately. The questionnaire was annotated with the UIN however the consent form made no reference to the UIN. This presented a few challenges particularly when a questionnaire was received before a consent form however liaison with the Quality Assurance and Clinical Compliance Officer helped identify the participant.

Participant Information Sheets for all cohorts raised awareness of the potential risk of identification and the steps taken to mitigate this risk (Appendix Q).

4.9.4 Safeguarding

It was not within the research aims to explore sensitive areas that may distress In-Pensioners as they revisited life-events. The focus of the interview was on their experience from the point of moving to Royal Hospital Chelsea rather than their experiences in the military or events leading up to their arrival. However, the reason for choosing to move to RHC was discussed which for some included bereavement, which had the potential to cause upset. Therefore, all participants, including Key Staff, were given the opportunity to be referred to the Royal Hospital's Director of Health and Wellbeing who is responsible for the overall wellbeing and safeguarding of all staff and In-Pensioners. This support was re-emphasised in post-interview correspondence with all participants.

It was also researcher responsibility to report any safeguarding concerns identified during the course of the interviews to the Director of Health and Wellbeing. This included anything that it was considered may put the participant or anyone else at risk. Participants were advised of this prior to the interview taking place.

4.9.5 Document Retention

All project documents and data containing personal details or relating to participants were retained in accordance with university data retention guidelines and statutory data protection and GDPR regulations (ICO, 2023). All copies of completed consent

forms were stored securely in a locked filing cabinet. Paper copies were scanned and stored within the university's 'OneDrive' cloud-based data storage facility.

4.9.6 Ethical Reflections

My primary ethical reflection was one of a duty of care to ensure In-Pensioners were kept as safe as possible, particularly during the interview process. It was my intention to minimise any potential risk of Covid-19 infection as much as possible. This included a commitment to walk for one hour to and from the Royal Hospital to ensure my own personal contact with members of the public was minimised as much as possible. I felt a significant amount of responsibility to do whatever I could.

I was also aware of my own risk to the exposure of Covid-19 having spent almost eighteen months in isolation as a result of home-studying and therefore keen to ensure my own safety as well as that of my participants.

In-person interviews with In-Pensioner participants was considered vital as I was aware that I would get the best engagement from them by establishing a connection which can be difficult using digital methods. I believe my own previous military experience fostered a connection and being an RAF Veteran instigated some 'banter' from the In-Pensioners as they teased me with comments such as "oh well, never mind!". There is always playful rivalry between the Armed Forces, and this was clearly evidenced during the course of the interviews which I believe would have been harder to nurture remotely.

I was confident that the engagement with Key Staff participants would be as effective using a digital platform as face-to-face interviews as the majority of staff were either already used to digital technology or its use had become the norm as a result of the Covid-19 pandemic as it forced everyone to work differently with digital technology a necessary method of working. However, there were some staff who preferred in-person interviews therefore steps were taken to include them in the interview schedule at the Royal Hospital even if this resulted in the interviews being delayed.

Participation for all three cohorts was voluntary with In-Pensioner engagement dependent on them contacting me directly to register their interest in taking part in the project. All In-Pensioners living independently, approximately 200, were invited to take part and a little over 10% responded which I feel demonstrates that there wasn't a

feeling of obligation to engage. Further, the initial response was remarkable with recruitment of In-Pensioners being complete within one week.

It is possible that some Key Staff may have felt some pressure to agree to take part as they were identified because of their job role rather than personally. However, one member of staff did decline to take part and throughout the course of the interviews I was not aware of any form of reluctance to take part. In contrast, I believe staff were enthusiastic to have an opportunity to be heard.

Maintaining participant anonymity was also very important particularly for the Key Staff some of whom occupied individual roles including Chief Executive, Governor or Head of Service.

Due to the complex mix of residential options, alongside the medical and social care available at the Royal Hospital, I wanted to ensure the ethical process was robust to provide reassurance that all areas had been considered.

4.10 Covid-19 Pandemic

The project commenced on 01 March 2019, approximately three weeks before full UK government restrictions were imposed because of the Covid-19 pandemic therefore steps to manage the project during the pandemic were considered from the beginning and factored into all project processes including ethics approval applications.

The Covid-19 pandemic had minimal impact on the first year of the project as the focus was on gaining project and ethical approval, creating participant documentation templates and commencing the systematic narrative literature review.

The impact on Key Staff recruitment was minimal but there was a direct impact on the interviews. Recruitment took place via email and postal communication however interviews were scheduled to take part at a time when the Royal Hospital had restrictions of movement for visitors therefore it was not possible to carry out face-to-face interviews. Ethics approval had already been given for interviews to take place using digital communication methods including Zoom or Microsoft Teams therefore direct contact with staff was made to identify their availability to take part in the interview. Electronic diary invitations were sent to secure dates and times in calendars. Sixteen interviews took place online.

Northumbria University required all projects to request permission to resume face-to-face interviews. As a result, an Ethics Amendment was submitted and approved in August 2021. Risk Assessments from the University and the Royal Hospital were completed detailing steps to be taken to minimise risk to participants and included as part of the application (Appendix R). It was not a requirement of the REC ethics approval to request permission to carry out in-person interviews as this method of interview was included in the original approved ethics application. Following the approval three Key Staff interviews took place face-to-face at the Royal Hospital in August and September 2021.

To minimise risk to any In-Pensioner participants all guidelines stipulated by the Royal Hospital were followed. These included social distancing, ensuring the interview space was Covid-safe, regularly cleaned and ventilated and wearing face masks where required. Furthermore, the researcher agreed not to use public transport within London whilst travelling to and from the Royal Hospital and conducted daily Lateral Flow Tests before arriving at the Royal Hospital to ensure any Covid-19 infection was identified at the earliest opportunity.

Twenty-two In-Pensioner interviews took place over two one-week periods in August and September 2021, one interview took place using a digital platform, and the remaining two interviews conducted in May 2022. The researcher received a call on the final day of the August interviews from an In-Pensioner interviewed on the previous day to advise that they had tested positive for Covid-19. As a result, three interviews arranged for that day were rescheduled. In line with UK government guidelines the researcher underwent a PCR (polymerase chain reaction) test which returned a negative result meaning no infection was present.

Covid-19 resulted in a total of five interviews being rescheduled as a result of either positive PCR tests or a requirement to self-isolate.

It was intended to hold an In-Pensioner recruitment coffee morning at the Royal Hospital to raise awareness of the project however this did not materialise due to ongoing restrictions of movement at the Royal Hospital.

The New In-Pensioner cohort was unaffected by Covid-19 restrictions as this engagement was intentionally planned to be part of the arrivals process for new In-Pensioners and with the support of the Quality Assurance and Compliance Officer.

4.11 Chapter Summary

This chapter has outlined the project design and processes applied to recruit participants, the documentation used to facilitate the recruitment, data collection, analysis procedures and ethical considerations.

A total of 19 Key Staff, 25 In-Pensioners and 17 New In-Pensioners were recruited to the project using purposive sampling. Key Staff in specific job roles were selected, whilst both In-Pensioner cohorts were residents of the Royal Hospital and were all aged over 65 years of age.

Two data collection methods were used. Key Staff and In-Pensioners were engaged in semi-structured interviews with New In-Pensioners and In-Pensioners completing quality-of-life questionnaires.

Qualitative data was analysed using a thematic analysis approach, utilising NVIVO software, and quantitative data was analysed using SPSS software.

Procedures utilised to mitigate the impact of the Covid-19 Pandemic were also discussed within this chapter.

Detailed descriptions of all materials used, and procedures applied are given, including the procedure following notification of In-Pensioner deaths that occurred during the project timescale.

CHAPTER FIVE

QUALITATIVE AND QUANTITATIVE FINDINGS

5.1 Overview

Chapter 5 presents the principal findings from the qualitative and quantitative data analysis, detailing the four elements of data collection. Qualitative data was obtained from Key Staff (Part A), and In-Pensioner (Part B) participants using semi-structured interviews. Quantitative data was obtained from In-Pensioner (Part C), and New In-Pensioner (Part D) participants using quality-of-life questionnaires. Key Staff and In-Pensioner qualitative data were merged for analysis. Similarly, In-Pensioner and New In-Pensioner quantitative data were merged for analysis.

As discussed earlier (see 3.2.3) qualitative data took precedence over quantitative data within this mixed method study as it was important to answer the project aims by capturing the voices of the Key Staff and In-Pensioner participants to evidence the influence the Royal Hospital Cheslea's model of care has on its' In-Pensioner residents.

5.2 Qualitative Data Collection: Part A and Part B

5.2.1 Overview

Three principal themes were generated from the qualitative data collected in Part A and Part B (Table 15); The Culture within, and Identity of, the Royal Hospital Chelsea; The Package: the Impact of Holistic Health and Social Support; and Investment and Reward: the impact on In-Pensioner lives as a result of living at, and representing, the Royal Hospital Chelsea.

Table 15. Qualitative Themes

Qualitative Themes	Sub-Themes
The Culture within, and Identity of, the Royal Hospital Chelsea	• Military Culture • Ex-Military Staff Influence on the Royal Hospital Chelsea Culture • What's in a Name? Identifying the Royal Hospital Chelsea • The Changing Culture of the Royal Hospital Chelsea
The Package: The Impact of Holistic Health and Social Support	• Access to Healthcare Support • The Impact of Access to Social Activities and Support • Resistance to Ageing
Investment and Reward: the Impact on In-Pensioner Lives as a Result of Living at, and Representing, the Royal Hospital Chelsea	• Gaining Pride and Belonging by Representing the Royal Hospital Chelsea • Community Spirit • Staff Commitment and Influence on the In-Pensioner Experience

Themes and sub-themes are presented within this section and are substantiated by the inclusion of participant quotes which support the narrative. Participant anonymity is maintained using Unique Identifying Numbers (UIN), however, for the In-Pensioner participant group the duration of residence is provided to offer context to the quotations.

5.2.2 The Culture Within, and Identity of, the Royal Hospital Chelsea

5.2.2.1 Introduction

The Royal Hospital encompasses several elements that collectively create a military focussed culture, or 'ethos', and identity. These elements include a military ethos established from its historical buildings designed and built specifically for British Army veterans, a military-style regime that In-Pensioners voluntarily follow, and a workforce which includes ex-military staff. Additionally, In-Pensioners intrinsically contribute towards the military culture due to their previous military experience and characteristics, and the commitment to represent the Royal Hospital as Chelsea Pensioners. The blend of residential options and ambiguous title of 'hospital' make

understanding the identity of the Royal Hospital challenging. Four sub-themes are presented in this theme: Military Culture; Ex-Military Staff Influence on the Royal Hospital Chelsea Culture; What's in a Name? Identifying the Royal Hospital Chelsea; and The Changing Culture of the Royal Hospital Chelsea.

5.2.2.2 Military Culture

The importance of a military culture, or 'ethos', was articulated by many In-Pensioners as they regarded the Royal Hospital's military-style environment as being one with which they were familiar. Military life can create an exclusive sense of belonging, identity, and camaraderie, as service personnel share experiences that can include engagement in conflicts, or wars. These experiences develop enduring bonds that pervade throughout an individual's lifetime. Many indicated the military influence as being a key factor in their decision to live at the Royal Hospital, believing this ethos to be a characteristic not found elsewhere.

> *"Well, for one thing, it is sort of military. I did 24 years as a regular soldier, and I sort of was looking for that sort of thing in civvy street which of course you don't get"* (P58, IP, 6 years)

> *"No argument, there isn't another care home that comes anywhere near it. Part of that is its organisation, it's military ethos […]"* (P52, IP, 9 years)

The military-style way of life and sense of familiarity extended to the discipline and rules the In-Pensioners agree to adhere to. This included a daily routine similar to that experienced in the Army such as regular communal mealtimes, the wearing of uniform, and the requirement to let people know when they are staying away from the Royal Hospital, similar to that of 'booking leave' when in the military.

> *"So, I think what works really well is routine and structure. You know, I think that would work well wherever you are, but […], it's fairly obvious here that we very quickly get into this routine. […] You know, I think whatever it is, there is a sort of rhythm to the place that I think, I think works really well."* (P32, Staff)

For most participants, the military-style routine was considered a beneficial component of life at the Royal Hospital as they found themselves living within a familiar environment reminiscent of that enjoyed whilst serving in the military. Whereas others resisted this military-style influence and identity, believing themselves to be like any other member of the ageing population with a determination to live their lives how they choose to rather than adhere to the military way of life at the Royal Hospital.

> *"Life is more orderly under a military regime and some people need sorting out in here because some people completely ignore everything, and they say to me "I am an old age pensioner I will do what I bloody like" and that is it. And you can't argue with it because they are, but when there is 300 of you, you need a bit of discipline, don't you, the place would be in chaos otherwise."* (P46, IP, 3 years)

An internal reporting structure, known as the 'Chain of Command', and similar to that of line-management within the workplace, continued the familiar military-style culture and offered further reminders of a previous life in uniform. This process was entrenched in an In-Pensioners memory and behaviour pattern, reinforcing familiarity with their environment and those supporting them.

> *"…it is something that we are used to, it is part of the organisation that we are used to. It gives us a clear, well, we call it the Chain of Command, but a clear chain of management and yes, it is really a help."* (P44, IP, 2 years)

In-Pensioners typically displayed collective traits whilst retaining their individuality. One such trait was the prevalence of a military thought pattern or 'mindset' often reflected in a 'no-nonsense' approach to dealing with things alongside a belief that some continue this way of thinking throughout their lives, which appeared to facilitate a comfortable transition when returning to a military way of life within the Royal Hospital.

> *"Oh yes, you must understand that military people are not civilians. Apart from definition, we have a different mindset. It was like you were telling me all the 'if's and but's' and all the rest of it and you were boring me to death. No, but in the nicest possible way, why didn't you cut to the chase?"* (P20, IP, 6½ years)

"I think what makes the difference is that mental attitude. You have that soldier… none of us are in the army anymore but you tell half these pensioners they are not in the army, they don't… they may agree with you but they don't believe you […] so I think they all have the same military mentality, and I think that is what makes this place tick" (P73, IP, 3½ years)

Another characteristic shared by many was the military sense of humour which, if misinterpreted by those unfamiliar with the military way of life, could be considered as offensive. However, staff make allowances, recognising that any inappropriate use of language may be generational and not intended to offend. Staff acknowledged that they supported In-Pensioners in their home and as a result displayed a level of tolerance.

"I mean there's sometimes, a lot of them are quite apologetic if you walk onto a ward and it's like, 'oh I'm sorry, I shouldn't have said that. I didn't realise that you were there', but it's their home at the end of the day." (P14, Staff)

"I think what was acceptable in their time of how people behave, is definitely not acceptable nowadays. So, it is kind of weighing up that re-education piece with them." (P62, Staff)

Juxtaposed with the similar mindset, shared experiences of military life, and sense of humour, an absence of other discernible characteristics was evident, indicating that despite the collective identity, In-Pensioners are still seen as individuals, retaining their independence and personal identity irrespective of the communal setting in which they lived.

"No, they are all different. They are all exactly as you would find them in the army, they are just 50 years older that is all, just the same" (P15, Staff)

"I think everybody is different, to tell you the truth" (P73, IP, 3½ years)

"I think people have all got their own characteristics." (P02 IP, 3 years)

The Royal Hospital was considered by many to be a military establishment, which supported the notion that some In-Pensioners considered themselves to still be military. They expressed little difficulty in settling back into a way of life they recognised, albeit many years after leaving the Army. There was also a feeling of

‘coming home’ as they settled back into a military-style environment that was familiar to them. This brought them a sense of security and a social network they are used to, supporting the concept that ageing in a familiar, or ‘right’, place contributes towards positive quality of life outcomes and the ability to age ‘well’. However, the acclimatisation from their previous home life to their new surroundings took some In-Pensioners longer than others.

> *“I still class this place as being in the military, that is what, I think, makes me, and there are a few out there that think the same way, we are still in the military and long may it last and I am very happy”* (P65, IP, 4 years)

> *“It’s home. I’d go nowhere else. If I had millions of pounds, I couldn't be any happier than I am here because I am home but then again, I grew up in the [military] system.”* (P20, IP, 6½ years)

> *“I am coming home, but it takes a while. It is like when you move house, isn't it, and it took me about a year to see this as my home and some people it might be sooner than that, some it might be much longer than that.”* (P61, IP, 7 years)

The military mindset prevails throughout an In-Pensioners life with ageing and the potential transition from independent living to the MTI nursing care facility believed by many to be a step closer to their ‘last posting’. This is in reference to their final military unit prior to discharge, or in this case, death. By adopting this mindset, receiving their ‘last posting’ appeared to bring a level of acceptance to some as it inferred In-Pensioners don’t die at the Royal Hospital but move on to their ‘final destination’.

> *“And you know, [they] will do everything they can to stay on the main site because they’ve got this thing about that being their last posting.”* (P03, Staff)

> *“The other thing, we don't talk of death here, no one dies in here, they get their final posting order […]. There’s an A3 slip of paper goes around in black, the Governor says, ‘so and so gets their final posting order’, because our life has been ruled by posting orders, […] so you get your final posting order in here. No one dies, so that is unique in itself.”* (P65, IP, 4 years)

5.2.2.3 Ex-Military Staff Influence on the Royal Hospital Chelsea Culture

The quasi-military environment, and familiarity with the 'chain of command' process, discussed earlier, was evident in the In-Pensioners predilection to engage with, and respond more effectively to, staff who have served in the military. Some In-Pensioners believed staff with no military experience or knowledge were unable to understand the military mindset, the military-specific language they use, or the experiences they have encountered as a result of their service. The preference to engage with former military staff was recognised by many participants as being important to In-Pensioners.

> *"…and I think it is absolutely critical that the military role is maintained. They can confide in me, they can tell me things that they won't tell the family, so I think it is absolutely essential that that [military] background is acknowledged."* (P15, Staff)

> *"I think it is very difficult for a civilian to get it into their napper [head]. It is a typical sort of thing, we have a language of our own […] they are excluded from all of the military jargon and the mindset, and I guess it must be tougher for them than it is for us"* (P20, IP, 6½ years)

There were suggestions that the workforce was being 'civilianised' as posts previously occupied by ex-military staff were replaced by staff with no previous military experience and consequently considered to be eroding the military ethos of the Royal Hospital. The dilution of the ex-military workforce was considered to negatively impact on the military culture and identity of the organisation and was resisted by some who emphasised the importance of having ex-military staff to support them. This was recognised by both In-Pensioners and staff.

> *"…it [ethos] is gradually being eroded and one of the crafty ways of doing that, bringing in civilians to do what should be done by a military person, or someone with military experience."* (P52, IP, 9 years)

> *"[…] I mean they all say to us, 'I wanted to come to somewhere I felt as if I was getting back into the Army and being with colleagues and friends', so, if it became so civilianised and was just care, I think you would lose that tangible thread towards the military"* (P15, Staff)

> *"The more posts that are civilianised I think the worse it will get, and I know there is a lot of concern around the pensioners around which posts are going to be civilianised next."* (P73, IP, 3½ years)

Irrespective of this perceived lack of military knowledge and 'civilianisation' of the workforce, In-Pensioners recognised that the support they received was not impacted negatively. Acknowledging a blend of skills was necessary to ensure they were supported appropriately. Despite the clear indication that In-Pensioners enjoyed living in a military-style environment, and preferred ex-military staff, there was an awareness that they needed to accept the Royal Hospital was a residence for older people, and therefore cared for accordingly, suggesting levels of conformity similar to that experienced whilst in military service.

> *"I hope that the Royal Hospital […] continue getting the best from experts in their fields from a civilian side of things. I also hope that the Royal Hospital remembers that the military deal is also part of the reason why pensioners come to live here and that we can adapt that as we go through and change."* (P72, Staff)

> *"Most of us that think about it understand that as a care facility for older people, that we have to obey the rules and we need to employ people who understand the process."* (P44, IP, 2 years)

As explained earlier (see 1.4), Captains, who unlike those staff employed in non-military style job roles, had all served in the Army and as a result, understood In-Pensioner personalities and characteristics and provided In-Pensioners with practical daily support. This ranged from encouraging them to engage in group activities, or more individualised hobby-like pastimes, to more specific personal wellbeing, or peer, support. This may, for example, include speaking to an In-Pensioner who may have been missing from breakfast or is thought to be behaving out of character and may therefore require assistance.

> *"When I came here, my Captain of Invalids spent a lot of time with me personally, getting to know me, and I realised much later how important that had been. Seriously important, not just to me personally but to my assimilation, if I can use that term, with in the community of ex-soldiers here, I truly believe that"* (P41, IP, 10 years)

> *"…they may come and say to you can I speak to you in confidence, and then they will tell you something, not necessarily about them, it could be about another in-pensioner, and then you would go and investigate to make sure that in-pensioner was ok."* (P21, Staff)

The Captain/In-Pensioner relationship reflected the familiar hierarchical rank structure within the military and the respect for the rank a person holds. This fostered positive interactions between the two and reassured In-Pensioners that their welfare is being monitored on a daily basis, which enhanced their feelings of security and influenced their quality-of-life.

> *"The Captains are very good because again, they speak our language, and they actually know what we are talking about where sometimes it is a bit difficult because a civilian wouldn't understand […]. I know we'd use the same words, but they wouldn't understand where we're coming from."* (P30, IP, 2 years)

Whilst many In-Pensioners appreciated the positive benefits that Captains brought to their lives as a result of their relationship and interactions outlined earlier, this opinion was not shared by all. Some believed the Captains were less helpful than they had been in the past with indicators that requests for support are ignored and the relationships are not as positive as previously experienced by some In-Pensioners.

> *"…the Captains of Invalids were different, they socialised, they came and talked to you, whereas now they just come and see you when they have got to and it's more of you've to go and see them. The days of closeness has gone"* (P11, IP, 11 years)

The level of understanding between In-Pensioners and staff with previous military experience was considered by most to be an essential element of the support offered to, and received by, In-Pensioners. It was felt that this support enabled them to engage with staff without concerns of being misunderstood within a quasi-military environment which facilitated, for some, the reversion back to their military service and an environment they were familiar with.

> *"It doesn't affect the care, it affects…. see they haven't got the knowledge about us, they don't understand us, they don't understand it."* (P76, IP, 8 years)

5.2.2.4 What's in a Name? Identifying the Royal Hospital Chelsea

As an establishment built specifically for ageing Army veterans within the Royal Borough of Kensington and Chelsea, the Royal Hospital Chelsea and it's Chelsea Pensioners are inextricably linked to its London location, considered by some to be a key element of its unique identity. However, the multifaceted establishment in which In-Pensioners live was considered challenging to succinctly identify, or 'label'. Considered by many to be best described as a care home, others were keen to stress it categorically was not a care home.

> *"Yeah, it would be like everyone else, we would lose that USP [Unique Selling Point] and so I think that we are the Royal Hospital Chelsea and for all its warts about living here, think we probably accept that if we upped sticks and went to a much much better designed retirement village […] the brand would start eroding."* (P72, Staff)

> *"It is **not** a care home that you see, like council care home for old folk and things like that, it is a sheltered housing association place for like-minded people to live."* (P73, IP, 3½ years)

Multiple descriptions of the Royal Hospital included a *'retirement village' (P37, Staff)* or a *'community of mostly like-minded people' (P44, IP, 2 years)*, however there was a distinct lack of reference to the establishment being a 'hospital' despite its name which may contribute towards the challenge of establishing a pertinent identity.

> *"It is a hospital in the old sense of the word, as in hospitality. […] It is a community of mostly like-minded people, it is a community of people who share mostly the same values, it's a community where it doesn't matter how you are or how you think of yourself that you feel included all the time and it is a community with a long history"* (P44, IP, 2 years)

The lack of a definitive identity had no impact on In-Pensioner perceptions of where they were living as many referred to it as *'home' (P20, IP, 6½ years)*, as discussed earlier, or the *'best care home in the world' (P52, IP, 9 years)*, associating the establishment with an environment that was familiar to them bringing a sense of security and belonging. The absence of a succinct identity may be more challenging to those who are unfamiliar with the purpose of the Royal Hospital, rather than those who already identify with the establishment as a result of their previous military service.

"I'd say you know, a lovely very large social care complex with really good facilities when you need more nursing care or dementia care or indeed palliative care…Well supported, well supplied, well-resourced and quirky" (P55, Staff)

"I always say the same thing, I have been accepted into the oldest, and most exclusive care home in the world" (P41, IP, 10 years)

In-Pensioners made a voluntary decision to move into the Royal Hospital, with most already aware of the establishment and its purpose because of their own military service. As a result of this pre-existing knowledge, and the voluntary nature of their admission to the Royal Hospital, the population group may be considered as already possessing the characteristics required to 'fit' into the environment and consequently more likely to enjoy a fulfilling life as a Chelsea Pensioner.

"So, I think there is something about the self-selection of people who have maybe been in the army. I mean lots of them, you know, even at the age of 90 they go to the gym […] because they want to stay mobile and active. […] and I think there is something about the group we've selected to actually be here which needs them to have that underlying kind of strength." (P37, Staff)

"I mean it is quite a self-selected crew of course you know. People come on their four-day visit and make a judgement about whether they fit in or not, and a judgement is made about whether they fit in." (P55, Staff)

5.2.2.5 The Changing Culture of the Royal Hospital Chelsea

The current, and future, composition of the Royal Hospital Chelsea residents is dependent on an interest by prospective veterans to consider living there. Historically a male-dominated environment, female veterans have been part of the In-Pensioner community since 2009, however their arrival caused consternation amongst some male residents with some reluctant to accept them, possibly due to a lack of engagement with female soldiers during their military careers. This reluctance has since diminished with many accepting females as fellow soldiers who have served their country, acknowledging the benefits a mixed population brings to the Royal Hospital, including enhancing the social interactions of the community, fostering valued relationships amongst residents.

"I came in here about 3 or 4 weeks after the first 3 ladies arrived […], it caused a lot of controversy and what have you." (P11, IP, 11 years)

"Well first of all you have ladies here, and I think a lot of soldiers are sort of open to conversations about affairs of the heart as it were […]. I watch women talking and I'm astounded because they are like listening to every word […] the women here are an element of therapy as well." (P78, IP, 1½ years)

Female In-Pensioners were considered by most to be resilient and capable of dealing with the reluctance of their male counterparts' acceptance of their arrival, possibly as a result of their own previous military experience within an Army dominated by men. However, there was uncertainty as to why there are limited numbers of female In-Pensioner's with some believing more needs to be done to attract more female residents. One female participant indicated an increase in numbers would be welcomed and any initial reservations she had on moving into a male dominated environment soon dissipated.

"I mean, I am shocked sometimes when I hear the way that they talk to the women pensioners, but the women pensioners don't seem to be that bothered about it because I think they probably experienced that in the army. They […] are quite tough actually and they give as good as they get." (P37, Staff)

"I would like to see more women, it would be lovely. I don't know why more women are not coming in […] At the start I might have felt a little bit out of it because there was so few of us but now it doesn't bother me." (Female, IP, 4 years)

With a decreasing population of Armed Forces personnel and, consequently, veterans, the prospect of the Royal Hospital being accessible to veterans from all British military services (tri-service) was mixed with some of the opinion that as someone who has served their country, all veterans should be considered eligible to live at the Royal Hospital irrespective of which branch of the military they belonged to.

"…the pool is reducing, we need to keep the numbers in the hospital, and we want to keep the hospital viable, so there is a lot of talk, a lot of discussion going on about the joint services" (P73, IP, 3½ years)

"We call them the Navy, the Army and the Air Force but we have all got to work together, we can't exist one without the other so eventually I think it will morph into something like that and in which case you are going to have a services retirement home. I mean the

only reason it [RHC] is Army is because in Charles II's day there was an Army, there wasn't a Navy as such, there was no Air Force" (P22, IP, 4 years)

However, some were against any suggestion of the Royal Hospital being anything other than a home for Army veterans as they believed the unique identity of each specific branch of the military made a union of all services, challenging. Each has its own language, rank structure, and traditions, therefore, the characteristics between each military service were considered too disparate for a tri-service Royal Hospital to be successful and may challenge the social fabric of the current environment.

"It's like taking three different companies and saying let's have a joint Christmas party. It just doesn't work and that's, you know, it's not a question of tribalism, it's just different families" (P26, Staff)

"…talking about tri-service, that should never happen and I will be the first one out of that gate, this is Army. If this place became tri-service, I would be out that door, I don't care how old I was or anything, this is Army and must remain Army" (P65, IP, 4 years)

There were mixed opinions regarding the potential of receiving future generations of In-Pensioners who have experienced limb loss as a result of engagement in recent conflicts. Some believed the Royal Hospital may not be the most appropriate establishment to support such complex injuries due to its age and Grade I Listed status which restricts the level of alterations that could be made to modernise the environment to make it accessible for amputees. Another concern raised by some was ensuring staff with the required level of skills and experience were employed to support this level of injury.

"And there's been quite a debate […] about the extent to which we should have facilities that would enable us to care for a much younger population of people as we move forward…with a much higher level of physical disability […] I am anxious about us moving…you'd need to employ an entirely different staff group, we simply don't have people with those skills." (P55, Staff)

The requirement to surrender the military or war/disablement pension on moving into the Royal Hospital was considered likely to be a barrier for potential future residents. The potentially substantial financial compensation given as a result of injuries, and

homes that have been adapted to support their day-to-day lives was thought to be a further barrier to whether the Royal Hospital would be a suitable residential option for this cohort of the veteran population.

> *"I don't think there are as many as what we think there are or that we thought there were, and I think also, as well, they are very well looked after out in the community by different organisations and charities and what have you and maybe they won't want to give that up to come and live here."* (P14, Staff)

Many believed that veterans who had experienced limb loss, and who would benefit from living at the Royal Hospital, should be allowed to do so irrespective of their age, suggesting admission earlier than is current accepted. It was also recognised that this group will age and potentially experience changes in personal circumstances, such as health deterioration or a loss of support network, therefore admission to the Royal Hospital should be assessed depending on need rather than age.

> *"…and they have got to look also at if someone has been injured in a war or an operation or a conflict, then I think they should be looked at more favourable than having to wait until they are 65 to come in here."* (P65, IP, 4 years)

5.2.2.6 Summary

The Royal Hospital Chelsea offered members of the older veteran population an opportunity to live within an environment reminiscent of a previous life experienced within the institution of the British Army. The familiarity of the military-style environment extended to the inclusion of several ex-military staff, employed in quasi-military positions. This reinforced a military culture that is ubiquitous throughout the Royal Hospital Chelsea and presented benefits for both the In-Pensioner population, and the ex-military staff who experience the continuity of working within a quasi-military environment as veterans, or 'civilians'.

Many considered the Royal Hospital as 'home', with living there likened to that of a 'last posting', indicative of the final location, or 'camp', prior to leaving the military. This suggested In-Pensioners considered the Royal Hospital to be their final resting place, demonstrating an acceptance that where they live now, is where they chose to live for the remainder of their lives.

A shared history, irrespective of the lives led since leaving the military, facilitated a connection amongst residents regardless of whether or not they had served together whilst in the Army. This connection fostered a sense of belonging and identity amongst In-Pensioners which engendered connections akin to that of being considered 'family'.

The In-Pensioner population presented multiple identities as they retained their individuality alongside that of representing the organisation in which they lived, as demonstrated by the requirement to wear a uniform reflective of that worn whilst actively serving in the military. Similarly, the Royal Hospital shared multiple identities which presented challenges when articulating its function due to the blended living options, however these challenges did not appear to impact on its residents or the care they received.

The Royal Hospital Chelsea culture and environment may be required to evolve as the demographics of the current, and future, generations of the British Armed Forces changes.

5.2.3 The Package: The Impact of Holistic Health and Social Support

5.2.3.1 Introduction

As discussed above, the Royal Hospital offers In-Pensioners a holistic package of health and social care support. An on-site medical centre offered expedited access to healthcare provision which facilitated the early identification of, and response to, illness. This enabled In-Pensioners to live independently for longer. In tandem with the healthcare support a package of social opportunities empowered In-Pensioners to remain active both within and outside of the Royal Hospital.

Some In-Pensioners believed the Royal Hospital 'over cares' with some demonstrating a stoic attitude, resisting the prospect of ageing, or being considered old, and losing their independence, which was found to be challenging for staff whose primary objective is to care for them.

The combination of living at the Royal Hospital and access to a holistic healthcare and social engagement package was reported by many to contribute towards living longer. Three sub-themes are presented in this theme: Access to Healthcare Support; The Impact of Access to Social Activities and Support; and Resistance to Ageing.

5.2.3.2 Access to Healthcare Support

The unparalleled access to healthcare services within the Royal Hospital led In-Pensioners to indicate feelings of privilege as they acknowledged the challenges faced by the general public when seeking medical support.

> *"It's good medical wise. I mean you go down there and say I would like to see the doctor and they say "today or tomorrow?" whereas in civvy street they say "yeah, we will make you an appointment for six weeks" [you] could be dead by then!"* (P40, IP, 6 years)

> *"I mean, if I want to go and see a doctor, I would see (anonymous) within 20 minutes or half-an-hour and he listens to you, which you then balance that up with, yes, well he has only got 256 people [to look after]"* (P65, IP, 4 years)

The impact of having a small patient group was reflected in the depth of knowledge staff had of the In-Pensioners, which often lead to early identification of declining health and subsequent early intervention, resulting in positive In-Pensioner health outcomes.

> *"So, we've got a GP who's got 300 patients. I mean that's, in my eyes that's a dream job as a GP. But, in a serious way, affords him the opportunity to be extremely thorough and, you know, manage people's health, probably in a better way than they would get anywhere else."* (P32, Staff)

Most In-Pensioners spoke of the impact having what was believed to be expedited access to hospital treatment, which some considered to be lifesaving, and in contrast to the service they would have received had they not been Chelsea Pensioners.

> *"I wouldn't be here today speaking to you if it hadn't have been for our doctor. […] in October he picked up that I was having problems with my PSA, prostate, immediately went up to the Chelsea and Westminster on the [date] […], I was on the operating table on the [January] and had my prostate out."* (P65, IP, 4 years)

In-Pensioners benefitted from a workforce that was empowered to deliver services and that ensured they received the care necessary to support positive health outcomes.

"We can just get on and do our jobs because we've got all…. we've got all these little departments [working] together and you know, we can just tap in and out of them as we need them." (P14, Staff)

"No, I don't think so at all. I am given immense encouragement from the Governor and the Chief Executive Officer, and I've never come up against any solid brick wall that says, you know, you can't do this, or we're determined to do you and your world down." (P71, Staff)

In-Pensioners were considered by many to receive 'preferential treatment' at the Chelsea and Westminster hospital including expedited access to appointments or treatment with some indicating that wearing their uniform when attending the hospital acted as a catalyst for this enhanced service. However, other than anecdotal evidence during participant interviews, there was no confirmation that this 'preferential treatment' is standard practice for the hospital or whether this had a detrimental impact on other patients.

"…. I mean these boys and girls are fast-tracked. You know, again when they go to Chelsea & Westminster hospital, in say their blues uniform, they bypass the queues you know. They are fast-tracked into whatever treatment they need." (P62, Staff)

"We go back to the privilege thing here. If I wear my uniform to go to the hospital for example, I always get a little bit more care, a little bit more consideration, I am often called for before time. That may not be as far as society is concerned a particularly good thing, but it certainly is a good thing for us in here." (P44, IP, 2 years)

Some believed the relationship with the Chelsea and Westminster hospital was due to the hospital staff having an 'affection' for Chelsea Pensioners as they live within the same catchment area as the hospital. Furthermore this 'affection' was perhaps as a result of the shared commitment to support veterans with the Chelsea and Westminster Hospital having a number of staff who serve in the Reserve forces, and the hospital having signed the Armed Forces Covenant, pledging their support to the Armed Forces Community (AFC, 2019).

"I have been down there [C&W hospital] when we had this little ceremony of signing the Covenant, and of course a lot of the doctors and nurses down there are all service people, they are all in the Reserves, and when I went down there for that ceremony, they all

turned up. There were nurses in their Naval uniforms…there were doctors in RAF uniform and Army uniform all reservists, so that all sort of knits [us] together." (P22, IP, 4 years)

A further indicator of 'preferential treatment' was the support received from the Army during the Covid-19 pandemic further emphasising the well-established relationship that exists between the Army and the Royal Hospital. However, this support resulted in some feeling discomfort at the imbalance between the In-Pensioners versus those in other care establishments who were facing the same challenges to keep their residents safe.

"So, the Army provided us with combat medical technicians and then 4 healthcare assistants and that was invaluable." (P37, Staff)

"But we're really lucky, and it is difficult to see the kind of injustice almost, and how we were able to just pick up the phone to the army and say, can you send us some medics to help us. No-one else can do that." (P25, Staff)

In-Pensioners considered themselves to be independent and whilst acknowledging the commitment from staff to look after them, it was interpreted by some as being over protected, with some stating a feeling of being 'nannied' or 'babied' which was openly resisted by some. Furthermore, some discussed a propensity for them to be treated like 'old people' which they rallied against, considering themselves to be living in a military establishment not a care home, as discussed earlier in this chapter.

"Sometimes I think they make us feel a little bit too safe and cared for. As I said, sometimes it feels like we are babied a bit and nannied a bit." (P30, IP, 2 years)

"When we are talking amongst ourselves on the ward or you are talking when you are having a drink or something like that, it comes out on a regular occurrence that, we are grown up, we are adults, sometimes they tend to think we are little children […] they have a tendency a little bit of treating us like old people. It is not an old people's home, we class it as a military establishment." (P76, IP, 8 years)

A stoic attitude, considered by some to be a characteristic of military service, was indicated by many participants. This may indicate a level of resilience but may also prevent In-Pensioners from seeking support, particularly in areas relating to mental

health. The embedded healthcare support available, and professional relationships that developed as a result, enabled staff to better understand the In-Pensioners (patients), and therefore by recognising the potential reluctance, encouraged In-Pensioners to seek support thus improving their physical and mental health outcomes, and contribution towards their ability to age 'well'.

> *"So, you know, they don't like to complain and… some people do but most of them are, you know, pretty stoic, but sometimes that gets in the way of them asking for the things that they actually need or saying what's wrong."* (P03, Staff)

Without exception, In-Pensioners described life at the Royal Hospital as contributing towards a peace of mind and reassurance that they associated with being able to live within an all-encompassing environment, for the rest of their lives, that looked after their needs. This peace of mind and ability to alleviate any concerns on family members was considered important to some In-Pensioners, bringing some relief that they would not consider themselves a burden on their families as they aged.

> *"It takes a lot of pressure off you there, that you know within yourself you are going to be cared for, even from the point of view of when your time comes [to die], so you can't fail them on that bit at all."* (P11, IP, 11 years)

> *"But the other thing was, it has taken that worry off my daughter's shoulders, she knows she can come at any time and has done, and she knows I am being looked after."* (P48, IP, 11 years)

The wrap around support available contributed towards a feeling of being cared for, however it was recognised that the level of support needed varied amongst In-Pensioners with some preferring to be left to get on with their lives. There was also a sense of physical safety attributed to the secure built environment within which they lived.

> *"Oh, yeah, without a shadow of a doubt, if I have got a problem, it doesn't matter whether it is a problem outside, whether it is a health problem there is someone here that I can go and talk to […] and I will get all the assistance that I need."* (P73, IP, 3½ years)

> *"I think it depends who you are, and I say this quite genuinely, I feel I don't need much in the way of support. Yes, if I have got a problem, I know who to go to but I so rarely do that."* (P52, IP, 8 years)

"I think there is very little worry about that [security] here. Lots leave their doors open all night. I think the security of the site allows people to feel pretty safe." (P32, Staff)

In-Pensioner quality of life was expressed in a multitude of ways with all endorsements being positive. Almost inextricably linked was reference to a widely considered viewpoint that living at the Royal Hospital extended an individual's lifespan. Some acknowledged that this belief may be as a result of the Royal Hospital's own publicity. However, this supposition appeared to be acknowledged and reinforced by all. In addition to physically living within the Royal Hospital environment, the reported longevity was also considered to be as a result of having ongoing access to the social engagement and healthcare support, alongside a population group who were predominantly active and independent when first moving into the Royal Hospital.

"Oh brilliant [QoL]. One of the things that people kept saying to me when I first came here, 'you a member of the Royal Hospital now, that immediately puts another 10 years on your normal life expectancy', and I totally agree with them, it does, it does." (P73, IP, 3½ years)

"I think, I am told, I am believing our own PR on this one, that it is actually prolonging people's lives. […] I mean lots of them, you know, even at the age of 90 they go to the gym and sort of you know, you see them coming back and they've been to the gym, and they have kind of done their exercises because they want to stay mobile and active." (P37, Staff)

"Well like I said earlier, it puts 10 years on our life, we are more active, and we are healthier, and we get good food as well, it all makes a difference." (P40, IP, 6 years)

The need to remain conversant of health trends and practices to ensure relevant care is delivered to current and future In-Pensioners was recognised with the caveat of ensuring the primary focus of care remains the In-Pensioners themselves. However, opinion on the evolution of the healthcare provision was divided, with some In-Pensioners indicating a reluctance to change, believing the care received has worked well over previous years therefore why consider altering it.

"I think the different morbidities that will be coming through for future generations of veterans, actually and what they will want, will be different from what is on offer at the moment. So, I think, for us, the challenge is our ability to adapt actually." (P74, Staff)

"I hope we continue to grow in that way, in that professional way, without losing, and I've not seen any sight of this, without losing sight of our essential core of serving the pensioner community." (P71, Staff)

"Whatever we are doing today, whatever we did when I first came here, let's just keep doing it, it works, and there is an old saying isn't there, if it works don't change it." (P41, IP, 10 years)

Furthermore, staff articulated an awareness of the privileged position In-Pensioners were in and a wish that the care afforded them be replicated within the general population.

"I do think about it a lot, how I wish the care in the community would be as good as the one we give to the Chelsea Pensioners because we are there, it is a small community, and we can see when something is going wrong, and we can follow up." (P60, Staff)

5.2.3.3 The Impact of Access to Social Activities and Support

In-Pensioners had access to a multitude of activities within the Royal Hospital, ranging from sedentary to more physical options dependent on choice and physical ability, which improved social connectivity with fellow residents, and fostered a sense of purpose.

"I wrote a few down here, whisk, crib, pottery, choir, pace sticking, which is a military thing, fishing, library, Saturday in the bar there is always entertainment, that is just a few of the thing is can think of off the top of my head. I mean, you can take part in as many or as little as you want." (P46, IP, 3 years)

"Well, I do the keep fit. I don't… there are all sorts of things they ask you to go to but a lot of them I am not interested in you know." (P12, IP, 2½ years)

Staff were committed to supporting In-Pensioners to engage in as many events as they chose to, including new interests and ideas, which facilitated engagement in meaningful activities, and improved physical health.

"Never before have I worked in a place where you can rock up to the media or Comms Team and say, 'Hey, I've got an idea. I really want

to wing walk and raise money for the Royal Hospital', and they just go, 'Yeah, great idea. We will help you make it happen'." (P32, Staff)

In-Pensioner choice was clear as they were free to engage in as many, or as few, opportunities as they wished, however there was evidence of an enthusiasm to be as involved as possible.

"They also know they can engage in the social life of the Royal Hospital and can take as much or as little out of that as they want and there is plenty more on offer for them." (P72, Staff)

To mitigate potential loneliness, In-Pensioners demonstrated a determination to remain active within the Royal Hospital, and socially engaged with fellow In-Pensioners, staff, and the wider community, even if reduced mobility as a result of ageing or decline in physical ability, restricted their ability to do so.

"Well, there is lots of activities going on and if you are able. […] I put my name down for a lot of things but now, of course I am like this [less mobile], but I do what I can." (P58, IP, 6 years)

The Outreach Programme presented opportunities for In-Pensioners to take part in civic engagement as they raised awareness of the Royal Hospital and enhanced their sense of purpose, which is discussed later in this chapter.

"I was part of the outreach programme before COVID, I used to go round and talk to schools and things like this and I used to run workshops in the National Army Museum next door with kids and things like this" (P73, IP, 3½ years)

"Before Covid we had outreach and served meals to homeless projects, visited ex-service men and women in prison and also we were involved in a project in Westminster, in a sort of a centre, where ex-service men and women had been literally picked up out of the gutter and trying to get back [into society]" (P71, Staff)

"In normal times [pre-Covid-19] there are people going out of here on visits and going off to give talks to people and help with…..my favourite example is, one week, two years ago, I started off the week by being invited to lunch at a top class hotel in Westminster and finished the week on a council estate in Peckham, helping with an appeal for a local hospital, so, the number of activities available here to us are just amazing, it is really good." (P44, IP, 2 years)

The restrictions imposed during the Covid-19 pandemic resulted in the cessation of all activities, however this impact was mitigated by the provision of activities that In-Pensioners could participate in within the confines of their Berths.

> *"…all of the advantages of the Royal Hospital pre-Covid, in terms of keeping people active, maintaining people, involving the locals in what we do, getting the pensioners out there, all became disadvantages."* (P37, Staff)

> *"They sent activity boxes around the wards and puzzle books and painting by numbers, all sorts of things in them for people to do in their berths and when we could get out the berths again, there were bits and pieces going around."* (P73, IP, 3½ years)

In-Pensioners highlighted the impact the social care team had on their independence by supporting them with routine tasks that would otherwise have proved difficult for them to complete. This assistance relieved anxiety gave In-Pensioners peace of mind, and helped increase resilience as they became better able to cope with challenging tasks, enabling them to maximise their quality-of-life.

> *"Well, the social care team, the office staff, they are women mostly and they are great. They bend over backwards. I have never ever been turned away or nobody has ever said no about a problem. They have always, even outside the box, if it is not their responsibility they will help you, no they are ok, got no complaints about that."* (P46, IP, 3 years)

> *"…. you have a social welfare team that is set about optimising your social, and your life with your peers, and also removing other pressures from you by helping with any number of things, power of attorney, assessments of any other benefits that you might be eligible for, helping you with that, assisting with you in all sorts of different ways."* (P72, Staff)

5.2.3.4 Resistance to Ageing

Most In-Pensioners lived independently within the Royal Hospital, accessing support as and when required, however there was a resistance to acknowledge that their needs may be increasing as they aged or their health declined, which brought challenges when staff offered to help. The stoic attitude discussed earlier may have

contributed towards the reluctance to seek support, however it was difficult to discern whether this stoicism was specifically due to the In-Pensioner's military service, or attributed to their age, and generalised to the older population.

> *"They don't want to be that person that needs something or that can't do what they should be able to do […] But I think the, I think the challenge with all of that is the attitude of pensioners here […] possibly because of their nature, or their experience, or their background or whatever, but they don't always want to admit that they're not okay."* (P32, Staff)

The levels of resistance were particularly evident where there was a requirement for In-Pensioners to relocate from their independent Long Ward berth to the MTI, with this move to a more nursing care focussed environment considered by many to be a signal towards the end of their lives despite suggestions that contradict this.

> *"There is a resistance to come in here [MTI], mostly, because people know that if they come in here they usually go out the other side in a box [coffin]."* (P15, Staff)

> *"People live very happy lives in the MTI building in our registered wards, but the perception, I think, is that those who go to the MTI, because they are frailer and they do need that bit more care, but they're still living just as long."* (P25, Staff)

This resistance was addressed as In-Pensioners were given the opportunity to stay in the MTI either due to a recent hospital admission, or if staff believed an In-Pensioner would benefit from a short period of respite. Providing this 'in-house' care within familiar surroundings enabled continuity of care with the added benefit of familiarising In-Pensioners with the care and support available within MTI, potentially alleviating any concerns they may have had.

> *"…. it is like 'tuck in' care, like they've had an operation, or they've had a procedure […] or they're not feeling very well. They can come in and have those few days respite, get the care they need and then they go back and live their lives as normal […]."* (P14, Staff)

> *"….but they understand that actually when they go in for respite, 'oh I am well looked after here', and it is not as bad as it seems."* (P15, Staff)

Conversely, there were some In-Pensioners who fully accepted that a move to the MTI was part of their journey within the Royal Hospital, with the offer of access to continued support within the same establishment, and amongst people they know for the rest of their lives, bringing a level of reassurance, peace of mind, and security.

> *"I think, this is something here that they don't offer anywhere else. We all know, all the guys that are on a Long Ward know, that we are going to go into the MTI eventually and we are going to leave the MTI in a wooden box. That is the transition through the hospital. We are all aware of it, we all know it and there is nobody that is really upset about it."* (P73, IP, 3½ years)

> *"Well, hopefully I am going to die in my sleep before I even get there [the MTI] but I know that if I did get to that stage then I would be looked after and I'd prefer it to be here than shipped off to somewhere else with the people I don't know."* (P30, IP, 2 years)

5.2.3.5 Summary

Access to the onsite medical practice, and a wide variety of activities, contributed towards positive In-Pensioner health and quality-of-life outcomes. However, all participant groups recognised this access placed In-Pensioners in a privileged position that was not available to the public, specifically those within the same age demographic. Support was enhanced as a result of what were perceived to be special relationships with the local hospital and the Army, which further contributed towards maintaining a 'well' In-Pensioner population.

Opportunities to engage in activities were encouraged by staff and peers. The ability to engage in numerous activities contributed towards an In-Pensioners' sense of purpose, with their status frequently elevated as they represented the Royal Hospital in their ambassadorial role of Chelsea Pensioner, setting them apart from many of their non-Royal Hospital Chelsea peers.

The notion of being considered 'old' was rejected by In-Pensioner participants, indicating a stoic and resilient attitude, however this presented as a potential barrier to seeking support.

In-Pensioner life satisfaction was influenced by access to health and social care provision that created opportunities to remain healthy and active at the Royal Hospital Chelsea, which many indicated resulted in the ability to live longer.

5.2.4 Investment and Reward: the Impact on In-Pensioner Lives as a Result of Living at, and Representing, the Royal Hospital Chelsea

5.2.4.1 Introduction

A key element of living at the Royal Hospital was the commitment by In-Pensioners to represent the establishment by wearing a uniform, referred to as the Scarlet(s) (Figure 2 & Figure 3 (p.29)). This representation engendered a sense of identity, belonging, purpose, and pride, all of which contributed towards a positive life experience. Camaraderie and peer support, akin to that experienced whilst serving in the Army, generated a sociable community which many In-Pensioners embraced.

Staff and In-Pensioners collectively contribute to the Royal Hospital Chelsea, be it as a place of work, or as a home. As a result, the investment in, and reward from, the Royal Hospital was shared. Part of this reward was the visible job satisfaction staff enjoyed as they committed to supporting In-Pensioner independence and ensuring they were cared for. Three sub-themes are presented in this theme: Gaining Pride and Belonging by Representing the Royal Hospital Chelsea; Community Spirit; and Staff Commitment and Influence on the In-Pensioner Experience.

5.2.4.2 Gaining Pride and Belonging by Representing the Royal Hospital Chelsea

In-Pensioners committed to represent the Royal Hospital for a minimum of two years. This commitment was through in civic engagement roles which enabled them to raise awareness of the establishment and represent past residents, which helped adopt proactive social engagement with members of the public, veterans, and the Armed Forces Community.

> *"So, I think, yeah, […] most of them understand the responsibility and what's due from them and if the man or the woman applies to join the Royal Hospital, we try to encourage 2 years of, you know, being*

positive, being proactive and getting the Scarlet coat on and flying the flag for the veteran community." (P62, Staff)

In-Pensioners embraced this commitment, seeing it as an opportunity to 'give something back' to the Royal Hospital, recognising the privilege they felt at being a Chelsea Pensioner, and the pride of having served in the Army. The enthusiasm to represent the Royal Hospital was evident from all In-Pensioners, irrespective of age or length of residence, with physical ability being the only evident barrier to prevent full civic engagement.

"For the first 2 years […] we should be out and about doing everything because we are the 'face' [of RHC]. After that, when you get a little bit more elderly, then you can sit back […] but our responsibility now is to be the face of the Royal Hospital." (P30, IP, 2 years)

The representational role of the Chelsea Pensioner facilitated opportunities for In-Pensioners to engage in numerous events which they would not have access to if they lived elsewhere. These opportunities indicated levels of prestige unlikely to be replicated in other residential establishments and reinforced the In-Pensioner sense of purpose and identity.

"I quite enjoy it but of course it does get you entry to places that I couldn't conceivably have entered if it had not been for the fact that I was a Chelsea Pensioner and I have met people that I could not have met if I hadn't been a Chelsea Pensioner." (P02, IP, 2 years)

The In-Pensioner representational role contributed towards valuable social civic engagement and enhanced an individual's identity which one participant believed is diminished as people get older. In-Pensioners maintained high visibility as they engaged in internal and external Royal Hospital commitments, with many recognising the juxtaposition between their lives and others of a comparable age having fewer opportunities to engage in similar experiences.

"I mean, it's an obvious thing to say but as you get older you get more invisible and I think a lot of older people feel very, very, invisible indeed. You are not invisible as a Chelsea Pensioner and almost universally, people kind of come up to you, say something to you, you know, they love you, they respect you so you're not just an old

person, you are seen as somebody who contributed to your country's safety, and you know…. I think that's huge." (P55, Staff)

In-Pensioners embraced opportunities to represent the Royal Hospital including internal 'jobs' such as mentoring new In-Pensioners, undertaking 'tour guide' roles escorting visitors around the Royal Hospital, supporting the internal postal system and accompanying other In-Pensioners to hospital appointments. This active civic engagement and representative positioning gave In-Pensioners a sense of purpose, reinforced their identity and engendered a sense of pride in themselves and the place in which they live.

"But they don't want to sit about. They want to be hard working. They want to be purposeful. They want to be active, and I know lots of older people want that too, but as a group here, you know, there is probably more of that […] but yeah, I think that just all comes together to make this place, you know, the special sort of melting pot that it is really." (P32, Staff)

"Quite a lot of people have internal jobs as I do. I do mentoring and so on and so forth." (P20, IP, 6½ years)

"And then the other thing that I think works really well is that building on the sense of pride that people have in terms of what the role is that they represent […] they're representational. People have got a real role here, so they are not marginalised. They're not…. it is a second chance at life. […]. (P37, Staff)

The exclusivity of the Royal Hospital instilled a sense of pride in In-Pensioners, who believed the environment in which they lived made a meaningful contribution to their lives. Some believed the decision to move into the Royal Hospital was life changing, which reaffirmed the importance of attachment to the place people live to ageing 'well' and in the 'right' place.

"People when they ask me what is it like being a Chelsea Pensioner, I tell them, well look I live on a palatial estate in the middle of London, in one of the most expensive areas of London and I eat my meals in dining hall designed by Sir Christopher Wren." (P44, IP, 2 years)

"Oh, well, it's my life and quite honestly if I hadn't have come here, the way I was looking back on since my wife died and the 2 years after that, if I hadn't have come here, I seriously do not think I would be around now. I would have committed suicide or done something

stupid by now, because I was really in a very bad deep depression, so coming here and living here is a new life for me. Well, it is an old life but it has brought my life back and it is just about everything as far as I am concerned." (P73, IP, 3½ years)

In-Pensioners were easily identified by their 'iconic' Scarlet uniform (Figures 2 & 3) which gave them a unique identity reminiscent of their time in the Army, with some demonstrating an eagerness to re-establish this identity which may indicate a desire to become part of something that connected them to their previous lives and set them apart from other members of the ageing population.

"We got 'Scarlet Fever', not what you think [the illness]. […] we got measured up for a Scarlet and they say 'it will be 3 months before you get it'. So, every day we were back over at the QM's [Quartermaster's] saying 'we want one off the peg so we can go out doing the stuff'." (P40, IP, 6 years)

"It's my Number 1 Dress, how do you feel? It's like if you go to a ball you wear a ball gown. […] but there is one thing I must say about any ceremonial uniform […] you turn up all of a sudden wearing a uniform and everybody goes 'Ooh'." (P20, IP, 6½ years)

"Without that [uniform] you are just another old man, there are too many of those anyway…we live too long." (P02, IP, 4 years)

The opportunity to represent the Royal Hospital and wider military community, alongside wearing the Scarlets, contributed to a sense of pride and belonging with some indicating the uniform acted as a camouflage against their personal identity. This representational role gave In-Pensioners a purpose in life, and the wearing of uniform helped boost their confidence and enabled them to engage with people who they would otherwise be reluctant to speak to, thus increasing their social network and life satisfaction.

*"When we put on our Scarlet coat it just reinforces that this is my regiment, this is my organisation, I am part of this organisation, same as guys have been for the same 300 odd years and I am proud to put that coat on and wear it. I might not say that every time, but I am sure most of us feel that." (*P44, IP, 2 years)

"It means a social prop […] In that I am quite shy without it […] It does give you great confidence […] I will talk to anybody when I have

got my red coat on, otherwise I wouldn't have done it." (P63, IP, 8½ years)

In-Pensioner status was elevated as a result of wearing the Scarlets making them the centre of attention, often giving them an almost celebrity status, which was not embraced by all as it made some feel uncomfortable. However, most In-Pensioners expressed little difficulty in returning to a life in uniform after a significant time lapse from their military service which may again indicate the desire to reconnect to their past life in uniform.

"2 weeks ago, we had a horse show here, Bob Geldof comes up and says, 'would you mind if I have my photograph taken with you?' and I said I was going to ask you [laughs]. Then he got his phone out and had a photo with him and his daughters, so you see, that wouldn't happen outside." (P78, IP, 1½ years)

"…. so you put on the Scarlet and you are a hero, well I am not a hero, I never was a hero, I could never be a hero, but the Scarlet makes you that and I don't feel comfortable with that." (P61, IP, 7 years)

"We're all soldiers or used to be soldiers [who] like to think we are soldiers, wearing the uniform is not a problem whatsoever […] Settling back in was dead easy.." (P40, IP, 6 years)

Being recognised brought challenges including the ability to get anywhere quickly as In-Pensioners were often approached by people out of curiosity or respect, asking for photographs with them or wanting to talk to them. The generosity towards them in recognition of what they represent, with frequent comments of people offering support, or drinks or food being purchased for them by members of the public, was appreciated by many, however some found this generosity uncomfortable.

"My one, it is not a complaint, it is what happens, the moment you walk outside in Scarlets, you attract attention, whether it is good or bad. People are so kind, people help you cross the road even if you don't want to go!" (P48, IP, 11 years)

"Sometimes you can get embarrassed about it, and you know I can pay my round, you get some chap coming up and saying thank you very much [for your service] and you know darn well he gets less than you, maybe, you know what I mean, and so that can be embarrassing, them looking after you all the time but of course some people like it." (P13, IP, 13 years)

Conversely, the uniform was deemed to be used inappropriately by a minority of In-Pensioners who, it was suggested, took advantage of the uniform and used it for personal benefit. Some In-Pensioners labelled these individuals as 'Scarlet Scroungers'. Additionally, there was an inference that this label was interchangeable with the term 'begging coat' for the same purpose, or as a requirement for the uniform to be worn on more formal fundraising activities to encourage more financial contributions.

> *"You have got to be careful. Some of them, my God, some of them go out there simply to be that celebrity and don't want to represent the hospital, they want to represent their Scarlet coats and get free drinks. We call them Scarlet Scroungers."* (P66, IP, 2½ years)

> *"I'll go put my Scarlet on, begging. We call it our begging coat […]. I have been doing it for 6 years and you stand there, you don't have a tin, we have got a big red plastic fire bucket […]. I mean, we call that begging, yeah."* (P13, IP, 13 years)

5.2.4.3 Community Spirit

The importance and impact of maintaining valued relationships was evidenced by the visible companionship, camaraderie, and peer-support amongst In-Pensioners. This was reflected in the community spirit and support network that encompassed the Royal Hospital. In-Pensioners had a strong desire to take care of each other, adopting a military-style 'leave no man behind' attitude to ensure their fellow residents, or friends, were looked after and supported.

> *"But I think another kind of massive thing is that sense of community and whether you like it or not, whether you want to be part of it or not, it's around you and kind of there for you."* (P32, Staff)

> *"If the member of staff isn't talking to them, the pensioners next door either side will certainly be talking to them. So, there is a buddy buddy system already built into the hospital […] and if somebody hasn't showed up for breakfast, they are not shy in knocking on the door or asking somebody to come and open the door to see what is going on."* (P67, Staff)

> *"…. it is just the whole togetherness, comradeship and helping one another too, [we're] very good at helping each other."* (P49, IP, 4 years)

The Long Wards provided an environment for In-Pensioners to socialise, whilst offering the freedom to return to their Berths when they wanted time to themselves. However, whilst the addition of bathroom facilities to the berths was welcomed, some indicated that the more self-contained living space resulted in some In-Pensioners engaging less and becoming isolated, potentially contributing towards a decline in the community spirit.

> *"Because, it is a community thing, and we are all looking out for each other as well. […] we all interact and talk to each other, and we have our rooms, and we have a lounge […], we can have a beer, a chat, a conversation and then when you finish, you walk back in your room and nobody bangs on your door again, it's just shut down time."* (P78, IP, 1½ years)

> *"Once they modernised it into what we have got, the pensioners go into their berths, they shut their door, they put the telly on and they sit and watch the telly […] so this modernisation has stopped any interaction between the pensioners, non-social interaction, which I don't think is quite what it should be."* (P73, IP, 3½ years)

Although In-Pensioners socialised with those who lived on other Long Wards across the Royal Hospital there appeared to be a tendency to mix predominantly with those within their immediate living environment. Although this was not generally found to impact negatively on the wider social engagement of In-Pensioners.

> *"You generally mix a bit more in your own Company, simply because of the proximity, but generally people have friends all over the site […]."* (P25, Staff)

There was a good social network both within, and outside of, the Royal Hospital environment, with friendships found to contribute towards a sense of life satisfaction. Furthermore, there was a recognition that the environment afforded opportunities to establish a wider network of friends that In-Pensioners would not have otherwise developed if they lived elsewhere.

> *"Yeah, so lots of people are independently sociable. They have a good network of friends in the hospital, a good network of friends outside of the hospital and family connections."* (P03, Staff)

> *"But yeah, I find my private life, for want of a better term, is much fuller here than it would have been back there [home]."* (P22, IP, 4 years)

The value of relationships and the ability for In-Pensioners to get on with each other was important for an amiable community atmosphere, with some likening this need to be sociable to the spirit experienced whilst in the Army. However, with a community of nearly 300 residents, there was less tolerance towards those were less sociable or who chose not to engage in the communal culture.

> *"I think the one thing that we all must do is that we all get on with each other. You don't have to get on with everybody, but you do have to get on with the majority and I think that is something that we learnt in the Army anyway because you live with a group of guys and it is pretty much the same"* (P73, IP, 3½ years)

> *"You can't be a misfit here, you can't be a one-off, you can't be a moaner. That sort of thing I mean is just not put up with, you do what you are told, or you keep quiet, do you know what I mean?"* (P59, IP, 14 years)

> *"I don't know if you have seen them, we have so many miserable people here. I could bring you a man in here that won't say a nice word about the place but stays."* (P66, IP, 2½ years)

Despite loneliness being a common reason for moving into the Royal Hospital, some, as mentioned above, preferred to live a less communal, or more solitary, life. Equally, there were In-Pensioners who were content to stay within the Royal Hospital environment, taking advantage of what it had to offer within familiar surroundings with neither preference adversely affecting their experience or satisfaction.

> *"….a lot of loners actually make a really good deal of it here, they really do well for themselves because they just live a quiet life on their own and just say 'leave me alone to live my quiet life, that is all I am interested in doing', and that is fine as well but they obviously miss out on some of the benefits from being at the Royal Hospital."* (P72, Staff)

> *"…because there are people in here, I know people that haven't been outside them gates in six or seven years. They don't want to, and if they don't want to…. [that's up to them]."* (P65, IP, 4 years)

The Royal Hospital has its own on-site social venue known as the Chelsea Pensioner Club, or CPC, and is a licensed bar that provides a focal space for In-Pensioners to meet and maintain their social networks. However, there was evidence that the CPC

is less popular than in the past, with some indicating this was as a result of the berths being refurbished with In-Pensioners choosing to socialise either in the Long Wards or in their own berths.

> *"When you first come here, one of the first places they take you to is the club, and so for the first sort of month you go in the club to meet people more than anything else, and you see the same people on there every night, same seats, knocking back."* (P73, IP, 3½ years)

> *"When you talk to people that have been here about 10 years, they say you couldn't get in the bar, in the early days but as soon as they made everybody single rooms and en-suite and all this, it died, everybody stayed in their rooms."* (P46, IP, 3 years)

One In-Pensioner specifically discussed avoiding events where alcohol may be present.

> *"I have learned a few things, I don't go away overnight with people now because you don't know who they are and you don't know if they are going to get drunk every night and embarrass you."* (P02, IP, 4 years)

There is ample empirical evidence on the relationship between alcohol and military service personnel, where drinking is considered part of the military culture. There were indicators of this culture continuing amongst some In-Pensioners who frequented the CPC, or drank in their berths, and consumed alcohol to excess. Nevertheless, there was no indication of a decrease in alcohol consumption as a result of the decline in attendance at the CPC, rather that the location had changed. Staff faced challenges in trying to support those who may be considered to have an issue with alcohol with In-Pensioners demonstrating an apathy towards engagement, which may be an indicator of an embedded military drinking culture and lack of acceptance of it being an issue.

> *"Most of them are from an era in the military where that was totally acceptable, lunch time drinking, going back to work drinking, the only time you couldn't drink alcohol in the military was if you were actually going on the ranges [firearms training]."* (P07, Staff)

> *"…and I know the doctor always says this about the alcohol thing to me, 'well you try telling an 85-year-old that they should stop drinking alcohol and you know what they will say, you know, 'I am at nearly…. I am at the end of my life, I will do what I like'."* (P37, Staff)

"… and I was chatting with him, and I said you know it is not normal to drink that much of a night, he said, 'Oh well I do, I have a couple of bottles [of wine] before I can go to sleep'." (P07, Staff)

Juxtaposed to the willingness to engage in social activities and represent the Royal Hospital, one of the biggest challenges articulated by In-Pensioners and staff was the requirement to generate income by hosting events within the Royal Hospital without it impacting on an In-Pensioner's home environment and their daily routine. However, this resistance was less evident when attendees were military rather than civilian, indicating a possible bias from In-Pensioners.

"I think it has become less of my home now they're struggling to raise money, perhaps unnecessarily, in that they have functions here which rather take away my feeling of this being my home. It is somewhere I live rather than it being my home." (P02, IP, 4 years)

"….I know that those teams are forever conscious that they are trying to raise money in the middle of an old person's home […] but they [In-Pensioners] never complain when it is a big military do going on." (P71, Staff)

Furthermore, some strongly felt that In-Pensioners should not be used as agents to improve the financial position of the Royal Hospital, however the task of ensuring sufficient income to maintain the establishment was recognised as a significant challenge.

"What the Scarlet coat represents. […] The Chelsea pensioners are there purely for…. to represent the veteran community and to be used in such a way to fly the flag for the veteran community. Not to be here, you know, as a cash cow and used and abused against the branding." (P62, Staff)

"Fundraising is always difficult but it's particularly difficult when people think that you're rich, you know, because of the estate, but the cost of maintaining, you know, grade I listed buildings is immense." (P74, Staff)

5.2.4.4 Staff Commitment and Influence on the In-Pensioner Experience

Staff were committed to making a positive influence on In-Pensioner lives. This commitment contributed towards job satisfaction and was central to the purpose of

staff roles, and with the knowledge that In-Pensioners have served their country, added to a sense of privilege to support them. The desire to spend time with In-Pensioners and make a difference to their lives was fundamentally important to staff, however there was recognition that the ability to meet every resident's needs may be unrealistic.

> *"Knowing that I am making a difference, I think is…. yeah, it is knowing that I am helping them, but by being able to help, my job is fulfilled, and I feel happy being able to do that." (*P60, Staff)

> *"… we try to design a way of doing things at the Royal Hospital that takes into account pensioners wishes and gives them the very best quality of life that they can possibly have but it can't work for everybody all the time."* (P72, Staff)

The commitment to support In-Pensioners transcended staff job remits, with those living within the Royal Hospital indicating a willingness to support In-Pensioners outside of their normal working hours, further emphasising the commitment to provide assistance and be part of the wider community. This commitment was readily acknowledged by In-Pensioners who demonstrated gratitude towards staff.

> *"And staff are on site 24/7, […] there is a ward opposite where I live and the other week someone is knocking on my door and he is holding his nose, 'I have got a nose bleed', this is at 8 o'clock at night […] so I cleaned him up, put an ice pack on and sent him back […] and I thought, where would you get that in normal life."* (P07, Staff)

> *"I will tell you now, the main thing is the staff. Here the staff, not like a care home, the staff care* ***for*** *us and the staff also care* ***about*** *us […] We won't have a good time if they don't look after us, and from the lady who is the Ward Maid and who vacuums my floor every Thursday, to the Governor."* (P66, IP, 2½ years)

Conversely, a minority of In-Pensioners believed some staff did not share the same level of commitment and regarded their roles as 'just a job'. However, this belief was not found to be typical, as staff turnover was considered lower than that of other organisations with some staff remaining in post for many years.

> *"The biggest problem we have is that I don't think the staff, it is just a job, it is not a passion, and they need to want to do this, and they need to understand what we are about."* (P30, IP, 2 years)

"…and the staff group, although we moan about our turnover, actually our turnover is tiny compared to out there in the world." (P55, Staff)

Staff were committed to support the independence of In-Pensioners with a key emphasis being on encouraging the freedom for them to live their lives how they chose on the understanding that they adhered to the conditions of their residence. This freedom was harmonised with the reassurance that staff were available to support In-Pensioners if, and when, needed. However, the desire to remain independent and self-sufficient was clear as In-Pensioners intimated that they guarded their independence closely and didn't need help.

"I think, they keep a careful eye on you but let you get on with it, I think that is the best way of putting it" (P63, IP, 8½ years)

"Yeah, well they retain their independence in the sheltered accommodation to the extent that, you know, they are free to come and go whenever they want. They can access the services and the activities provided for them as they wish." (P10, Staff)

Because I have still got my grey matter, I am still capable of looking after myself and I didn't need anybody looking after me to reach this age other than medical, so I mean I make my own decisions, I do what, how I want, when I want." (P13, IP, 13 years)

Unsurprisingly perhaps, In-Pensioners were at the heart of the Royal Hospital with indications that staff sought to champion an enablement approach, rather than the more dependency style of support said to exist historically. This may have complemented the aim of maintaining In-Pensioner independence and helping them to age 'well' for as long as possible.

"We, as an organisation, are trying to move away from that kind of overbearing care to almost, to more of an enabling care." (P25, Staff)

"Now, it is like 'no, let's try to maintain you with your independence' […]. So, yes, I think between the social care team and with us as well, with the assistance with the medication and everything, they can stay longer being independent and not coming into the care home [MTI] and I think that is a group effort from all the different fractions of the hospital." (P60, Staff)

The commitment to enable In-Pensioners to live in the Long Wards as independently as possible, for as long as possible, rather than be relocated to the MTI, was extended to those with dementia who were supported by fellow In-Pensioners who, as previously discussed, looked out for each other and indicated an enthusiasm to understand the condition more by engaging in training, to further support their neighbours and friends.

> *"So I think that one of the places which deserves particular attention is the benefits of this place for, you know, the early stages of dementia and the continued quality of life, significantly beyond that which they could expect in a normal housing scenario."* (P10, Staff)

> *"I've been surprised at how much interest there's been amongst the In-Pensioners in things like dementia friends. […] it's part of the military ethos as I understand it, you know, you're looking out for your mates, and so I think that will get better."* (P55, Staff)

It is clear that the commitment to support In-Pensioners encompassed all staff groups, and indeed the In-Pensioners themselves, who collectively looked out for any changes in In-Pensioner health and wellbeing needs and reported any concerns via the appropriate channels.

> *"Because they are always monitored daily by each other and we normally pick up a kind of ailment or an issue very, very quickly and to be honest at getting the doctor over, getting the domiciliary care over, getting a staff nurse member. No, I mean it's instantaneous."* (P62, Staff)

5.2.4.5 Summary

Representing the Royal Hospital Chelsea was seen as an integral part of living within this environment, with In-Pensioners unequivocally embracing the opportunity to do so, irrespective of their age or ability.

The role of Chelsea Pensioner increased the visibility of this population group as In-Pensioners experienced enhanced social status, and afforded access to prestigious events and venues, contributing towards a sense of purpose, identity, and pride.

Living within a communal environment facilitated social engagement, peer-support, and camaraderie, which reduced loneliness and contributed towards positive In-

Pensioner wellbeing. Many had social networks external to the Royal Hospital Chelsea, indicating maintenance of independence.

Staff commitment to supporting In-Pensioners extended beyond those staff directly responsible for service provision, suggesting a panoptic attitude towards ensuring In-Pensioners were cared for, and given optimal opportunities for living well, healthily, and safely.

5.3 Quantitative Data Collection: Part C and Part D

5.3.1 Overview

There were two collection points for the quantitative data with In-Pensioner (Part C) and New In-Pensioner (Part D) participants who completed the ICECAP-A (ICEpop CAPability Adult), and WHOQOL-BREF (World Health Organisation Quality of Life BREF) quality-of-life questionnaires.

Quantitative data was collected from In-Pensioner and New In-Pensioner participants who completed ICECAP-A and WHOQOL-BREF quality-of-life questionnaires.

All 25 In-Pensioner participants completed questionnaires after their semi-structured interviews, in their own time, returning them to the researcher by post.

New In-Pensioners completed their questionnaires in two stages, on arrival at the Royal Hospital and six months later. A total of 40 New In-Pensioners were invited to participate in this part of the project. Seventeen New In-Pensioners (n=2 female and n=15 male) completed both sets of questionnaires, indicating a response rate of 42.50%.

Quantitative data collection took place from August 2021 to May 2022 for the In-Pensioner participants, and May 2021 to November 2022 for the New In-Pensioner participants, allowing sufficient time to collect the second set of questionnaires from the New In-Pensioners. The questionnaires and process for data collection are discussed in more detail within the Method chapter (4.6.1.4; 4.7.2; 4.7.3).

Quantitative findings are presented in two sections, firstly the ICECAP-A results which cover stability; attachment; autonomy; achievement; and enjoyment, followed by the WHOQOL-BREF results which explores four areas, or Domains, namely: Physical

Health; Psychological; Social Relationships; and Environment. Results are presented in tables with supporting narrative.

Differences in mean scores will be discussed below. One-Way ANOVA tests were carried out to determine any statistically significant differences of the mean scores between the participant groups. Statistical equations for non-significant results are not reported here (for further details on outputs from homogeneity of variance testing and the analyses see Appendices W & X). Due to the small group sizes, all statistical analysis results should be treated with caution.

5.3.2 ICECAP-A Results

As discussed in the Method Chapter (see 4.6.1.4) The ICECAP-A questionnaire is a capability measure for adults that comprising of five statements relating to stability, attachment, autonomy, achievement, and enjoyment, and is considered an appropriate measure for healthcare and economics research (Flynn et al., 2015; Engel et al., 2017).

All In-Pensioners completed the ICECAP-A questionnaire, and all New In-Pensioners completed the ICECAP-A questionnaire in Part 1 however one New In-Pensioner omitted to complete the ICECAP-A questionnaire at Part 2 of the data collection process (Table 16). All scores were out of 4 and the greater the score, the greater the level of stability, attachment, autonomy, achievement, or enjoyment reported.

Table 16. ICECAP-A mean scores – all quantitative participant groups

ICECAP-A						
Participant Group		**Q1 Feeling Settled and Secure**	**Q2 Love, Friendship and Support**	**Q3 Being Independent**	**Q4 Achivement and Progress**	**Q5 Enjoyment and Pleasure**
In-Pensioner (Established)	Mean	**3.40**	**3.20**	**3.56**	**3.04**	**3.52**
	N	25	25	25	25	25
	Std. Deviation	0.764	0.707	0.583	0.611	0.510
New In-Pensioner Part 1	Mean	**3.41**	**3.53**	**3.59**	**3.35**	**3.53**
	N	17	17	17	17	17
	Std. Deviation	0.712	0.624	0.618	0.702	0.800
New In-Pensioner Part 2	Mean	**3.75**	**3.56**	**3.69**	**3.56**	**3.63**
	N	16	16	16	16	16
	Std. Deviation	0.447	0.629	0.479	0.629	0.500

Collectively, all participant groups reported high mean scores across all five questions, with autonomy (Q3) being the highest (mean=3.60, SD=0.560) indicating all participants had high levels of stability, attachment, independence, sense of achievement and enjoyment.

In-Pensioner mean scores were lower than New In-Pensioner Part 1 and Part 2 mean scores for all questions (no statistically significant differences). This may indicate that In-Pensioners demonstrated a general level of accomplishment in all areas as a result of being established in their environment. This is in contrast to the New In-Pensioners facing a substantial change in their living circumstances, moving into the Royal Hospital. However, when considering In-Pensioner and New In-Pensioner Part 1 scores for stability (Q1) and enjoyment (Q5) mean scores only differed slightly (0.01) showing little difference.

New In-Pensioners indicated an increase in scores across all questions when comparing Part 1 and Part 2 scores suggesting a positive impact as a result of moving into the Royal Hospital.

5.3.2.1 Stability

New In-Pensioners demonstrated the greatest increase in feelings of Stability (Q1) from Part 1 (mean=3.41, SD=0.712) to Part 2 (mean=3.75, SD=0.0447), suggesting an increase in feeling safe and secure within their new environment as they settle into their new home (no statistically significant difference). Conversely, In-Pensioners demonstrated a comparative score to the New In-Pensioner Part 1 score (mean=3.40, SD=0.764), which may indicate well-established feelings of security.

5.3.2.2 Attachment

For New In-Pensioners living at the Royal Hospital for six months the smallest impact was on their feelings of attachment (Q2). Scores for Part 1 (mean=3.53, SD=0.624) and Part 2 (mean=3.56, SD=0.629) were comparable. However, New In-Pensioner scores were higher than In-Pensioner scores by comparison (mean=3.20, SD=0.707

- no statistically significant difference). This may suggest a decrease in feelings of attachment the longer In-Pensioners live at the Royal Hospital, however the small sample sizes present challenges when drawing conclusions.

5.3.2.3 Autonomy

New In-Pensioners demonstrated comparable levels of autonomy (Q3) when moving into the Royal Hospital (Part 1) (mean=3.59, SD=0.618) when compared to In-Pensioners (mean=3.56, SD=0.583). There was a slight increase in this score after six months (Part 2) (mean=3.69, SD=0.479). This may infer that the New In-Pensioner participants experienced the benefits of the holistic support available from staff and fellow In-Pensioners, resulting in increased feelings of independence (no statistically significant differences were found).

5.3.2.4 Achievement

Achievement (Q4) indicated the lowest scores of all five questions for both participant groups, with In-Pensioner scores remaining lower than that of New In-Pensioner Part 1 scores (mean=3.04, SD=0.611 -v- mean=3.35, SD=0.702), however New In-Pensioners continued to demonstrate an increase in their Part 2 scores with achievement being mean score of =3.56 (SD=0.629). An ANOVA indicated a significant difference in mean scores across participant groups on levels of achievement, $F(2.55)=3.39$, $p=.041$. Following a Post-hoc Tukey test, a significant difference was found between the In-Pensioner (mean=3.04, SD=0.611) and New In-Pensioner Part 2 (mean=3.35, SD=0.702) mean scores ($p=.037$).

The variation in mean scores may indicate that New In-Pensioners experienced feelings of achievement as a result of making the decision to move into the Royal Hospital, with these feelings continuing as they became established in their new home. Conversely, the lower In-Pensioner score may imply an indifference to the opportunities available to them perhaps as a result of being established within their environment.

5.3.2.5 Enjoyment

Similarly, New In-Pensioners demonstrated almost no difference in scores for enjoyment (Q5) on arrival (Part 1) (mean=3.53, SD=0.800), when compared with established In-Pensioners (mean=3.52, SD=0.510). New In-Pensioner scores increased after six months residency (Part 2) (mean=3.63, SD=0.500), which may indicate that the New In-Pensioner cohort were enthusiastic about moving into the Royal Hospital with this enthusiasm continuing as they settled in. In-Pensioners may be used to their surroundings and opportunities available, therefore their enjoyment levels may be stable (no statistically significant differences were found).

5.3.3 World Health Organisation Quality-of-Life Brief (WHOQOL-BREF) Results

As discussed in the Method chapter (4.6.1.4), the WHOQOL-BREF questionnaire is a shorter version of the World Health Organisation's quality of life questionnaire, WHOQOL-100, and contains 26 questions relating to physical and psychological health, socialising and circumstances relating to finances, access to information, healthcare provision and feelings of security.

Question 1 and Question 2 on quality of life and health satisfaction are reported separately in accordance with the WHOQOL-26 scoring guidelines (WHO, 1996, p.10). The remaining 24 questions are divided into four areas, or Domains, namely Domain 1 – Physical Health; Domain 2 – Psychological; Domain 3 – Social Relations; and Domain 4 – Environment. Overall domain scores are considered first for participant groups followed by further comparisons of scores on individual questions by domain.

5.3.3.1 Quality of Life and Health Satisfaction

Question 1 and Question 2 gave an overall indication of participant quality of life, and health satisfaction, respectively, with the maximum mean score being 5.0. See Table 17 for mean scores and standard deviations for all participant groups.

Table 17. WHOQOL-BREF Question 1 and Question 2 Results

WHOQOL-BREF Q1 and Q2			
Participant Group		**Q1[1] How would you rate your quality of life?**	**Q2[1] How satisfied are you with your health?**
In Pensioner	Mean	**4.64**	**3.76**
	N	25	25
	Std. Deviation	0.569	0.926
New In-Pensioner Part 1	Mean	**4.18**	**3.71**
	N	17	17
	Std. Deviation	0.809	0.985
New In-Pensioner Part 2	Mean	**4.71**	**4.00**
	N	17	17
	Std. Deviation	0.470	0.612

[1]Not reported within Domain data, in accordance with WHOQOL-BREF scoring guidelines (WHO, 1996, p.10)

All participant groups reported high levels of quality of life, with a mean score of 4.53 (SD=0.653). However, New In-Pensioner scores six months after moving to the Royal Hospital (mean=4.71, SD=0.470) were higher than New In-Pensioner scores on arrival (mean=4.18, SD=0.809) and slightly higher than In-Pensioner participants' scores (mean=4.64, SD=0.569). This suggests that following six months at the Royal Hospital, New In-Pensioners quality of life increases with further increase over a long period of time as a result of being established at the Royal Hospital and accessing available services.

Likewise, suggestions of positive life satisfaction were indicated for all participant groups with a mean score of 3.81 (SD=0.861). New In-Pensioner Part 2 scores (mean=4.00, SD=0.612) were higher than New In-Pensioner Part 1 scores (mean=3.71, SD=0.985) and higher than In-Pensioner participants' scores (mean=3.76, SD=0.926). These results indicate that New In-Pensioners appeared happier with their health status after six months of living at the Royal Hospital.

5.3.3.2 All Domains

In line with the WHOQOL-BREF scoring guidelines (1996), total mean scores for each Domain were calculated out of a maximum score of 100 to facilitate comparisons to the WHOQOL-100 questionnaire and are presented in Table 18.

Table 18. WHOQOL-BREF mean scores for all participant groups and across all Domains

WHOQOL-BREF All Domains					
Participant Group		Domain 1[1] Physical Health	Domain 2[1] Psychological	Domain 3[1] Social Relationships	Domain 4[1] Environment
In Pensioner	Mean	**69.29**	**77.97**	**70.33**	**84.89**
	N	25	25	25	25
	Std. Deviation	17.678	9.614	11.987	8.433
New In-Pensioner Part 1	Mean	**69.75**	**73.38**	**66.91**	**84.87**
	N	17	17	17	17
	Std. Deviation	14.678	17.474	15.761	14.614
New In-Pensioner Part 2	Mean	**73.63**	**76.96**	**72.79**	**87.97**
	N	17	17	17	17
	Std. Deviation	14.665	13.020	17.060	7.652

[1] Unanswered questions have been averaged to report overall mean scores in accordance with the WHOQOL-BREF scoring guidelines (WHO, 1996, p.10)

In-Pensioners demonstrated higher mean scores across Domains 2 and 3 when compared with New In-Pensioner Part 1 scores. Domain 1 scores were slightly greater for New In-Pensioners Part 1 (mean=69.75, SD=14.678) than for In-Pensioner's (mean=69.29, SD=17.678). Little difference in scores were found for Domain 4. The Domain scores suggest those who are established at the Royal Hospital have better psychological health and better social relationships, than New In-Pensioners who have just arrived with minimal differences in their environment. New In-Pensioners reported slightly better physical health than In-Pensioners, this may be due to ageing and unrelated to the Royal Hospital.

When comparing New In-Pensioner only scores, Part 2 scores were all higher than Part 1 scores. These results suggest that after six months at the Royal Hospital, New In-Pensioners experienced better physical health, psychological health, social relationships, and environment. The greatest increase in scores were found for

Domain 3, Social Relationships, between Part 1 (mean=66.91, SD=15.761) and Part 2 (mean=72.79, SD=17.060). However, as discussed later in this chapter (5.3.3.7), Domain 3 had the greatest number of missing responses and consequently the greatest number of averaged scores which may have impacted on the overall mean scores.

The In-Pensioner group indicated lower mean scores across Domains 1, 3 and 4 when compared to New In-Pensioner Part 2 scores. Only Domain 2, Psychological, demonstrated a higher score for In-Pensioners (mean=77.97, SD=9.614) than for New In-Pensioners Part 2 (mean=76.96, SD=13.020). These results may indicate an increasingly positive impact of living at the Royal Hospital with increases in psychological health from New In-Pensioners' first six months to those more established at the Royal Hospital. This is in contrast to lower scores on the physical health, social relationships, and environment for In-Pensioners who have lived at the Royal Hospital significantly longer and who may, therefore, be used to the impact of the environment. Poorer physical health of the In-Pensioners may be due to ageing and unrelated to the Royal Hospital.

One-Way ANOVAs were carried out on all domain scores to determine if there were any statistically significant differences in mean scores across participant groups, no statistically significant differences were found (for further details on outputs from the analyses see Appendix W)

5.3.3.3 Domain 1 – Physical Health

Domain 1 encompassed seven questions which explored areas including an individual's physical condition, the impact of pain they may be experiencing, their mobility, daily functioning, and employment ability (Table 19).

Table 19. Domain 1: Physical Health

WHOQOL-BREF Domain 1: Physical Health								
Participant Group		Q3[1] To what extent do you feel that physical pain prevents you from doing what you need to do?	Q4[1] How much do you need any medical treatment to function in your daily life?	Q10 Do you have enough energy for everyday life?	Q15 How well are you able to get around physically?	Q16 How satisfied are you with your sleep?	Q17 How satisfied are you with your ability to perform your daily living activities?	Q18 How satisfield are you with your capacity for work?
In Pensioner	Mean	**3.72**	**3.68**	**4.12**	**3.68**	**3.40**	**4.12**	**3.68**
	N	25	25	25	25	25	25	25
	Std. Deviation	0.980	1.030	0.781	0.900	1.080	0.971	1.108
New In-Pensioner Part 1	Mean	**3.76**	**3.65**	**4.00**	**3.94**	**3.53**	**4.18**	**3.47**
	N	17	17	17	17	17	17	17
	Std. Deviation	1.300	0.931	0.612	0.827	1.068	0.728	1.281
New In-Pensioner Part 2	Mean	**4.18**	**3.88**	**4.06**	**4.00**	**3.29**	**4.41**	**3.88**
	N	17	17	17	17	17	17	16
	Std. Deviation	1.015	0.928	0.659	0.935	1.213	0.618	0.719

[1] Q3 & Q4 negatively framed questions transformed to positively framed questions (reverse scored)

Sleep satisfaction (Q16) presented the lowest mean scores for all participant groups (In-Pensioner, mean=3.40, SD=1.080; New In-Pensioner Part 1, mean=3.53, SD=1.068; and New In-Pensioner Part 2, mean=3.29, SD=1.213), within this domain. Further, the New In-Pensioner Part 2 score, decreased by mean=0.24, when compared to the New In-Pensioner Part 1 score, which may indicate an underlying cause, for example, a challenge with settling into their new communal surroundings and lack of personal space.

All participant groups indicated high mean scores relating to energy levels (Q10), with In-Pensioners demonstrating a slightly higher mean score (mean=4.12, SD=0.781) than both New In-Pensioner Part 1 (mean=4.00, SD=0.612) and Part 2 (mean=4.06, SD=0.659) mean scores. These results potentially indicate that living at the Royal Hospital, and utilising the support available, increased energy levels.

Similarly, all participant groups indicated high levels of functionality in carrying out daily tasks (Q17), with all scores means being =4.12 (In-Pensioner) or above. New In-Pensioner Part 1 mean scores (mean=4.18, SD=0.728) were higher than their Part 2 mean scores (mean=4.41, SD=0.618), indicating a positive effect on their ability to manage daily tasks as a result of living at the Royal Hospital. However, as In-Pensioners are expected to be able to live independently when first accepted into the

Royal Hospital, it is perhaps unsurprising that the New In-Pensioner mean scores were high.

Additionally, results indicated participants experienced minimal limitations on their lives as a result of pain (Q3), with New In-Pensioners demonstrating a positive reduction in the impact of pain restricting their daily lives, when comparing Part 1 (mean=3.76, SD=1.300) and Part 2 scores (mean=4.18, SD=1.015), with the higher score indicating less impact. This positive change may indicate the impact of having access to the on-site medical services at the Royal Hospital resulting in a reduction of physical pain. However, In-Pensioners demonstrated a lower mean score (mean=3.72, SD=0.980) than New In-Pensioner Part 1 and Part 2 scores which may be reflective of In-Pensioner demographics, such as age and duration of residence at the Royal Hospital, with established In-Pensioners being potentially older and experiencing age-related conditions resulting in increasing pain levels and subsequently reducing activity levels.

New In-Pensioners indicated an increase in their mobility levels (Q15), with scores rising from mean=3.94 (SD=0.827) on arrival at the Royal Hospital, to mean=4.00 (SD=0.935) six months later. Conversely, In-Pensioner scores were lower than the New In-Pensioner Part 1 scores (mean=3.68, SD=0.900), which as discussed earlier, may be as a result of In-Pensioner demographics with the cohort potentially being older, and experiencing reduced mobility levels.

Notwithstanding challenges with sleep (Q16), New In-Pensioners demonstrated increased scores across all other questions within Domain 1, when comparing their Part 1 and Part 2 responses, indicating an overall improvement on their physical health since moving into the Royal Hospital. Similarly, New In-Pensioners exhibited higher scores than the In-Pensioner cohort, in all other areas apart from energy levels (Q10), after six months of residency at the Royal Hospital.

Despite all participants being of retired status, scores demonstrated an inclination to engage in work (Q18), with New In-Pensioner scores increasing to mean=3.88 (SD=0.719), and In-Pensioner scores being mean=3.68 (SD=1.108) possibly indicating positive levels of the ability to represent the Royal Hospital.

5.3.3.4 Domain 2 – Psychological

Domain 2 collectively reports on six questions relating to life satisfaction, mental wellbeing, attention span and acceptance of how an individual physically looks (Table 20).

Table 20. Domain 2: Psychological

WHOQOL-BREF Domain 2: Psychological							
Particpant Group		Q5 How much do you enjoy life?	Q6 To what extent do you feel your life to be meaningful?	Q7 How well are you able to concentrate?	Q11 Are you able to accept your bodily appearance?	Q19 How satisfield are you with yourself?	Q26[1] How often do you have negative feelings such as blue mood, despair, anxiety, depression?
In Pensioner	Mean	**4.28**	**4.21**	**3.92**	**4.24**	**4.04**	**4.16**
	N	25	24	25	25	25	25
	Std. Deviation	0.542	0.658	0.702	0.663	0.889	0.473
New In-Pensioner Part 1	Mean	**4.18**	**3.75**	**3.88**	**4.18**	**3.82**	**3.82**
	N	17	16	17	17	17	17
	Std. Deviation	0.883	1.065	0.600	1.015	1.015	0.809
New In-Pensioner Part 2	Mean	**4.18**	**4.06**	**3.94**	**4.19**	**4.29**	**3.88**
	N	17	17	17	16	17	17
	Std. Deviation	0.636	0.827	0.827	0.750	0.686	0.781

[1] Q26 negatively framed question transformed to positively framed question (reverse scored)

Across Domain 2, In-Pensioner, and New In-Pensioner (Part 2), mean scores were 4.04 and above for all questions apart from concentration levels (Q7) and experiencing negative feelings (Q26). This indicates overall positive psychological outcomes for all participants.

Life enjoyment (Q5) remained the same for New In-Pensioners for Part 1 (mean=4.18, SD=0.883) and Part 2 scores (mean=4.18, SD=0.636) however established In-Pensioners demonstrated higher levels of enjoyment (mean=4.28, SD=0.542). Similarly, In-Pensioners (mean=4.21, SD=0.658) were found to consider their lives more meaningful (Q6) than New In-Pensioners (mean=4.06, SD=0.827), who had been at the Royal Hospital for six months (Part 2). This may indicate the positive

impact of life at the Royal Hospital for those established In-Pensioners, compared to New In-Pensioners who were still settling into their new surroundings.

The ability to concentrate (Q7) presented the lowest mean scores for all participant groups. However, In-Pensioner and New In-Pensioner (Part 2) mean scores were comparable (mean=3.92, SD=0.702 -vs- mean=3.94, SD=0.827), with New In-Pensioners also demonstrating an increase when compared to their Part 1 score (mean=3.88, SD=0.600), indicating an improvement in their concentration levels after six months living at the Royal Hospital.

New In-Pensioners demonstrated the greatest increase in how satisfied they were with themselves (Q19) when comparing Part 1 (mean=3.82, SD=1.015) and Part 2 scores (mean=4.29, SD=0.686). Part 2 scores were higher than that of the In-Pensioner cohort (mean=4.04, SD=0.859).

In-Pensioners demonstrated the lowest levels of issues relating to poor mental health (Q26), (mean=4.16, SD=0473), indicating positive wellbeing levels. New In-Pensioners showed a slight increase in their scores when comparing their arrival at the Royal Hospital (mean=3.82, SD=0.809) to six months later (mean=3.88, SD=0.781). This may indicate a positive influence as a result of living at the Royal Hospital with opportunities to access mental health support if required.

Collectively, the higher In-Pensioner scores, when compared with New In-Pensioner Part 2 scores, within this Domain may indicate that In-Pensioners are settled within their environment and the opportunities available, which had a positive influence on their psychological wellbeing. It may be suggested that, over time, New In-Pensioners may demonstrate similar scores as they further settle into their new lives.

5.3.3.5 Domain 3 – Social Relationships

Domain 3 captures the results of three questions relating to social engagement including friendship, support, and intimate relations (Table 21).

Table 21. Domain 3: Social Relationships

WHOQOL-BREF Domain 3: Social Relationships				
Participant Group		Q20 How satisfield are you with your personal relationships?	Q21 How satisfied are you with your sex life?	Q22 How satisfied are you with the support you get from your friends?
In Pensioner	Mean	**4.40**	**2.67**	**4.12**
	N	25	21	25
	Std. Deviation	0.645	0.856	0.526
New In-Pensioner Part 1	Mean	**3.88**	**2.77**	**4.06**
	N	17	13	17
	Std. Deviation	0.697	0.927	0.556
New In-Pensioner Part 2	Mean	**4.18**	**2.79**	**4.41**
	N	17	14	17
	Std. Deviation	0.636	1.051	0.618

In-Pensioner participants demonstrated higher satisfaction with personal relationships (Q20) (mean=4.40, SD=0.645) than New In-Pensioner's for both Part 1 scores (mean=3.88, SD=0.697) and Part 2 scores (mean=4.18, SD=0.636), which may indicate the positive impact of the social engagement available at the Royal Hospital. More specifically, New In-Pensioners showed an increase in satisfaction with personal relationships from their arrival to six months later, indicating living at the Royal Hospital had some positive effect.

(Q21) indicated the lowest rating of all questions with In-Pensioners suggesting a dissatisfaction with their sex lives (mean=2.67, SD=0.856). On arrival at the Royal Hospital, New In-Pensioner's had a mean score =2.77 (SD=0.927) and demonstrated a slight change in mean score after six months residence (mean=2.79, SD=1.051). The Royal Hospital admission criteria stipulates that In-Pensioners must not have dependents (i.e., be married), however the comparable scores suggest living at the Royal Hospital may not impact on the In-Pensioner satisfaction with their sex lives. This question also recorded the highest number of missing responses, suggesting a

reluctance to answer this question may be related to the ages of the participants and a reticence to share information on intimate matters.

All participants demonstrated satisfaction with the support they received from friends (Q22), with In-Pensioner mean scores of =4.12 (SD=0.526). New In-Pensioners showed a positive increase when comparing Part 1 scores (mean=4.06, SD=0.556) and Part 2 scores (mean=4.41, SD=0.618), indicating an increase in valued relationships as they became more established at the Royal Hospital.

5.3.3.6 Domain 4 – Environment

Domain 4 contained eight questions, the greatest number of all domains, and captured data relating to satisfaction around the living environment, finances, activities, transportation, healthcare and feelings of safety (Table 22).

Table 22. Domain 4: Environment

WHOQOL-BREF Domain 4: Environment									
Participant Group		Q8 How safe do you feel in your daily life?	Q9 How healthy is your physical environment?	Q12 Have you enough money to meet your needs?	Q13 How available to you is the information that you need in your day-to-day life?	Q14 To what extent do you have the opportunity for leisure activities?	Q23 How satisfied are you with the conditions of your living place?	Q24 How satisfied are you with your access to health services?	Q25 How satisfied are you with your transport?
In Pensioner	Mean	**4.56**	**4.00**	**4.44**	**4.40**	**4.67**	**4.32**	**4.56**	**4.24**
	N	25	25	25	25	24	25	25	25
	Std. Deviation	0.507	0.707	1.044	0.577	0.482	0.690	0.507	0.779
New In-Pensioner Part 1	Mean	**4.47**	**4.24**	**4.41**	**4.47**	**4.38**	**4.53**	**4.76**	**3.88**
	N	17	17	17	17	16	17	17	16
	Std. Deviation	0.717	0.831	1.004	0.624	0.885	0.874	0.437	0.885
New In-Pensioner Part 2	Mean	**4.53**	**4.29**	**4.47**	**4.53**	**4.53**	**4.65**	**4.94**	**4.19**
	N	17	17	17	17	17	17	17	16
	Std. Deviation	0.624	0.470	0.874	0.514	0.514	0.493	0.243	1.167

Mean scores for all participants on satisfaction with transport (Q25), were 4.00 or higher, apart from New In-Pensioner Part 1 scores (mean=3.88, SD=0.885), indicating a high level of satisfaction with the environment in which they lived. Challenges with transport may have been a reflection on the adjustment to a new living environment and a potential loss of independent transport means. Furthermore, findings indicated New In-Pensioner satisfaction was high when they arrived (Part 1 responses), with all questions demonstrating mean scores of over 4.00, apart from Q25 as discussed here.

The New In-Pensioner participant group indicated increased scores across all questions when comparing their arrival at the Royal Hospital (mean=4.94, SD=0.243) to six months later (mean=4.76, SD=0.437) with the availability of healthcare provision (Q24), demonstrating the highest mean score. These results suggest New In-Pensioners have an overall satisfaction with their new home, alongside access to the on-site medical centre and wider support, having had a positive effect.

Similarly, the availability of leisure activities (Q14), had a positive impact on New In-Pensioners as their arrival score 4.38 (SD=0.085) increased after six months to 4.53 (SD=0.514), as they settled into their new environment and engaged in new interests. Opportunity to engage in activities was also reflected in the In-Pensioner responses, being the highest mean score within Domain 4 for this cohort (mean=4.67, SD=0.482), endorsing the impact of meaningful activities on the opportunity to age well.

All participants indicated high satisfaction relating to financial security (Q12), with New In-Pensioners demonstrating an increase after six months (mean=4.47, SD=0.441) compared to on arrival (mean=4.47, SD=0.874), potentially indicating the impact of financial reassurance, or reduction of financial concerns, as a result of deciding to live at the Royal Hospital.

Both participant groups demonstrated satisfaction with the environment in which they lived, however In-Pensioner scores (mean=4.32, SD=0.690) were lower than New In-Pensioner Part 2 scores, (mean=4.65, SD=0.493). These results may indicate In-Pensioner familiarity of their home and potential complacency with their surroundings, compared with New In-Pensioner enthusiasm with their new environment. Nonetheless, the In-Pensioner mean scores were still high, indicating some level of satisfaction.

5.3.3.7 Missing Questions

A total of 19 questions were unanswered across all domains, with Q21, relating to intimate relationships, recording the most missing scores, being 11 (Table 23). The process for calculating missing scores is discussed in the Method chapter (4.8.2).

Table 23. Missing Questions Summary

WHOQOL-BREF Missing Questions Summary						
Participant Group	Q6 To what extent do you feel your life to be meaningful?	Q11 Are you able to accept your bodily appearance?	Q14 To what extent do you have the opportunity for leisure activities?	Q18 How satisfield are you with your capacity for work?	Q21 How satisfied are you with your sex life?	Q25 How satisfied are you with your transport?
In Pensioner	1		1		4	
New In-Pensioner Part 1	1	1	1		4	1
New In-Pensioner Part 2				1	3	1
Total	2	1	2	1	11	2

5.3.4 Summary

Quantitative data collection produced a baseline indicator of quality of life for New In-Pensioners, supplemented with data from the In-Pensioners cohort, who also engaged in the semi-structured interviews.

New In-Pensioners demonstrated an increase in scores for all ICECAP-A questions, indicating a positive effect on their quality of life, specifically stability, attachment, autonomy, achievement, and enjoyment, as a result of living at the Royal Hospital. Conversely, In-Pensioners presented lower mean scores across all ICECAP-A questions when compared to New In-Pensioner Part 2 mean scores, which may be an indicator of familiarity with their surroundings and ongoing stability as established residents. However, all In-Pensioner mean scores indicated an overall positive level of wellbeing.

Similarly, New In-Pensioners indicated increased levels of quality of life across the WHOQOL-BREF questions.

All participants were comfortable with their ability to carry out daily tasks, and had sufficient energy levels, with both areas scoring equal highest for In-Pensioners, within the physical health domain. However, New In-Pensioner's demonstrated higher scores than In-Pensioners in both areas, and additionally experienced a decrease in restrictions caused by physical pain after six months of living at the Royal Hospital.

Challenges with sleep satisfaction presented the lowest score for all participants, which may indicate that New In-Pensioners may be adjusting to their new environment. This may require further investigation to identify a cause and seek a solution to support residents, if the questionnaires are repeated and identify similar results.

In-Pensioners appear to enjoy life more, had higher energy levels, find life more meaningful, and have fewer mental health issues, when compared to the New In-Pensioners after their six months of residency. However, this may be because of the ongoing effect of life at the Royal Hospital, which the established In-Pensioners have experienced for longer.

All In-Pensioners and New In-Pensioners (Part 2) indicated satisfaction with their social engagement, however satisfaction with intimate relationships presented the lowest score across any domain.

In-Pensioners indicated higher levels of satisfaction regarding safety, access to leisure activities, and transport. New In-Pensioners, after six months of residency, demonstrated higher satisfaction levels relating to the living environment, having sufficient finances, and access to information and healthcare, suggesting that established In-Pensioners are used to their surroundings and the facilities on offer, whereas New In-Pensioners have experienced benefits in some areas but are yet to fully settle into their new environment.

A total of 19 questions were unanswered on the WHOQOL-BREF, with the highest number of non-responses being for Q21 regarding an individual's satisfaction with intimate relationships (n=11), which indicated a reluctance for both cohorts to divulge personal, or 'private', information.

Caution should be applied when comparing New In-Pensioner and In-Pensioner results as the variables for the In-Pensioner cohort would likely influence their feedback. Variables include In-Pensioner age and duration of residence as some participants may have been resident at the Royal Hospital for several years and be less active, less mobile, with declining health which is in contrast with New In-Pensioners who are required to be able to live independently and represent the Royal Hospital for a minimum of two years, and therefore arguably younger and fitter at the time of admission.

Furthermore, the small sample sizes across all participant groups make the transferability of the results challenging therefore consideration should be given when making comparisons with other findings.

5.4 Chapter Summary

This chapter presented the findings from the qualitative and quantitative analysis data. Qualitative findings highlighted the military influence of the Royal Hospital Chelsea environment and how it is integral to the impact on the In-Pensioner experience. The employment of ex-military staff in quasi-military positions created a structure that was familiar to In-Pensioners.

There were challenges to succinctly identify the Royal Hospital as it offered a blend of accommodation options. This identity may be subject to further challenge should the composition of the In-Pensioner population expand to include members from other branches of the Armed Forces.

Access to healthcare and social opportunities appeared unrivalled and undoubtedly provided enhanced quality of life outcomes, due to the prompt attention received by healthcare professionals within and external to the Royal Hospital Chelsea. The provision of innumerable social activities contributed to In-Pensioner wellbeing and physical health. However, In-Pensioner resistance to being considered ‘old’, presented challenges for some as they aged, and their health needs increased.

Civic engagement was a key component of In-Pensioner life, in their representational roles as Chelsea Pensioners. These activities, and the wearing of uniform, elevated In-Pensioner status which contributed towards a sense of identity, purpose, and belonging.

Quality of life data indicated high levels of satisfaction for both In-Pensioner and New In-Pensioner cohorts. New In-Pensioners were found to have higher satisfaction levels in areas such as physical ability, daily functioning levels and their new environment than established In-Pensioners, which may be considered predictable as New In-Pensioners were required to be able to live independently and represent the Royal Hospital for the first two years of their residency. They may also be potentially younger, more able, and more enthusiastic than In-Pensioners as they looked forward to their

new lives at the Royal Hospital, whereas In-Pensioners were established and therefore familiar with their environment, the opportunities, and the support available.

For these reasons, caution must be applied when comparing quality of life results, as in isolation, both cohorts indicated good levels of life satisfaction, with New In-Pensioners demonstrating increased levels of quality of life after six months of residency at the Royal Hospital, however, they also had high levels of quality of life at the time of admission.

CHAPTER SIX

DISCUSSION

6.1 Chapter Overview

Chapter 6 will discuss and appraise the project findings from the literature review and the qualitative and quantitative data collection Parts A, B, C, and D, in relation to the project aims and will draw on relevant theories and extant research. The triangulation of all elements generated four principal areas for discussion, namely: The Environment; Identity; Staying Active; and Staying Healthy.

Several internal, and publicly accessible, Royal Hospital Chelsea documents, including policy documents specifically relevant to In-Pensioners, were reviewed as they were considered relevant to inform the discussion. A summary and brief overview of the documents reviewed is available at (Appendix Y).

The strengths and limitations of this project will be outlined and will include a researcher reflexive summary. Finally, this chapter will present the original contribution to knowledge, implications for future research, and conclusion.

6.2 Project Overview

Within the globally ageing population are those who have completed military service, some of whom choose to live within veteran-specific residential establishments. However, there is minimal research that evidences the impact that living in these establishments has on veteran health and social care outcomes. Therefore, this study aimed to gain an understanding of the current Royal Hospital Chelsea model of care by evidencing the influence this has on In-Pensioner health and social care outcomes, and the contribution the environment has on the In-Pensioner experience and their quality of life. The project also aimed to inform the future provision of the Royal Hospital by exploring current services the future need and sustainability of the model of care, projecting findings to inform the growth of existing services, including its outreach programme, for current and future generations of ageing veterans.

A mixed-methods non-traditional convergent design was carried out comprising four data collection elements. Triangulating the findings from all data led to an understanding of the elements required to enable individuals to age well and in [the right] place.

The literature review illustrated the opportunity to age 'well' is influenced by several factors including an individual's health and cognitive status, their accessibility to, and engagement in, appropriate health and social care provision, and is linked to the place in which they age. These factors, when combined, shape an individual's outcomes, and influence their quality of life. The focussed systematic narrative review presented a global picture of residential options for military veterans over 65 years of age and identified available evidence of the impact living in these establishments had on resident outcomes. Opportunities to engage in residential activities were evidenced, however the impact on the individual, as a result of taking part in these activities was minimal, identifying a gap in outcomes knowledge for this demographic.

The data collection phase presented findings from the three participant groups, namely Key Staff (Part A), who took part in semi-structured interviews, In-Pensioners, who engaged in semi-structured interviews (Part B) and quality-of-life questionnaires (Part C), and New In-Pensioners (Part D), who completed quality-of-life questionnaires across two separate timeframes. Findings indicated the importance of the environment in which the In-Pensioners lived, with the embedded military culture and community living reinforcing their identity and sense of belonging. Accessing numerous activities and representing the Royal Hospital contributed towards an In-Pensioners a sense of purpose and enabled them to develop and maintain social relationships. Supported by a committed workforce and with access to on-site healthcare services, In-Pensioners were encouraged to live independently for as long as possible, however a deep-seated stoicism suggested a resistance to ageing, evident in a reluctance by some to transfer from Long Ward living to the residential, or nursing, care available at the MTI. New In-Pensioners indicated an improvement in their quality-of-life after the first six months of living at the Royal Hospital, however challenges with sleep were identified for both New In-Pensioner and In-Pensioner participants. New In-Pensioners were also found to have higher quality-of-life indicators when compared to In-Pensioners in areas including physical ability, satisfaction with their living arrangements, and access to

services, however In-Pensioners did indicate an overall satisfaction with their quality-of-life. These themes demonstrated an interdependence which indicated the importance of each element and their contribution to enabling In-Pensioners to experience positive ageing in a place of their choosing, or the 'right' place.

Overall, the findings from this study illustrate that In-Pensioner health and social care outcomes are dependent on four areas (Figure 10), namely:

1. The environment in which they live (Environment)
2. Their personal, military, and organisational identity (Identity)
3. The activities they engage in (Staying Active)
4. Their ability to stay healthy (Staying Healthy)

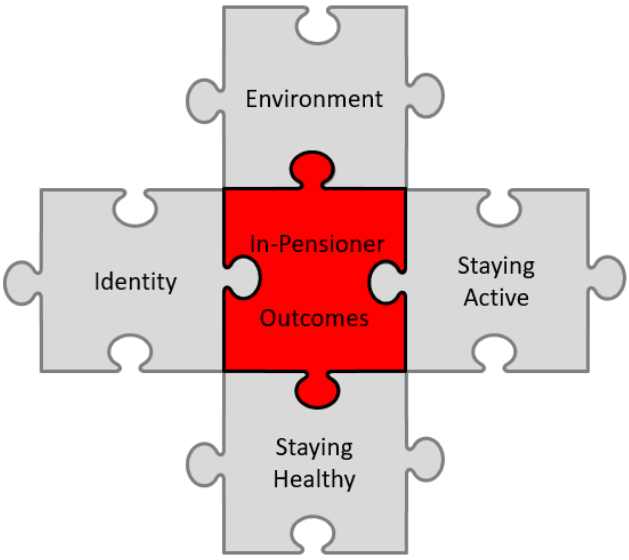
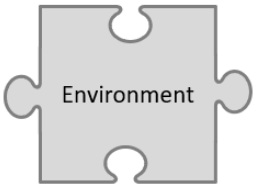


Figure 10. Key contributors to In-Pensioner outcomes

Each area will be discussed in more depth.

6.3 The Environment



6.3.1 Introduction

The environment in which we live is an important contributor towards experiencing positive life outcomes. Access to adequate resources whilst living in familiar surroundings facilitates opportunities to age ‘well’ and in [the right] place (Kahana et al., 2003; Sixsmith & Sixsmith, 2008).

Familiarity with an environment creates place attachment which engenders positive connections and feelings of ‘home’ to be established (Netherland et al., 2011; Reed et al., 1998). However, ageing in place is not always possible or practicable, as the living environment may become unsuitable to meet the needs of the individual. The requirement for some to relocate later in life, as their age increases and health status declines, is resisted by many which can negatively impact on health outcomes (Falk et al., 2013; McCann et al., 2012; Severinsen et al., 2016).

The Royal Hospital Chelsea is familiar to those who have served in the British Army and offers a community environment where individuals with shared experiences can live alongside each other whilst accessing services that facilitate positive life outcomes. However, the Royal Hospital challenges the perception of ‘institutionalised’ living as most In-Pensioners live autonomously, have freedom of movement, and live within an environment that is accessible to the public, which contrasts with the traditional ‘institution’, or residential, setting.

Four sub-themes are presented in this principal area: Military Environment; The Royal Hospital Chelsea as a ‘total’ Institution; Social Environment, and The Royal Hospital as ‘home’.

6.3.2 Military Environment

The Royal Hospital environment offers facilities akin to those of a small village community through providing access to support services such as doctors, shops, green space, and leisure facilities, which are considered important for a positive interaction between the person and the environment, resulting in satisfaction with the place in which an individual lives (Kahana et al., 2003). It could be argued that this environment is resonant of the military camp setting In-Pensioners may have experienced during their military service, particularly post-World War Two, where health, social, educational, and leisure, facilities were all likely to be within the camp boundaries and therefore easily accessible (Tivers, 1999). Furthermore, as a gated community with a secure perimeter, access to the Royal Hospital is controlled by security staff. This enables In-Pensioners to live within a safe and secure environment, which, as identified by Mulliner et al. (2020) is an important factor for the older population when choosing where to live. The project narrative indicates the security offered by the Royal Hospital Chelsea environment provides levels of peace of mind to In-Pensioners and their families that may not be experienced if they were living independently outside of the Royal Hospital.

Satisfaction with the environment in which all In-Pensioners live is further reflected in the quality-of-life data that suggest high levels of satisfaction regarding access to facilities and activities, and overall happiness with their surroundings (Table 22, p.184). The literature review identified a small number of residential establishments that provide access to similar facilities (Kheirbek et al., 2018; Montross et al., 2006), however the availability of an embedded medical centre, offering medical support aside from that received within a care home or nursing facility, appears to be distinctive to the Royal Hospital.

The importance of a military structure is emphasised with the quasi-military positions that ex-military staff hold, in roles such as Captain of Invalids (CoI), Regimental Sergeant Major (RSM), and Quartermaster (QM). The emphasis on military culture is also reflected in the rules and regulations In-Pensioners agree to adhere to, with familiar military language and procedures used in documents such as the In-Pensioner Handbook and the In-Pensioner Agreement (Appendix Y). Guidance extends to what items of clothing (referred to as ‘civvies’) are acceptable, either in or out of uniform,

how to wear the uniform correctly, and the requirement to book ‘annual leave’ to register periods of absence from the Royal Hospital, all of which are rules reminiscent of the time of military service and as indicated in the project findings, creates a sense of familiarity for In-Pensioners.

There are clear indicators within the narrative of the importance, and positive influence, ex-military staff have on the In-Pensioner experience, with many believing that understanding the military mindset, language, and culture, helps to break down any communication barriers and encourages engagement. The relationship between In-Pensioners and ex-military staff brings a level of reassurance and peace of mind as they feel they can communicate with people who ‘get’ them, which is further supported by the familiarity of the quasi-military rank structure and awareness of who to go to for assistance. There appears to be an absence of evidence relating to the impact of employing ex-military staff within veteran-specific residential care settings. Whilst the literature review identified the multidisciplinary support of staff from veteran agencies such as the VHA HBPC teams (Gilman et al., 2018; Haverhals et al., 2016; Levy et al., 2013), it is unclear from available evidence whether these teams include ex-military staff.

It could be argued that the Royal Hospital’s ex-military staffing structure resembles that of peer support worker, or ‘veterans-supporting-veterans’, which is known to improve veteran engagement and outcomes (Drebing et al., 2018; Repper et al., 2013; Weir et al., 2019). In their study of a public sector funded mental health and wellbeing clinic for UK veterans in Scotland, Weir et al. (2019) identified several findings that resonate with the project narrative, when discussing the influence ex-military staff have on supporting In-Pensioners. The clinic’s peer support workers were all Army veterans, resulting in a shared veteran status between them and the veteran ‘client’ which facilitated engagement and communication, using a mutually understood language and building trust. Additionally, the peer support workers acted as a bridge between the veteran ‘client’ and the staff without military experience which resulted in positive outcomes. These findings mirror the relationship between the Royal Hospital’s ex-military staff and the In-Pensioners, suggesting the importance of employing veterans when supporting other veterans to ensure positive wellbeing outcomes. Conversely, Weir et al. (2019) found the veteran-veteran relationship presented challenges when the connections were too familiar, for example when each party had

served together, or engaged in operational duties at the same time, indicating this created a barrier to engagement for some veterans. It could be suggested that, whilst it is possible the Royal Hospital ex-military staff may have served within the same regiment(s) and potentially experienced the same operational duties, the hierarchical status of the Royal Hospital staff positions may lessen any challenges to engagement as In-Pensioners are already cognisant of the 'officer -vs- soldier' relationship status. However, further research is needed to explore these relationships to provide greater depth of evidence on the impact having an ex-military staff group has on supporting In-Pensioners. It could be argued that the peer support attributes, discussed above, are similarly relatable to the In-Pensioner population who, by the very nature of their communal living and shared military experience, offer peer support to each other, both consciously and subconsciously.

Notwithstanding the peer support evidence discussed above, and the benefits to the peer support worker which include feelings of empowerment and establishing an identity (Repper et al., 2013), it is suggested that the opportunity for veterans to be employed in quasi-military positions, where a quasi-military uniform is worn, may be of mutual benefit as those holding these positions are working within a familiar environment and supporting individuals they understand, and who understand them, and may subsequently gain benefit if they themselves have experienced challenges when transitioning from a military environment, enabling them to retain a connection to their military past whilst maintaining a veteran, or 'civilian' status. Challenges with transitioning from military service are well documented (Ashcroft, 2014; Binks, 2017; Bowes et al., 2018; Cooper et al., 2017). It could be argued that the position of Army Reservist, for example, provides a uniformed 'status' of employment (Edmunds et al., 2016) that provides opportunities to retain a military connection, however the commitment to the British Army as a reservist includes the potential for operational deployment, which distinctly contrasts with that of the Royal Hospital Chelsea ex-military staff positions where they are 'civilians' and devoid of such commitment. There appears to be a lack of evidence relating to the influence wearing quasi-military uniform, in non-military, or 'civilian', environments and in employment roles that support other veterans, has on the individual. Therefore, further research may contribute towards this gap in evidence.

Several In-Pensioners express a desire for a completely ex-military staffing structure, with some suggesting the level of understanding between themselves and ex-military staff is difficult to replicate with those who are unfamiliar with the military lifestyle. The narrative highlighted communication issues and a lack of understanding of the military language or sense of humour, however despite voicing these challenges there is no evidence of this negatively impacting the support In-Pensioners receive, or on their overall experience at the Royal Hospital. It is therefore suggested that a combined workforce appears mutually beneficial to In-Pensioner outcomes. However, to better understand the influence ex-military staff employed in quasi-military roles, has on the life satisfaction of veterans, it is suggested that further research with other veteran-specific residential care providers may help explore the impact having an ex-military staffing structure has on resident outcomes, and on the ex-military staff themselves.

It could be argued that the current In-Pensioner population, some of whom regard the Royal Hospital as a military establishment, may be more familiar with a healthcare provision delivered by uniformed personnel as they may have served in the military at a time when the Armed Forces had its own military hospitals and medical centres that were staffed by military personnel, and therefore may prefer a similar arrangement. However, it is suggested that the resistance highlighted in the narrative may change as the In-Pensioner population changes and is replaced by veterans who are more familiar with a military-civilian blend of provision following the changes to military healthcare delivery following the ‘1994 Defence Costs Study’ (House of Commons, 2023).

6.3.3 The Royal Hospital Chelsea as a ‘total’ institution

Residential care establishments can also be referred to as ‘institutions’, however challenges exist to clearly separate one from the other as the terms are used interchangeably, with both indicating a place where long term care is received (Giraldi et al., 2022). Individuals find themselves living in an environment where routine is necessary to ensure all residents receive the care they need (Cook et al., 2015; Ettelt et al., 2022), with the requirement to accept the restrictive day-to-day routine of residential care contrasting with the freedom of living at home (Cook et al., 2015; Falk et al., 2013). Furthermore, the term ‘institution’ is often believed to present negative

connotations and is terminology actively avoided by service providers, who consider it to be the antithesis of what their establishment represents, as they strive to create an image of 'home' for residents (Ettelt et al., 2022).

As a quasi-military establishment that has cared for British Army veterans for over 300 years, some may consider the Royal Hospital to be a 'total' institution. In his work '*Asylums, Essays on the Social Situation of Mental Patients and Other Inmates',* Goffman (1961, p.xxi) describes the 'total' institution as being:

> *"a place of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life"*

Similarly, Baldwin et al. (1993, p.70) cite Townsend's *'The last refuge: a survey of residential institutions and homes for the aged in England and Wales',* who considered residential establishments for older people to be:

> *"In the institution people live communally, with a minimum of privacy, yet their relationships with each other are slender. Many subsist in a kind of defensive shell of isolation. Their mobility is restricted and they have little access to general society they are subtly oriented towards the system in which they submit to orderly routine, lack creative occupation and cannot exercise much self-determination... the result for the individual seems fairly often to be a gradual process of depersonalisation (Townsend 1962: 79).*

Furthermore, and notwithstanding the fact that the Royal Hospital is a home for retired Army veterans, it could be argued that the Royal Hospital sits within two of Goffman's five categories of the 'total' institution, the first being, *"…institutions established to care for persons felt to be both incapable and harmless: these are the homes for the […] aged […]"* (1961, p.4), and the fourth being *"…institutions purportedly established to pursue some worklike task and justifying themselves only on these instrumental grounds: army barracks […]"* (1961, p.4), with both reminiscent of the representational role of the Chelsea Pensioners and the quasi-military environment in which they live.

Whilst the Royal Hospital Chelsea shares some similarities to the 'total' institution, including a considerable number of individuals living communally, experiencing elements of daily routine, and being people of similar mindset, the projects findings are largely juxtaposed to the definitions of Goffman and Townsend, as outlined above.

In-Pensioners are encouraged to, and supported in, maintaining their independence. Additionally, in their representational role of Chelsea Pensioner, their identity and status are enhanced as civic engagement takes place with the public, veterans, and the wider Armed Forces Community, which can extend to international travel as they respond to invitations to represent the Royal Hospital at numerous events. Moreover, the project findings indicate a close community as In-Pensioners articulate the family-like environment of the Long Wards as they reconnect with their military-style camaraderie and support. In further contrast to Goffman and Townsend, whilst In-Pensioners agree to adhere to residency rules, as outlined in the In-Pensioner Handbook and In-Pensioner Agreement (Appendix Y), which it could be argued is likely to be comparable with any establishment an individual chooses to live in, In-Pensioners have freedom to choose how to live their lives, which includes periods of absence from the Royal Hospital for holidays or other personal commitments, to the levels of health and social care support they decide to accept or decline.

Additionally, the Royal Hospital environment differs from evidence that suggests residential establishments, or 'institutions', are found to be inaccessible, or segregated, from society (Goffman, 1961, in: Anderson & Dabelko-Schoeny, 2010), as members of the public have access to some areas of the Royal Hospital, including the chapel, museum, gift shop, and green space known as Ranleagh Gardens (Appendix Y – In-Pensioner Handbook). Similarly, public access is permitted when attending fundraising events such as the annual Royal Horticultural Society (RHS) Chelsea Flower Show (RHS, 2023), or when engaging in the In-Pensioner led tours of the Royal Hospital (RHC, 2023), reinforcing the juxtaposition between the Royal Hospital and the 'total' institution

In further contrast to the criteria articulated in the 'total' institution description, there is no evidence within the participant narrative to indicate that In-Pensioners are exposed to the depersonalisation that takes place as part of military training, where one's civilian identity is broken down and subsequently re-built into a collective military identity, resulting in a body of individuals willing to adhere to rules and regulations and follow orders without question (Maringira, 2016; Yamada et al., 2013). However, it could be argued that In-Pensioners would have experienced this process as part of their own military training, which suggests the resultant strong affiliation to their military identity may support their transition and organisational 'fit' when they move into the

Royal Hospital. This prior ‘institutionalisation’ may contribute to the ease at which most In-Pensioners settle into their new home, and the eagerness and pride they experience when wearing uniform and thus representing the Royal Hospital, as evidenced in the findings.

In their study, Baldwin et al. (1993), suggest the focus on institutionalisation centres on the power the organisation has over its residents, as it creates a culture of dependency, whilst overlooking the residents themselves, their attributes and personal histories. Furthermore, to infer there is only one form of institutionalisation omits to consider other contributing factors including economical and geographical positioning (Baldwin et al., 1993). Moreover, the process of decreased independence, increasing reliability on others, isolation, and poor health outcomes, may be experienced by those receiving care in their home environment, which could arguably be likened to institutionalisation, but within the confines of one’s own home (Baldwin et al., 1993).

Rather than that of ‘total’ institution, Davies (2003) suggests that an environment that offers a holistic approach to the needs of the residents, including physical and psychological welfare, with investment from residents, staff, and family members, creates the ‘complete community’, which it could be suggested is redolent of the Royal Hospital Chelsea model of care.

The project narrative highlights the enthusiasm with which the Royal Hospital is considered by many to be a military, or quasi-military, establishment that enables In-Pensioners and ex-military staff to establish an identity and affiliation reminiscent of their previous lives in the Army. Furthermore, the project findings indicate the term ‘institution’ is used affectionately and is affiliated with the age and historical nature of the Royal Hospital, rather than as a disparaging connotation.

6.3.4 Social Environment

The importance of the friendships and social connectivity experienced by In-Pensioners was emphasised throughout the participant narrative and is supported in the quality-of-life results which indicate high levels of satisfaction with support networks (Table 21). Many likened their relationships to the camaraderie experienced

whilst in military service, considering each other as ‘family’, particularly those living within their immediate Long Ward environment.

The familial regard identified at the Royal Hospital is recognised within the military setting, as personnel learn to rely on each other for support and protection, with bonds and military cohesion developing early in, and throughout, their careers (Käihkö, 2018; Kirke, 2009; Siebold, 2007). This contrasts with Abbott et al. (2000) who found sheltered housing and residential home occupants enjoyed elements of social engagement, yet the development of friendships was limited, with evidence of adapting to their surroundings rather than becoming friends with the people they were now living with, keeping fellow residents at arms-length.

In their study to identify factors that influence ‘living well’ in a residential care setting, Bradshaw et al. (2012) found four areas to be important contributors, namely acceptance and adjustment to new surroundings, being connected to other people, living somewhere that felt homely, and finally, the way care is delivered. Being accepting of new surroundings creates a resilience towards the potential loss of independence and empowers individuals to develop new friendships, which are found to mitigate against feelings of loneliness (Bradshaw et al., 2012). The relationship between resident and staff is also found to contribute towards ‘living well’ particularly where emotional support is given, where staff understand the resident’s needs, and more person-centred care is delivered (Bradshaw et al., 2012). Furthermore, the ability to live in a homely environment contributes towards positive quality-of-life outcomes.

McKee et al. (1999) suggests developing friendships within residential care settings is influenced by personal choice and the structural composition of the environment residents live in. Relationships ranged from being ‘friends’ to ‘good friends’, with both levels being influenced by engagement in activities, as some residents preferred to remain in their rooms and were not encouraged by staff to engage with fellow residents. This finding is in contrast to the Royal Hospital, where In-Pensioners are actively encouraged to engage in many activities, as discussed later, and build existing and new friendships. Interestingly, McKee et al. (1999) found those who were connected through similar interests before becoming residents formed ‘good’ friendships, which it could be argued concurs with the shared military connection experienced by In-Pensioners.

In their study, Abbott et al. (2000) found residents recognised that living in the same residential space does not automatically result in communal harmony. The project findings indicate that despite evidence of consternation by some In-Pensioners towards those who did not embrace the communal lifestyle of the Royal Hospital, they were still considered 'family' and were looked out for by their fellow residents, suggesting tolerance, acceptance and respect for individual choice is evident. Similarly, Carr and Fang (2022) found residents who chose to live in a retirement village environment to enable them to age in [the right] place, adopted a 'them' and 'us' attitude towards those residents who were considered older and in poorer health. This contrasts to the project findings which demonstrates that In-Pensioners are accepted by each other irrespective of their age and health status. However, the narrative indicates that In-Pensioners do distinguish themselves from the older population who live 'outside' of the Royal Hospital, although this is not disparagingly, but more of a wish that others could experience the benefits and privileges they have access to. Arguably, it may be considered challenging to directly compare the Royal Hospital to the retirement villages in the Carr and Fang (2022) study, however, it is suggested that as both residential types are populated voluntarily and share similar variances in age range and health status, findings are relatively comparable.

6.3.5 The Royal Hospital as 'home'

As discussed earlier, the findings from this study show that In-Pensioners clearly identify with the Royal Hospital, considering it to be a military-style environment. Moreover, the connection to their previous military lives generates feelings of familiarity that leads some In-Pensioners to describe living at the Royal Hospital as 'returning home' as they indicate feeling comfortable in military-style surroundings. This familiarity is further strengthened as In-Pensioners reconnect with fellow residents who share the common bond of having served in the Army. The project narrative reflects the findings of Netherland et al. (2011), who identified the importance of living in familiar surroundings as it facilitates 'positive' ageing, enables individuals to stay connected to the place they call home, and within a community they recognise.

Juxtaposed to the feelings of home, the living environment of the Royal Hospital Long Wards brings with it restrictions that are not commensurate with living in a traditional

home environment but are reminiscent of military communal living. For example, In-Pensioners are required to observe daily ‘quiet times’, wear headphones when listening to the television or playing music at night and are not allowed to have overnight guests although visitors are permitted to stay at the Royal Hospital in guest accommodation for short-stay visits (Appendix Y – In-Pensioner Handbook). These restrictions indicate elements of compromise are required to live within the Royal Hospital, and arguably any residential setting, however the project findings did not elicit any evidence of resistance or reluctance by In-Pensioners, suggesting minimal or no impact on their lives as a result of these limitations.

Ageing in place traditionally indicates receiving social care support in the place people call home, thus enabling people to retain levels of autonomy, connectivity with their extant community, and life satisfaction, as they remain in their homes for as long as possible (Kaul et al., 2020; Rogers et al., 2020; Sixsmith & Sixsmith, 2008). However, the concept and terminology has begun to evolve, to include ageing in ‘the right’ place (Kagan, 2023), in recognition that the extant home environment may not be the most appropriate choice, or meet the needs of the individual, however an alternative location may be the ’right place’ in which to age, even though it isn’t the historical home (Severinsen et al., 2016). Opportunities for individuals to age well, and in place, can be challenged by homes that may be considered physically and geographically unsuitable, if they are, for example, inappropriate for adaptation, costly to maintain, or thought too big for those who may be living alone (Kagan, 2023). Furthermore, living in an area that may be isolated or without access to necessary facilities including shops, healthcare, and community services, may impede ageing well and in place (Kagan, 2023; Severinsen et al., 2016; Sixsmith et al., 2017). It is these challenges that have modified the concept of ageing in place to one of ageing in ‘the right’ place, as people relocate from their long-standing home into more suitable accommodation, with access to amenities that meet their needs, and still enable them to remain ‘at home’ rather than relocate to a higher needs residential establishment (Kagan, 2023; Severinsen et al., 2016; Sixsmith et al., 2017). As frequently highlighted in the narrative, the Royal Hospital is considered by many to be an In-Pensioners ‘last’, or ‘final’, ‘posting’, in reference to their final military location prior to leaving the Army, suggesting that this move is the final one, and therefore arguably considered by In-Pensioners to be the ‘right place’ in which to age. Indeed, many have suggested that

‘no one dies’ at the Royal Hospital, they simply receive their final posting, further linking their inevitable death to a military language and understanding they can relate to.

Relocating in later life can be a worrying time as the individual comes to terms with change, leaving an environment they are both familiar with and connected to, alongside the acknowledgement that their independence may be challenged or their health deteriorating (Falk et al., 2013). In contrast to Falk et al. (2013), the project narrative highlighted the ease at which most In-Pensioners settled into their new environment with some, likening the Royal Hospital to returning home, as they re-familiarise themselves with the communal living setting experienced whilst serving in the Army. Burnell et al. (2017) suggest the support network veterans experience declines as those who understand them the most die, leaving the veteran with a void in this support. It could be suggested therefore, that moving into the Royal Hospital replaces this void and provides a community of individuals with shared experiences, which, it could be argued, becomes a protective factor against these losses. However, the project findings also indicate there are some In-Pensioners who found the move into the Royal Hospital more challenging. This may highlight the individual personalities and characteristics of In-Pensioners and is perhaps reflective of the lives they may have led and their reasons for moving into the Royal Hospital, which includes bereavement, and the environment they have left behind. Further research into the challenges experienced by those In-Pensioners who do not settle into life at the Royal Hospital as well as others, may provide the Royal Hospital with valuable information to support future In-Pensioners as they transition into their new surroundings.

In contrast with In-Pensioner feelings of returning ‘home’, Falk et al. (2013) found residents in their study considered their new residential establishment as a temporary dwelling and were reluctant to add personal touches to their rooms, believing they could go ‘home’ if they didn’t like where they were currently living. Making the decision to move into the Royal Hospital, which is situated in London, requires a relocation that for some may be of considerable distance. Subsequently, this move takes In-Pensioners away from their extant support network which may include family and friends, their local community, and areas that are familiar to them. However, the narrative indicates an acceptance of this relocation, and little evidence of compromise, as In-Pensioners articulate the benefits of providing families with peace of mind and the reassurance that they are being well cared for and are among like-minded

individuals, seemingly outweighing any of the challenges being away from their former environment brings. Furthermore, several participants believe living at the Royal Hospital removes the 'burden' of caring for them, away from their families, which also gives the In-Pensioners peace of mind.

When deciding which residence to live in, the importance of familiarity was highlighted by Reed et al. (1998), who found residents felt connected to an establishment that was known to them, even if this knowledge was merely as a result of it being located in their own town or village, rather than that of having first-hand experience of the establishment. This connection facilitated attachment and became part of the individuals own *'personal history',* which supported their transition into their new environment Reed et al. (1998, p.863). It could be argued that the awareness In-Pensioners have of the Royal Hospital Chelsea, as a result of their military service, creates levels of familiarity and attachment many years ahead of being eligible to live there, potentially mitigating any relocation challenges and may assist the transition from their previous home to the Royal Hospital.

The resistance to move into supported accommodation as a result of ageing and increased need, is well documented (Falk et al., 2013; McCann et al., 2012; Pannell, et al., 2012; Severinsen et al., 2016), with many preferring to remain in their homes and receive care within a familiar environment, thus ageing in place, which brings positive health and social outcomes (Sixsmith & Sixsmith, 2008). This resistance contrasts with the Chelsea Pensioner experience as Army veterans make a proactive and voluntary decision to move into the Royal Hospital. It could be argued that the number of years In-Pensioners live at the Royal Hospital, which can be in excess of 20 years, indicates positive satisfaction with their decision as they are free to leave should they wish to do so. Furthermore, as discussed earlier, the quality-of-life findings indicate New In-Pensioner satisfaction with their new environment, as their initial satisfaction demonstrated an increase after six months residency (Table 22), arguably indicating the decision to move to the Royal Hospital had a positive influence on their quality-of-life.

Place attachment theory posits an emotional connection between the individual and components of the environment, or place, such as positive memories of a similar environment, its amenities, and the community, which usually comprises of people

from similar backgrounds (Hashemnezhad et al., 2013). In addition, place identity introduces the significance of attachment to the built environment and its influence on the identity of the individual, suggesting *"places are not only contexts or backdrops, but also an integral part of identity"* (Hauge, 2007, p.50). Thus, the propensity for In-Pensioners to consider the Royal Hospital as home suggests an emotional connection to an environment with facilities that remind them of their time served in the Army, the Army community, and is indicative of place attachment. In addition, positive memories strengthen the connection, which suggests the quasi-military environment of the Royal Hospital facilitates place identity as In-Pensioners connect their military experience to their home and fellow residents who share a similar military history.

The concept of the 'sense of place' is considered ambiguous (Shamai, 1991) however, building on extant evidence, Shamai (1991, p.350) suggested seven levels that individuals may identify with, ranging from an absence of sense of place (level 0), or a disconnect from the place (level 1) to a level where individuals are prepared to make sacrifices for the place (level 6). The project findings indicate In-Pensioners associate with four of Shamai's levels, dependent on the depth of their attachment to the Royal Hospital, namely: level 2 *"Belonging to a place",* a feeling of belonging and togetherness; level 3 *"Attachment to a place",* identifying with the significance of the place; level 4 *"Identifying with the place goals*", a connection to the purpose of the place and demonstration of loyalty and agreement to the purpose; and, level 5 *"Involvement in a place",* a full commitment to engage with the environment, sharing a collective behaviour to support the place. The narrative suggests that In-Pensioners relate to levels 2 and 3 as there are clear indications that many regard the Royal Hospital as 'home' and also a 'military' environment, connecting their past and present lives. Furthermore, the narrative evidence a clear association with the purpose of the Royal Hospital and an enthusiastic commitment to support, and subsequently promote the Royal Hospital in their representative role of Chelsea Pensioner which, it is suggested, clearly relates to levels 4 and 5. However, I would suggest that the levels of connection may change as In-Pensioners become more established, or conversely, disenfranchised, with the Royal Hospital. In addition, the depth of connection may vary subject to an In-Pensioners experience in the Army, for example, a more positive experience may indicate a stronger affiliation to the Royal Hospital.

6.3.6 Section Summary

There are several facets that influence the environment of the Royal Hospital, not least its physical composition which is reminiscent of the military ‘camp’ familiar to all In-Pensioners. The secure environment generates feelings of physical security leading to reassurance and peace of mind.

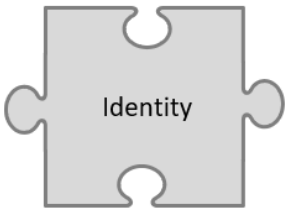
The quasi-military culture is omnipresent and is reflected in the rules and regulations In-Pensioners agree to abide by, alongside a contingent of ex-military staff who wear quasi-military uniforms recreating the ‘chain of command’ reporting structure that is familiar to all In-Pensioners. There is evidence that the ex-military staff offer peer-support to In-Pensioners but arguably also benefit from working within the quasi-military establishment. Further research into the impact this environment has on ex-military staff may be beneficial to the Royal Hospital and other veteran-specific establishments.

The concept of the ‘total’ institution contrasts with the Royal Hospital as it provides a more flexible and autonomous environment for In-Pensioners, who are encouraged to maintain their independence and live active lives which includes engaging with a wide range of individuals as part of their representational role as Chelsea Pensioner.

In-Pensioners share a connection ultimately created as a result of their shared military service, which leads to many regarding each other as ‘family’ which results in an active and supportive social network, and contrasts with other residential establishments.

The Royal Hospital is widely regarded as home, with many believing it to be their last home, suggesting they are ageing in [the right] place. The transition to the Royal Hospital is trouble-free for most however some In-Pensioners take a little longer to settle into their new surroundings.

6.4 Identity



6.4.1 Introduction

Several theories explore identity, including social identity theory, self-categorisation theory, and collective identity theory (Ashmore et al., 2004; Brown, 2020; Hornsey, 2008; Tajfel, 1978). Furthermore, social identity complexity seeks to consider where an individual places their identity within in a group, or multiple groups (Roccas & Brewer, 2002). Social identity theory posits that people see themselves as having an individual and a group identity which come together as a social identity when each is concurrently active (Brown, 2020) However, Ashmore et al. (2004) suggest most people have more than one identity, with each applied depending on the environment or situation they are in.

Notwithstanding the contrast with the 'total' institution, as discussed in Environment (see 6.3.3), the blend of accommodation options available at the Royal Hospital Chelsea, including the quasi-military environment, wearing uniform, and commitment to represent the place In-Pensioners call home, present challenges in concisely identifying the establishment, particularly to those unfamiliar with its history. Eligible veterans predominantly live independent lives safe in the knowledge that as they get older, and their needs increase, they can be supported in their Berths, or transition into the onsite nursing home, thus adapting the care needs around the individual whilst living at home and for the remainder of their lives, arguably facilitating the opportunity to age in [the right] place (Kaul et al., 2020).

Four sub-themes are presented in this principal area: Collective Identity; The Chelsea Pensioner; The Royal Hospital Chelsea Identity; and Inclusivity.

6.4.2 Collective Identity

The findings of Ashmore et al. (2004) resonate with the project narrative as In-Pensioners indicate multiple identities, as they retain their personal identity, reconnect to their previous military identity, and adopt an organisational identity as Chelsea Pensioners, thus representing the Royal Hospital, which inextricably links them to the place they call home.

Interestingly, the civilian, or non-military, identity appears lost as many In-Pensioners seemingly identify with either their former military self, or that of a Chelsea Pensioner. Whilst exploring the civilian experience of In-Pensioners was not part of the project aims, there was minimal evidence of their civilian identity assuming prominence during the semi-structured interviews, suggesting a comfortable acceptance of a military related identity. However, notwithstanding a visible absence of their civilian identity, the narrative clearly indicates that, despite sharing similar characteristics such as a military sense of humour or mindset, In-Pensioners are individuals and keen to be regarded as such, subsequently retaining a personal identity that enables them to hold onto traits that are exclusive to them (Ashmore et al., 2004). It could be argued that this contradicts the willingness to also assume a military identity, but supports the multiple identity characteristic (Ashmore et al., 2004).

The project narrative demonstrates that living in an establishment that has a quasi-military environment, influences, enables, and encourages, In-Pensioners to reconnect to their military identity, particularly their Army identity, specifically in their representational role as Chelsea Pensioners. This reconnection is evident in the willingness by many In-Pensioners to wear uniform on a daily basis, live within a communal setting, and follow the comprehensive rules and regulations as detailed in their In-Pensioner Handbook (Appendix Y), with some positively embracing a return to the military-style structure. Demonstrating commitment, positive regard for others, and allegiance, all contribute towards conformity (Yamada et al., 2013), which is clearly demonstrated within the findings of this project.

The overriding connection that In-Pensioners have is the fact that they have all served in the British Army, which gives them a collective identity (Ashmore et al., 2004). However, for this association to be fully achieved, individuals must actively consider

themselves to be an integral part of this identity, sharing similar characteristics to other members of the collective, such as a shared language, values, or beliefs (Ashmore et al., 2004). This perhaps indicates the reservation by some over the Royal Hospital's shifting culture and environment through the perceived consideration of expanding its admission criteria to include veterans from all British military service and become a 'tri-service' establishment. This idea was discussed by many participants, with some welcoming the notion and others fiercely rejecting the idea believing each Armed service to be different and therefore difficult to blend. This resistance to change is historical and evidenced in the reluctance by some when female veterans were admitted to the Royal Hospital in 2009. This change in In-Pensioner demographics caused initial controversy, however female veterans are now fully integrated in the Royal Hospital. The literature review identified a mix of UK residential establishments that were primarily accessible to all veterans regardless of which branch of the Armed Forces in which they served, however, in addition to the Royal Hospital which is a single-service establishment, the Royal Naval Benevolent Trust is specifically for those who have served in the Royal Navy and Royal Marines (Table 7). The remainder of provision identified in the literature review did not specify service type but did detail whether the provision was veteran-only or whether spouses were eligible (Appendices J & K). Moreover, there was an absence of empirical evidence relating to the impact of living in a multi-service residence. To assess the potential impact of expanding the Royal Hospital Chelsea's inclusion criteria, it is suggested that engagement takes place with extant veteran-specific establishment(s) who accept veterans from all services to assess the feasibility of expansion and the potential impact this may have on the historical identity of the Royal Hospital and its current and future In-Pensioner population.

The findings of this project clearly indicate a collective identity amongst the In-Pensioners, who demonstrate a shared military language, sense of humour, and commitment to represent the Royal Hospital, however the level at which individuals are fully embedded within this collective is subjective and challenging to confirm without further research. I would suggest, however, that based on the narrative, there is a considerable indication that many In-Pensioners are embedded, as the Royal Hospital, the social, and active, network, are all integral to the In-Pensioners lives, and to lose this would have considerable implications (Ashmore et al., 2004).

The narrative shows some In-Pensioners consider themselves as still being part of the military and refute the notion of being classed as ‘old people’, welcoming the sense of familiarity that the quasi-military culture brings. As Marques et al. (2015) note, being aware of one’s age and associating oneself with being ‘old’ can have negative influences on self-perceived health status, including an increase in anxiousness which results in a decrease in cognitive function, therefore it could be argued that an In-Pensioners resistance to being considered ‘old’ may act as a protective factor. Equally however, some In-Pensioners are found to resist the military persona, preferring to maintain their ‘civilian’ identity, which appears to indicate the levels of flexibility and compromise required by some as they manage the multiple identities they adopt as residents of the Royal Hospital. The narrative did not evidence whether those who prefer to maintain a ‘civilian’ identity, considered themselves as part of the Royal Hospital Chelsea identity, and therefore an ‘in-group’ member, or whether they preferred to adopt a more individual status.

Furthermore, it could be argued that the collective identity extends to the ex-military staff who also share similar characteristics and traits, such as military language, sense of humour, values and beliefs. However, whilst ex-military staff may be considered to be ‘in-group’ members because of their shared Army experience, they are also ‘out-group’ members as they are not In-Pensioners, some of whom may be considered to be in hierarchical positions (Ashmore et al., 2004; Yamada et al., 2013). The project narrative highlighted the impact of the relationship between the In-Pensioners and the ex-military staff, as discussed earlier (see 6.3.2), however the influence of ‘in-group’ or ‘out-group’ status was not evidenced.

6.4.3 The Chelsea Pensioner

Distinctly evident in the project narrative is the passion and pride felt by In-Pensioners when representing the Royal Hospital in their role of Chelsea Pensioner. Yamada et al. (2013, p.392) state *“once a service member is no longer military connected then he or she joins the “ranks” of the “veteran” culture”*. It could be argued that In-Pensioners have expanded the ‘veteran’ culture group identity, to which they belong by default, to include a ‘Royal Hospital Chelsea’ group identity, to further reconnect with their military past but subsequently distinguish themselves from others within the

same age demographic, or veteran status. Group membership is found to have positive implications on an individual's wellbeing as it improves mental and physical health, and personal robustness (Hornsey, 2008; Marques et al., 2015), which I would suggest increases levels of activity, contributes towards a sense of belonging, and the development of valued relationships which are positive indicators for ageing well (Ballesteros, 2019). Quality of life results within Part C indicate that In-Pensioner's believe their lives to be meaningful (Table 20, Q6) which I would further suggest is as a result of identifying and engaging with the Royal Hospital Chelsea 'group' identity. Further, New In-Pensioners demonstrated an increase in life meaningfulness following six-months residency, however results were lower than that indicated by In-Pensioners, which I would assert is reflective of the fact that the In-Pensioner cohort were more established residents and therefore benefitting from the enduring impact of living at the Royal Hospital.

The project narrative clearly highlights the unique identity that Chelsea Pensioners hold which brings with it an elevated, and an almost celebrity-style, status. However, some indicated discomfort with this elevated status. Belonging to a higher society group affords its members elevated status, engenders feelings of pride and belonging, and increases wellbeing (Marques et al., 2015). Conversely, individuals who may be considered part of a lower social group may experience negative levels of wellbeing and self-perception (Marques et al., 2015). I would therefore argue that most In-Pensioners benefit from the social identity positioning, and 'in-group' membership that living in, and representing, the Royal Hospital brings.

Identity and self-esteem are central to an individual's 'good life' and are attributes that are often diminished when people move into residential care (Bowers et al., 2009; Walker & Paliadelis, 2016). This contrasts with the findings in this project where identities are elevated, and confidence increases, especially when In-Pensioners represent the Royal Hospital as Chelsea Pensioners. However, it could be argued that In-Pensioners lose an element of their identity when leaving the army and subsequently adopt a veteran status, as discussed earlier, and that this identity is regained, in part, when they return to the quasi-military environment of the Royal Hospital.

The In-Pensioners' sense of identity and connection to the Royal Hospital, and fellow residents, was evident in the narrative, however Flack and Kite (2021) suggest that having strong interdependencies with veterans, who are often regarded as family, as has been articulated in this project's narrative, may impede the development of social connections outside of the military, or veteran, environment. It could be argued that the strong family-style bonds that are indicated in the project narrative suggest In-Pensioners may experience a degree of separation from the non-military environment. However, it could be suggested that this is counter-balanced by the representational role that In-Pensioners hold which brings frequent engagement with many members of the public and non-military associates.

6.4.4 The Royal Hospital Chelsea Identity

Notwithstanding the juxtaposition between the Royal Hospital Chelsea identity and that of the 'total institution' as discussed earlier (see 6.3.3), and the Chelsea Pensioners themselves who act as a visual representation of the Royal Hospital, the findings clearly indicate a challenge in succinctly describing the establishment. This may present challenges in understanding its purpose, particularly to those with little or no military knowledge. Multiple definitions include a 'retirement village', a 'home for old soldiers', or a 'hospital' in the sense of offering hospitality, however there was a strong resistance by many to it being called a 'care home', which it could be argued refers back to the perception by many In-Pensioners that it is a 'military' establishment.

The ambiguity of the Royal Hospital's identity does not impact on the In-Pensioners identification with, or understanding of, its purpose, possibly due to their prior knowledge of its support for fellow soldiers, as a result of their military service. The term 'Hospital' is often misunderstood by those unfamiliar with the Royal Hospital as the definition of a hospital can be varied, for example: *"a hospital is a place where people who are ill are cared for by nurses and doctors"* (Collins, 2022, para.1); *"a charitable institution for the needy, aged, infirm, or young"* (Merriam Webster, 2022, para.1); or a place to *"complement and amplify the effectiveness of many other parts of the health system, providing continuous availability of services for acute and complex conditions"* and where they *"should reflect the needs and values of the communities in and around them, while also being resilient and able to maintain and*

scale up services in emergency situations" (WHO, 2022b, para.1). I would argue that whilst the term 'hospital' does not present any day-to-day operational challenges, the potential misinterpretation of this term may result in confusion for those who are unfamiliar with the purpose of the Royal Hospital, for example those without military connections or those who live outside of the UK. Furthermore, it may present strategic challenges when raising awareness with the public and generating the funds required to run the Royal Hospital.

As demonstrated within the findings, the enduring relationship between the MoD and the Royal Hospital is evident in its governance structure with several members of the Board of Commissioners being current or former military officers, and the annual financial 'Grant in Aid' contribution received to support the care of the In-Pensioners (RHC, 2022g). The project findings indicate the funding of residential care is varied and includes defence, self, and state, funding options, or a combination subject to eligibility and affordability (Table 1; Appendices H, J, & K), however, the project did not evidence a similar Royal Hospital Chelsea governance structure in other veteran-specific residential establishments. Using England as an example, there are numerous ways to finance a place within residential care (Age UK, 2023) with affordability being means-tested. Currently, any individual with capital above £23,250 is required to pay for their care in full, with a subsequent sliding scale of capital -vs- state funding contributions (Age UK, 2023). The cost of residential care varies, with Age UK (2023) indicating residential care costs averaging £600 per week, rising to in excess of £800 per week for nursing care. By comparison, the literature review identified UK costs ranging from £581 - £1030 per week for residential care, and £743 - £1800 per week for nursing care, indicating the not insignificant cost of living in residential establishments (Appendix J).

In addition to the funds received from the MoD, In-Pensioners undergo a financial assessment to establish their personal financial contribution towards living at the Royal Hospital, which includes the mandatory surrender of their army and/or War Disablement pension, for those to whom this is applicable (Appendix Y – Financial Contributions Policy). Furthermore, additional income is generated through fundraising events which, as indicated in the narrative, causes conflict for some In-Pensioners. Whilst appreciating the need to raise money several participants believe some events are intrusive and the feeling of 'home' is being eroded, presenting a

challenge for the Royal Hospital to balance the need to ensure financial security without impacting on its residents. A comparable, but somewhat smaller veteran-specific residence identified within the literature review is the Royal Home for Retired Military Veterans and Museum Bronbeek, in the Netherlands (Appendix K), which offers a home for 50 veteran residents and is also a museum, restaurant and conference facility, suggesting a similar requirement for income generation, however there is no evidence available of the impact this may have on its residents.

The findings clearly demonstrate an interdependency between the Royal Hospital and the In-Pensioners, and it could be argued that neither element would be viable without the other. Furthermore, it could be suggested that the Royal Hospital relies on the In-Pensioners to represent the organisation, as Chelsea Pensioners, to raise awareness and thus maintain its profile. It is therefore posited that there may be a requirement to ensure the In-Pensioner resident is the right 'fit' for the organisation.

As highlighted in the narrative, the Royal Hospital's compulsory four-day stay, which forms part of the admissions process, is considered beneficial as it gives both parties the opportunity to explore suitability from an establishment and personal perspective. A short stay visit in a prospective residential establishment aligns with Reed et al. (2003) who suggest that enabling individuals to experience what, to them, may be a new home, enables choice and supports the notion that older people are actively selecting where they choose to 'live', rather than being 'situated' in an unknown environment. However, it could be argued that the four-day stay gives the Royal Hospital an opportunity to be judicious over which applicants they accept, potentially selecting those considered to be the 'best fit' in preference to 'outliers' or a less-preferable demographic, such as veterans with a criminal record or those who have experienced homelessness. It is important to note that there is no evidence within the project findings to suggest a biased selection process, nor is there any empirical evidence to indicate that this occurs in other residential care settings. Equally, it could be argued that a robust selection process may be necessary to ensure the Royal Hospital safeguards both the extant In-Pensioner population and its reputation, further underlining the interdependency between the organisation and its residents.

6.4.5 Inclusivity

Observationally, the In-Pensioner and New In-Pensioner demographics indicate a lack of diversity. However, apart from the male/female demographic, the project did not collect participant or organisational diversity data, and there was no evidence within the findings to suggest that the Royal Hospital is non-inclusive.

As highlighted in the literature review, veteran-specific establishments are predominantly occupied by male residents. This finding is reflected in the In-Pensioner participant demographics and the Royal Hospital as a whole. Of the 42 In-Pensioners and New In-Pensioners engaged in the project, three were female, representing 4.76% of both cohorts, compared to the overall In-Pensioner population of 258 male (94.19%), and 15 female residents (5.81%) (RHC, 2022g). This contrasts with the current female population of the British Army of 10% (House of Commons Library, 2022), however it is suggested that the percentage of female In-Pensioners will naturally increase over time, as more female soldiers become veterans and subsequently become eligible to join the Royal Hospital. It is reasonable to assume that the current In-Pensioner demographic is reflective of the Armed Forces population. Irrespective of age as 88.9% of the total UK veteran community are identified as male, and 98.3% identify as white (RBL Household Survey, 2014). Furthermore, of the 2.5 million UK Armed Forces veterans identified in 2016, 63% were over 65 years of age, with a 90% male and 10% female demographic split (MoD, 2019b).

A further observation was the apparent lack of In-Pensioners from the LGBTQ+ community, which may infer reservations by some residents to declare their sexual orientation. This may be a reflection of the Army Act 1955 where it was against military law to be homosexual and serve in the Army (UK Government, 2022b). This law was abolished in 2000 (UK Government, 2022b), therefore it is suggested that the visibility of the LGBTQ+ demographics of In-Pensioners may change over time. Research into the LGBTQ+ veteran population is scarce (Paige et al., 2015), however Vickers (2015) found, that out of a military strength of over 6.5 million, over 350,000 military personnel who served in World War II considered themselves to be gay. Furthermore, Mankowski (2017) indicates there are approximately one million sexual and gender minority (SGM) veterans and approximately 134,000 transgender veterans in the USA.

The reluctance of the ageing population to discuss their sexuality, alongside a hesitation by staff to broach the subject introduces barriers to delivering and receiving support within residential care settings (Hafford-Letchfield et al., 2018). Adopting a position of not discussing an individual's sexuality because it is considered 'a private matter' further increases the barriers to support (Hafford-Letchfield et al., 2018). With this in mind, and considering the stoic attitude demonstrated by In-Pensioners within the findings of this project, I would, as mentioned earlier, argue the possibility that there may be a hidden LGBTQ+ demographic within the In-Pensioner community. It is important to note however, that diversity information is not requested, or disclosed, as part of the admissions process, and that the Royal Hospital safeguards In-Pensioner sexual orientation in the form of its 'Sexuality and Intimate Relationships' policy (Appendix Y), therefore demonstrating the practice of inclusivity even though it is not evidenced within the findings of this project.

The project narrative indicates broad recognition that the future In-Pensioner population may include veterans with complex physical and mental injuries, following recent conflicts such as the War in Afghanistan (2001-2014) and the Iraq War (2003-2011) (Imperial War Museum, 2023), with suggestions that the Royal Hospital may not have adequate services in place to support them. Whilst it is reasonable to suggest that the Royal Hospital has been caring for wounded soldiers since it opened its doors in 1692, advances in battlefield medicine mean military personnel are surviving injuries, such as limb loss or head injuries, that would have proved fatal in earlier conflicts (Gauntlett-Gilbert et al., 2013), therefore it is equally reasonable to suggest that future In-Pensioners may have more complex needs. Irrespective of the potential challenges, the narrative indicates a welcoming attitude towards ensuring such individuals are catered for with some suggesting flexibility in the admission criteria to permit veterans who are not yet in receipt of their state pension to reside in the Royal Hospital.

Conversely, the level of care offered to veterans who have sustained injuries such as limb loss, means that many are able to return to paid employment, live 'normal' lives and therefore, arguably, may be at no greater need to consider living at the Royal Hospital than someone without such injuries. Dharm-Datta et al. (2011) found that of 52 UK personnel who had sustained combat-related limb loss between 2001-2008, 33 were still employed within their respective military service, with a further five

discharged from the military but in employment. The charitable association Blesma, The Limbless Veterans, supports all UK veterans who have either lost limbs or sight, or lost the use of their limbs, and has a current membership of 2725, with 1267 of these being over 70 years of age. Membership numbers presented here include widow(er)s of members who have died therefore actual veteran numbers will be lower. During 2021, membership increased by 118, indicating not all limb loss is attributable to combat duties but may include accidents or disease (Blesma, 2021). Similarly, older veterans are likely to experience musculoskeletal challenges due to the physicality of life in the military, with 60% of Army personnel discharged in 2011 due to these physical problems (Gauntlett-Gilbert et al., 2013). Considering the changing demographic of the current Armed Forces, the Royal Hospital may wish to consider a more visibly inclusive approach to its admissions process to ensure the Royal Hospital is seen as an accommodating option for future generations of In-Pensioners.

6.4.6 Section Summary

Identity is an important contributor towards the Royal Hospital Chelsea model of care and presents itself in several ways. In-Pensioners assume a number of identities that enable them to retain their personal characteristics whilst at the same time, live within an environment where they share a collective, quasi-military identity that underpins their past military experience to their current home. The military connection to the Royal Hospital is shared by those staff who have also served in the military, and therefore enjoy a shared affiliation to the In-Pensioners as fellow veterans, but also maintain elements of separation as non-residents and as a result of their employment status.

The identity of In-Pensioner, or Chelsea Pensioner, affords an almost celebrity status that is welcomed by some, but resisted by others. However, irrespective of whether individuals actively seek this elevated status, the project findings indicate that the collective identity enjoyed by In-Pensioners contributes towards positive wellbeing outcomes and enhances their sense of belonging.

The raison d’être of the Royal Hospital Chelsea is likely to be more familiar to those who have direct, indirect, or tenuous links to the British military, however for those

without these links, it could be argued that the identity of the Royal Hospital is ambiguous, with its blended accommodation options, images of members of the older population wearing uniform, and term ‘Hospital’, creating confusion to others. This ambiguity does not impact on the care In-Pensioners receive, however it may impact on potential fundraising opportunities. Furthermore, the blended living options do present challenges when empirically critiquing the model of care.

The speculation that the future Royal Hospital environment may include eligible veterans from other branches of the Armed Forces was met with mixed opinion. Engagement with other veteran-specific establishments that already support combined services may assist the Royal Hospital with any future considerations.

There is evidence of a lack of diversity amongst the In-Pensioner residents, however there is no evidence of an intentional lack of inclusivity. This suggests that the diversity and inclusivity of the In-Pensioner population will increase as the future generations of In-Pensioners begin to reflect the changing demographics of the currently serving, and consequently future, veteran population.

6.5 Staying Active

6.5.1 Introduction

As discussed earlier (2.2.1) the activity theory of ageing preceded the development of successful ageing theories (Adams et al., 2011; Knapp, 1977), with both theories suggesting being recreational activity and social engagement influences positive experiences in later life which result in benefits including feeling useful, valued, and needed. Moreover, expanding recreational pastimes to include regular physical activity is found to further contribute towards an individual’s ability to age successfully,

or ‘age well’ (Ballesteros, 2019; Baltes & Baltes, 1990; Kruse & Schmitt, 2015; Rowe & Khan, 1997).

Consistent with this, health policy proposes *“activity and exercise which improve physical health, increase the sense of well being and also tend to promote more positive social interaction and will in turn promote positive mental health”* (Dept. of Health, 2001, p.110), however evidence suggests a decline in activity levels as we age, with 10% of males and 20% of females older than 75 years of age considered to be below the threshold of good health due to inactivity (Public Health England, 2014).

Opportunities to stay active may be constrained by an individual’s built environment which may itself represent a barrier, as people consider residential establishments to be institutions that are isolated from the ‘outside world’, are therefore impenetrable, and not welcoming of visitors (Goffman, 1961). Furthermore, those who live in institutional settings may be disadvantaged as a lack of resources may restrict opportunities for residents to participate in activities (Anderson & Dabelko-Schoeny, 2010).

In addition to the recreational and physical activities In-Pensioners take part in, the representational role of Chelsea Pensioner’s reflects that of civic engagement, where individuals willingly engage with others to benefit wider society (Anderson & Dabelko-Schoeny, 2010). However, the benefits older people bring to society as a result of this engagement, particularly those over 80 years of age, are often overlooked by the public. Furthermore, this area is under-researched by academia, with assertions that this age group are not expected to take part in such engagements due to their increasing age and frailty (Kruse & Schmitt, 2015). This assertion may serve to exclude a cohort of the population who demonstrate a desire to contribute and share life experiences with younger generations, which is considered to be a natural part of the life course (Kruse & Schmitt, 2015).

Two sub-themes are presented in this principal area: Access to Opportunities that Facilitate Staying Active, and The Representational Role of the Chelsea Pensioner.

6.5.2 Access to Opportunities that Facilitate Staying Active

The impact of staying active is reflected in the literature review which identified access to, and engagement in, activities improved general health status and contributed towards positive quality-of-life outcomes for individuals living in residential establishments (Guihan et al., 2009; Kheirbek et al., 2018; Montross et al., 2006). Similarly, Brownie & Horstmanshof (2012) found being socially engaged and taking part in meaningful activities are positive contributors that enhance an individual's life experience as they age. The project findings clearly indicate that Royal Hospital Chelsea In-Pensioners are afforded access to an exceptional variety of social activities, with many participants eager to articulate the availability of numerous pastimes, ranging from sedentary card and board games through to more physically engaging activities such as hobby clubs, on-site allotments, fitness suite, bowls and boules clubs, alongside an on-site café and the Chelsea Pensioner Club to facilitate social engagement, as highlighted in the In-Pensioner Handbook (Appendix Y). In contrast, Cook et al. (2015) found that despite the willingness of sheltered housing residents to engage in activities, and demonstrating the desire to remain healthy and enjoy their lives, a lack of provision limited their opportunities to do so. Furthermore, a lack of financial and staff resources is found to impact on the ability to provide activities for those living in residential establishments (Anderson & Dabelko-Schoeny, 2010; Kruse & Schmitt, 2015; Smith et al., 2018).

The project narrative highlights how In-Pensioners are encouraged to stay active and are supported to push the boundaries of possibilities, with one participant making explicit reference to being empowered to complete a sky-dive, reflecting the Royal Hospital's proactive approach to encouraging In-Pensioners to engage in meaningful activities, which is found to contribute towards ageing well (Ballesteros, 2019), and the In-Pensioners enthusiasm to remain active. Furthermore, the narrative clearly evidences the strong desire by In-Pensioners to remain active participants of Royal Hospital life even if they are physically restricted. This is evidenced as In-Pensioners articulate a determination to take part in the annual Founders Day event, which is a 'mandatory' quasi-military parade, attended by all those able to do so, to remember the founder of the Royal Hospital Chelsea. Irrespective of the expectation to attend 'mandatory' events such as Founders Day, or Governors Parade (Appendix Y – In-Pensioner Handbook), the narrative indicates the presence of In-Pensioner choice and

the ability to exercise control over their decision-making, which helps maintain independence and contributes towards the ability to age well (Brownie & Horstmanshof, 2012).

In-Pensioner satisfaction with opportunities to engage in activities is further supported in the quality-of-life data (Table 22, Q14), with this question receiving the highest score by the In-Pensioner cohort across all questions, and New In-Pensioners indicating an increase in satisfaction after six months residency, suggesting a better awareness of the opportunities available, however not necessarily an indication of increased engagement. Nevertheless, anecdotal evidence suggests there are some In-Pensioners who prefer to live more sedentary lives, which is acknowledged by participants to be acceptable and 'their choice'. However, this lack of engagement is considered to reflect a lonely existence. It is worthy of note that this sedentary approach was not evident in any In-Pensioner participants, therefore without further research this anecdotal evidence cannot be verified.

Exploring the impact of the Covid-19 pandemic was not a specific aim of this project. However, as access to the broad variety of activities In-Pensioners are routinely engaged in was severely curtailed during this period, the narrative has relevance to the project findings and is therefore considered important to discuss. Some individuals living in residential establishments may have limited access to physical and social activities, as discussed earlier, however this was further compounded by the Covid-19 pandemic as normal routines and social contact were dramatically reduced (Richardson et al., 2022). In contrast, Smeitink et al. (2022) found service providers of nursing homes in the Netherlands sought to maintain access to activities throughout the Covid-19 pandemic, however they were modified to remain compliant within the necessary guidelines which is reflective of the approach applied by the Royal Hospital and highlighted in the project findings. At the time of the pandemic government policy understandably concentrated on minimising the spread of the disease, however as Richardson et al. (2022) found, the physical and mental impact was afforded much less priority.

The project findings highlight a staff commitment to ensure In-Pensioners were given opportunities to engage in some level of Covid-19 compliant activity during periods of isolation as they were supplied with a variety of pastimes, which they could engage in

whilst in their Berth's, enabling them to remain occupied during long periods of isolation. Furthermore, participants highlighted the determination to connect In-Pensioners with their friends and family by providing digital technology and teaching those residents who were unfamiliar with such technology how to use it. This commitment by staff and appreciation by In-Pensioners is clear throughout the narrative, with many recognising the challenging, and unprecedented, circumstances they were working and living in. It could be argued that the Covid-19 restrictions may have had a greater impact on In-Pensioners due to their engagement with the wider community, however it could be further argued that In-Pensioners were more fortunate than those in other residential establishments as they had access to 66 acres of green space within the secure grounds of the Royal Hospital. Access to green space for those living in residential care during Covid-19 was found to be an important factor that supported positive physical and mental wellbeing and reduced the potential for infection (Klemenčič & Leskovar, 2022).

Notwithstanding the fact that In-Pensioners were restricted to engaging with fellow residents within their specific Long Ward, these mini communities enabled social engagement to take place, within the specified governmental and Royal Hospital guidelines, which, it could be argued, was more than was afforded the wider population, and others living in residential establishments, at the time of the restrictions. The impact of this opportunity is widely reflected in the participant narrative as In-Pensioners acknowledge the fortunate position they found themselves in during the pandemic.

The narrative clearly demonstrates In-Pensioner access to, and engagement in, activities is a fundamental component of life at the Royal Hospital and is one that is facilitated by a bespoke social care team, who work alongside other members of staff, including the Captains, to ensure optimal engagement by In-Pensioners in activities of their choosing. This contrasts with Smith et al. (2018) who, when exploring the impact of engaging in meaningful activity in care homes in England, found that provision of activities and encouraging resident engagement was seen as separate to the core objective of providing care and support for residents, even though residents indicated a desire to engage in activities within and external to their residence, including "day trips".

Juxtaposed to Abbott et al. (2000), who found a lack of communication, combined with a non-engaging resident population, was considered by staff to indicate resident happiness, the Royal Hospital utilises multiple communication methods to engage with In-Pensioners to ensure they are kept informed. An internal radio channel, information monitors in each Long Ward, and a weekly 'Bulletin', or newsletter, inform In-Pensioners of internal and external activities and opportunities, with additional information shared by the social care team and cascaded by the Captains or Ward Representatives (Appendix Y – In-Pensioner Handbook). Furthermore, satisfaction regarding accessibility to information is reflected in the quantitative data as all In-Pensioners indicate high mean scores (Table 22, Q13), which suggests effective communication mechanisms are in place.

In further contrast to the project narrative, Smith et al. (2018) indicated both residents and staff assumed that those with declining health or ability were more accepting of engaging in fewer activities, which the study indicated may be as a result of over-worked staff who prioritised practical elements of resident care over opportunities to engage in activities, however studies also suggest that those living in residential care are not physically active (Król-Zielińska et al., 2011). Health guidelines suggest activity levels for those over 65 years of age should include daily light activity such as walking slowly, or undertaking light household tasks, alongside a weekly activity routine of a minimum of two and a half hours of 'moderate intensity' activity such as walking at pace, or dance classes, or a minimum of one hour and fifteen minutes of 'vigorous intensity' activity such as going for a run, swim, or fast bike ride (UK Government, 2019; NHS, 2023).

In-Pensioners clearly indicate a desire to be proactive and are enthusiastic in their approach to engaging in activities which juxtaposes with Brownie & Horstmanshof (2012), who found residents experienced levels of inactivity and boredom, with long periods of time spent in their own rooms, or within communal areas watching television, which can lead to a loss of meaning in life, a loss of independence, and an increase in helplessness. Whilst it is acknowledged that In-Pensioners primarily lead semi-independent lives and have a freedom of movement that may be less likely in other residential establishments, it could be argued that In-Pensioners with impaired mobility and declining age may be susceptible to experiencing a more institutionalised way of life. However, the narrative indicates that all In-Pensioners continue to be

supported by staff and are encouraged to remain as active as possible, within their personal capabilities, thus minimising the risk of isolation or loss of independence and maximising opportunities to remain active and enhance their life satisfaction.

6.5.3 The Representational Role of the Chelsea Pensioner

As discussed previously (see 6.4.2) In-Pensioners have multiple identities, one of which is their more formal representational role of Chelsea Pensioner. I would argue that this ambassadorial position aligns with civic engagement, where individuals are involved in activities that may include volunteering, community events, and educational engagement (Gottleib & Gillespie, 2008; Kruse & Schmitt, 2015).

The narrative clearly demonstrates the enthusiasm of In-Pensioners to voluntarily engage in numerous internal roles, which include helping in the post-room, the library, and on-site shop, or as tour guides where visitors are escorted around the Royal Hospital to learn about the history of the Chelsea Pensioners and the built environment. This enthusiasm and willingness to engage extends to the In-Pensioner external-facing ambassadorial role with many participants indicating this is seen as a duty and one with which they positively embrace, as they represent past residents of the Royal Hospital, currently serving military personnel, and the wider veteran community.

Volunteer-style engagement and participating in social activities is found to increase satisfaction with life, create a sense of purpose and be a positive indicator towards living longer (Gottleib & Gillespie, 2008; Lum & Lightfoot, 2005; Wang et al., 2023), however this impact is found to decrease in those over 85 years of age (Wang et al., 2023). It could be suggested that In-Pensioners experience these positive outcomes as a result of living at, and representing, the Royal Hospital as indicated in the project findings.

Interestingly, despite being retired and in receipt of the UK State Pension, quality-of-life data indicates In-Pensioners consider themselves suitable for, and capable of, engaging in work-like activities, and able to perform daily activities with minimal support (Table 19, Q17 & Q18), which may reflect their eagerness and ability to engage in their representational and volunteer-style activities.

It could be argued that, with an established military-related history of over three centuries, the Royal Hospital has advantages over other residential establishments as there is an interest by external parties to engage with the establishment, which may therefore afford increased opportunities for In-Pensioners to engage in civic engagement style events, as reflected in the 285 official military related In-Pensioner engagements, and the 150 Royal Hospital tours, that took place in 2020 (Appendix Y – Engagement Report, 2020).

Benefits to engaging in civic-style engagements can include an increase in both physical and psychological outcomes, as individuals recognise their own self-worth, enhance their ability to engage with others, develop a sense of belonging, enjoy life more, and potentially live longer (Abbott, et al., 2000; Anderson & Dabelko-Schoeny, 2010; Kruse & Schmitt, 2015; Wang et al., 2023). However, despite these benefits, there is a paucity of evidence that relates to the opportunities for, and impact of, civic engagement by those living in residential establishments (Anderson & Dabelko-Schoeny, 2010). It may be considered that this project's findings will contribute towards this knowledge gap. It could also be considered that the benefits of engagement are mutually exchanged as Chelsea Pensioners may be seen to enhance the event they are attending, which subsequently raises the profile of the event organiser, raises awareness of the Royal Hospital, and contributes towards positive outcomes for In-Pensioners. However, it is suggested that other veteran, or employment-specific residences, or establishments that have comparable unique identities, such as Brinsworth House, the residential and nursing home for former members of the entertainment industry (The Royal Variety Club Charity, 2015), may have the potential to access, or generate, similar opportunities.

Furthermore, the narrative indicates that being a Chelsea Pensioner, wearing the Scarlets, and representing the Royal Hospital, situates In-Pensioners in an exclusive position which facilitates opportunities for them to engage in many activities and events that they would not have access to if they lived elsewhere. Moreover, there is a clear acknowledgement in the project findings that without their uniform and unique identity In-Pensioners would be indistinguishable from any other member of the older population, suggesting this identity contributes towards their sense of status and purpose, as discussed earlier (see 6.4).

Role theory suggests that as we age, we experience a loss of position in roles such as that of spouse, parent, or employee, with options to replace these functions limited and declining with age, however engagement in civic-style activities is considered to offer a potential substitute for these lost roles (Anderson & Dabelko-Schoeny, 2010). Equally, civic engagement levels are found to diminish as people get older, however causes for this decline are uncertain but may be attributed to staff perception or a direct indication by residents that individuals do not wish to engage, a lack of opportunity, resources, or an assumption that age itself is a barrier, which may result in individuals being overlooked simply because of their age (Anderson & Dabelko-Schoeny, 2010; Kruse & Schmitt, 2015).

As demonstrated within the project narrative, and in contrast to the findings of Anderson and Dabelko-Schoeny (2010), and Kruse and Schmitt (2015), In-Pensioners are encouraged to establish new roles that help to create a sense of purpose and identity, with some indicating living at the Royal Hospital has engendered a new lease of life, creating a new purposeful element to their lives that some indicate had been lost. Furthermore, as part of their external engagements, which includes the outreach programme (see 5.2.3), In-Pensioners take part in intergenerational knowledge exchange as they connect with the Armed Forces Community which includes currently serving military personnel, veterans, and their families; with schools; and the wider public. Evidence shows older people consider knowledge exchange with younger generations to be an obligation borne out of concern, with the imparting of information seen as human instinct, which results in increased levels of personal satisfaction and achievement by the information giver (Kruse & Schmitt, 2015). Cook and Bailey (2011) highlight the positive impact children, young adults, and various local organisations, can have when visiting care homes, as residents and visitors engage in activities, sharing knowledge and skills that result in a mutually beneficial experience that contributes to positive wellbeing. It is suggested that the project findings concur with this evidence as In-Pensioner benefits, as a result of engagement with others, are demonstrated throughout the narrative.

Moreover, the wearing of the Scarlets, as part of the commitment to represent the Royal Hospital, creates a continued opportunity for public engagement and mutual information exchange which perpetuates the sense of identity and purpose for In-Pensioners. However, the narrative indicates that this visibility brings challenges for

In-Pensioners as they attempt to go about their daily lives with many participants articulating routine tasks such as shopping, taking considerably longer. Nevertheless, there is a clear understanding and acceptance that this is part of the commitment to being a Chelsea Pensioner.

6.5.4 Section Summary

The participant narrative clearly highlights opportunities for In-Pensioners to access a multitude of options to remain active, whether taking part in hobbies, or interests, within the Royal Hospital environment, or in a more ambassadorial, civic-style, role as Chelsea Pensioners. These activities enable In-Pensioners to be socially interactive, developing relationships with others that cross the generational divide, whilst maintaining their independence, visibility, and relevance, which are all important factors in the ability to age well (Ballesteros, 2019; Baltes & Baltes, 1990; Rowe & Khan, 1987; 1997; 2015).

The lack of empirical evidence concerning the impact of civic engagement within a residential setting provides an opportunity for the Royal Hospital to explore this area in more detail and contribute to the knowledge gap. Moreover, challenges exist when comparing the Royal Hospital with other establishments as discussed earlier (see 6.4.4), however this challenge is deliberated when critiquing the project findings to present an objective response.

Staying active is one of four key components identified as being integral to In-Pensioner health and social care outcomes and the Royal Hospital model of care. This section highlights the accessibility to, and impact of, activities for residents of the Royal Hospital Chelsea.

6.6 Staying Healthy

6.6.1 Introduction

Opportunities to age well, or 'successfully', depend on several factors, not least the ability to stay healthy. Notwithstanding the natural process of ageing, and experiencing age-related decline, ageing well requires individuals to have low incidence of disease, or conditions connected to disease, alongside continuing positive physical and mental health status (Bowling, 1993; Rowe & Khan, 1995; 1997; Urtamo et al., 2019).

To facilitate successful health outcomes in later life, individuals require access to adequate healthcare provision, which subsequently contributes towards positive quality-of-life outcomes and may impact on longevity (Galvani-Townsend et al., 2022). Veterans may be more susceptible to additional physical and mental health challenges as a result of their service, therefore access to provision that recognises this is important to older veteran health and social care outcomes (Burnell et al., 2017). Furthermore, having access to adequate healthcare services, within an environment of ones choosing is an important contributor to enabling individuals to age in [the right] place, and is part of UK policy (Sixsmith & Sixsmith, 2008).

Five sub-themes are presented in this principal area: Access to Provision; In-Pensioner Satisfaction; Alcohol, Mental Health, and Stoicism; On-site Rehabilitation; and Delivering Effective Health and Social Care to Older Veterans.

6.6.2 Access to Provision

It is abundantly clear from the narrative that In-Pensioners have unprecedented, and potentially unrivalled, access to health and social care provision at the Royal Hospital. This is facilitated by an on-site medical practice and social care team, with many

indicating opportunities to see a doctor almost immediately, on the same day, or at most, within 24-hours. This compares with general practice data which indicates 40.6% of patients receive same day 'urgent' appointments, 6.5% are seen within one day, and 34.3% wait 2-14 days for an appointment (NHS, 2019). Furthermore, there is a clear acknowledgment and appreciation from all participants that the on-site medical centre benefits from a small patient caseload of approximately 300 In-Pensioners. This contrasts sharply with other medical practices within London where there are, on average, 2400 patients per fully qualified GP, and 6700 patients per nurse (ONS, 2022). Consequently, this small patient group affords staff the time to offer high levels of care and attention, with the pressures experienced in other medical practices not evident at the Royal Hospital, thus facilitating effective healthcare which contributes towards an In-Pensioners potential to remain healthy and age well.

As highlighted in the literature review, residential establishments offer varying levels of assistance with daily living activities or domiciliary care (see 2.4.3.1). This is reflected in the provision available to In-Pensioners, however there is an absence of evidence identifying residences with access to an on-site medical centre, suggesting this level of service may be unique to the Royal Hospital.

This project's findings highlight the impact that this expedited access has on the early identification and treatment of health conditions such as cancer, with some suggesting their lives have been 'saved' by the prompt action of the on-site healthcare provision, and the intervention by local healthcare facilities, such as the Chelsea and Westminster Hospital. However, notwithstanding the recognition by many participants that access to this level of health and social care provision is a privilege, the Key Staff narrative reveals a professional dilemma when comparing the dichotomy of services available to In-Pensioners alongside those available to the general population, with many indicating a clear desire to offer this level of accessibility to everyone.

Considered a *"strong pull factor",* Aitken et al. (2016, p.4) highlight the importance placed on the provision of health and social care services within the place people choose to live. Access to doctors and other healthcare professionals in many UK residential establishments is via community based primary healthcare services where provision may be intermittent, rather than being an in-house resource as found at the Royal Hospital (Gage et al., 2012; Robbins et al., 2013). Despite acknowledging the

importance of the relationship between doctor and residential establishment, Robbins et al. (2013) found inconsistencies in the way healthcare support is delivered as some establishments engage with doctors from a specific GP practice, whilst others receive support from a number of practices, and consequently, different doctors, with visits to the residences ranging from weekly or 'as required' attendance. It could be argued that this hinders continuity of care for residents and fosters a reactive rather than proactive approach as healthcare professionals are time constrained. This contrasts with the embedded nature of the Royal Hospital model of care, where In-Pensioners have consistent access to a variety of healthcare professionals, including access to doctor(s), nurses, physiotherapy, and occupational therapy, with visiting audiologists and podiatrists to support In-Pensioner health needs (Appendix Y – In-Pensioner Handbook). However, for any emergency, or out-of-hours assistance, In-Pensioners living independently in Long Wards were required to access the services provided by the NHS, namely the NHS 111 telephone assistance service, or the 999 service for emergencies. Further challenges experienced in residential homes include the exchange of patient information, for example hospital discharge documentation, or communication issues between healthcare professionals and residential staff (Gage et al., 2012; Robbins et al., 2013). Findings suggest the relationship between the medical centre and other care providers, such as the Chelsea & Westminster Hospital, as highlighted within the project findings, may mitigate any delay in an In-Pensioners treatment pathway or rehabilitation needs, subsequently removing barriers to continuity of care.

Evidence suggests the impact of having access to a doctor to whom a patient is specifically allocated is unclear (Tammes et al., 2016; Lautamatti et al., 2022). The introduction of a 'named GP scheme' in UK NHS medical practices, aimed to offer individuals continuity of care as it was believed the doctor-patient relationship would result in a greater understanding of an individual's needs, and subsequently better health outcomes (Tammes et al., 2016). However, some patients were unaware of the scheme therefore developing the doctor-patient relationship was compromised from the outset, with the scheme results failing to indicate any impact of continuity of care, or whether there was a reduction or increase in hospital admissions (Tammes et al., 2016). In contrast, Lautamatti et al. (2022) found older patients with long-standing health conditions who had access to a named doctor, developed a doctor-patient

relationship which increased engagement with health services and hospitalisation rates, indicating an increase in patient confidence due to the continuity of care, which is also contributed to positive quality of life outcomes (Lautamatti et al., 2022).

I would argue the project narrative, and the available evidence as discussed, demonstrate the benefits of the on-site medical centre within the Royal Hospital. This alleviates many of the challenges experienced by other residential establishments, as it provides timely access to health and social care support, enables continuity of care and fosters a positive relationship with patients. Project findings suggest this results in increased patient confidence and influences an In-Pensioner's ability to stay healthy, and consequently, enhances their quality-of-life outcomes. Whilst recognising that implementing an on-site medical centre may not be a feasible option for many residential establishments, I would argue that the Royal Hospital's approach is worthy of exploration by service providers to consider a comparable service which may benefit residences willing to adopt a similar approach.

It is important to note that In-Pensioners have the freedom to register with a GP practice of their choosing (Appendix Y – In-Pensioner Handbook), however there was no evidence within the narrative of In-Pensioners doing so. Furthermore, there are some services that are not available within the Royal Hospital, such as emergency or out-of-hours care (notwithstanding the MTI nursing facility), pharmacy, dentistry, or access to an optician, with this provision accessed locally, and arguably, more aligned to services utilised by those not living in residential establishments (Appendix Y – In-Pensioner Handbook).

Access to healthcare services extends to what is referred to by many as a 'special relationship' with the Chelsea and Westminster Hospital, as participants articulate fast-tracked appointments or treatment, especially when In-Pensioners attend hospital wearing their uniform. It could be argued that, as signatories of the Armed Forces Covenant (Armed Forces Covenant, 2019), and recognising that the Royal Hospital sits within the same catchment area, the Chelsea and Westminster Hospital enthusiastically honours its commitment to support members of the Armed Forces Community. This may, therefore, be interpreted as offering an expedited service. The Armed Forces Covenant (Armed Forces Covenant, 2023), enshrined within the Armed Forces Act, 2011 (UK Government, 2011a), and part of the NHS Constitution for

England (UK Government, 2011b), is a commitment to ensure members of the Armed Forces Community are not disadvantaged in areas such as access to healthcare as a result of their military service (Bacon, 2022). Nevertheless, neither the Armed Forces Covenant, nor the Care Act 2014 explicitly acknowledge the healthcare needs of the older veteran, as there is a reliance on the individual to declare their veteran status, which Burnell et al. (2017) suggest offers service providers the opportunity to increase levels of awareness amongst healthcare professionals to facilitate appropriate care for this population group.

Furthermore, the enduring relationship that exists between the Royal Hospital and the Army is clearly evidenced by participants who articulate the support In-Pensioners received during the Covid-19 pandemic. A contingent of Army personnel were assigned to the Royal Hospital to help with practical matters such as delivering food to individual berths during the enforced 'lockdown' periods, to assisting with healthcare provision, including Covid-19 vaccinations (RHC, 2021). The project narrative clearly indicates the impact having younger generations of soldiers had on the morale of the In-Pensioners as they were able to share stories of their time in the military, which I would argue, emphasises the importance of the intergenerational exchange as discussed earlier (see 6.5.3). It is important to note that the British Military supported the UK during the Covid-19 pandemic in several ways which included supporting the NHS with emergency planning, establishing Covid-19 hospitals and delivering essential supplies (Watts & Wilkinson, 2020), however it may be considered that the seemingly 'extra' support afforded to the Royal Hospital may be indicative of the high regard with which the In-Pensioners are held by the Army and Ministry of Defence, and reflective of their ongoing commitment to support the Royal Hospital (RHC, 2022g).

It is suggested that the Royal Hospital enables all In-Pensioners to age well, and in [the right] place, as they live in an environment that offers access to onsite medical facilities, and social care support, combined with the reassurance of living within a physically secure establishment (see 6.3.2) that generates feelings of safety.

6.6.3 In-Pensioner Satisfaction

In-Pensioner satisfaction with access to health provision at the Royal Hospital is reflected in the 2018-19 Practice survey (Appendix Y). Combined responses of 'outstanding or excellent' indicate satisfaction with listening to patient needs (80%), engaging with the patient (83%), and fully understanding the patients' concerns (81%). Similarly, In-Pensioners were supported in taking control of their health (83%) and developing an action plan (83%), with an overall satisfaction rating of 'outstanding or excellent' indicated by 87% of respondents. Moreover, patient satisfaction is further reflected in both the narrative and quality-of-life data, with responses to the question "how satisfied are you with your access to health services?" (Table 22, Q24), indicating high levels of satisfaction for both In-Pensioners and New In-Pensioners. It could be argued that these responses may be a predictable when considering the availability of the provision at the Royal Hospital.

The qualitative and quantitative data presented within this project clearly demonstrate the impact living at the Royal Hospital has on an In-Pensioner's quality-of-life. These findings provide a platform, or baseline, from which the Royal Hospital may wish to build on to establish a longitudinal evidence-base of In-Pensioner quality-of-life outcomes.

Both In-Pensioner and New In-Pensioner cohorts indicate high levels of satisfaction with their overall health status (Table 17, Q2). This contrasts with Ikin et al. (2008), who found Australian veterans engaged in the Korean War, and the study control group, demonstrated lower levels of health status when answering the same quality-of-life question. It could be argued that the elevated satisfaction levels of the In-Pensioner and New In-Pensioners participants may be as a direct result of access to the health and social care provision available to In-Pensioners.

The project narrative clearly demonstrates that In-Pensioners experience enjoyable and meaningful lives, as participants frequently articulate the impact living at the Royal Hospital has on their satisfaction with life. This narrative is strengthened by the quantitative data results which reveals high satisfaction levels when exploring these specific areas (Table 20, Q5 & Q6).

As indicated by Bowling (1993), Rowe & Khan (1995; 1997), and Urtamo et al. (2019), an important aspect of the ability to age well is maintaining good physical health, which

enables individuals to remain active as discussed earlier (see 6.5). The enthusiasm demonstrated by In-Pensioners to engage in multiple activities is supported by the quantitative data findings which indicate positive levels of energy and mobility (Table 19, Q10 & Q15), with one undoubtedly influencing the other, which may suggest the ability to be mobile and energetic fosters the enthusiasm that is evident in the project findings.

Interestingly, In-Pensioners have higher energy levels than New In-Pensioners which may be reflective of the impact of being established at the Royal Hospital longer, and therefore experiencing the health benefits this brings. Conversely, New In-Pensioners have higher levels of mobility, however I would argue that as new residents, who are expected to be able to live independently and represent the Royal Hospital for approximately two years (Appendix Y – In-Pensioner Handbook), this is perhaps unsurprising. Maintaining good levels of mobility positively influences quality-life, maintains independence, and can contribute towards living longer, however mobility levels are known to decrease as we age (Stathi et al., 2022). I would therefore further argue that even the lowest scores recorded in the quality-of-life data (Table 19, Q15) demonstrate high levels of physical mobility for In-Pensioners irrespective of residency duration.

The positive health status of In-Pensioners and New In-Pensioners is further indicated by evidence of low levels of physical pain with minimal medical intervention needed to support their daily functioning (Table 19, Q3 & Q4), which may infer that In-Pensioner participants are a relatively mobile and healthy individuals. However, further research across the wider In-Pensioner population would be needed to draw generalised conclusions.

Notwithstanding what could be argued are overall positive quality-of-life results, all In-Pensioners have problems sleeping (Table 19, Q16), with New In-Pensioners showing sleep satisfaction declining over six months, possibly indicating challenges with settling into a communal living environment which may take a period of adjustment. Sleep challenges in older age can be exacerbated by physical and mental health issues (Boswell et al., 2015; Gulia & Kumar, 2018), however irrespective of seemingly ‘low’ satisfaction rates, sleep issues do not appear to impact negatively on other areas

of In-Pensioner quality-of-life and may be considered commensurate with ‘usual’ ageing factors.

Furthermore, and interestingly, as highlighted in the quantitative data, both In-Pensioner and New In-Pensioner groups are reluctant to discuss intimate relationships (Table 21, Q21), with this question having the most unanswered responses (Table 23). Sexuality was not discussed during participant interviews therefore it is challenging to interpret this reluctance. However, Bauer et al. (2013) found residents considered the lack of privacy within residential establishments to be a barrier to developing intimate relationships, staff ignored resident need for intimacy, and that matters relating to sexuality were considered ‘private’ and therefore nothing to do with anyone else. The Royal Hospital has a ‘Sexuality and Intimate Relationship’ policy in place (Appendix Y) which indicates a recognition of this important element of an individual’s life, and balancing this with the environment in which In-Pensioners live.

6.6.4 Alcohol, Mental Health, and Stoicism

Whilst the quantitative data suggests In-Pensioners enjoy positive quality-of-life experiences, the narrative indicates that challenges exist in some areas that are likely to have a detrimental impact on physical and mental wellbeing. Staying physically and mentally healthy are important contributors towards the ability to age well (Bowling, 1993; Rowe & Khan, 1997; Urtamo et al., 2019), therefore it is important to promote healthy behaviour to minimise the impact these challenges may have.

For example, the Key Staff narrative indicates challenges with encouraging In-Pensioners to seek support for mental health issues. The reluctance by veterans to seek support, or indeed even acknowledge the presence of a problem, alongside the stigma attached to poor mental health is well researched and evidenced (Finnegan & Randles, 2022; Kiernan et al., 2018; Williamson et al., 2019a). Burnell et al. (2017) suggest veterans who have been exposed to events that impacted on their mental health in earlier years, may experience a recurrence as their cognitive function declines and traumatic memories resurface. It could be argued that the quantitative quality-of-life data may be an accurate reflection of those In-Pensioners engaged in this project, with the Key Staff narrative perhaps more indicative of challenges within the wider In-Pensioner population. Conversely, the lack of In-Pensioner narrative

relating to mental health is perhaps confirmation of the reluctance to discuss the topic. Irrespective of any correlation between the In-Pensioners engaged in this project and the Key Staff narrative, it could be suggested that the challenges articulated by Key Staff may be reflective of an ongoing reluctance by some to seek support for issues that may have a negative impact on their ability to age well. However, as highlighted by Burnell et al. (2017), it is possible that these issues may reappear as In-Pensioners continue to age and potentially experience cognitive decline.

Furthermore, and not evidenced within the quantitative data, the narrative indicates challenges with alcohol consumption and encouraging In-Pensioners to engage in adopting healthy behaviours, which is required to influence positive ageing (Wang et al., 2003). As with veteran's mental health, the relationship between alcohol and the Armed Forces Community is well documented (Burnell et al., 2017; Goodwin et al., 2017; Kiernan et al., 2018; Murphy & Turgoose, 2019; Rhead et al., 2022) and is recognised as an entrenched part of military culture (Hayes et al., 2020; Sundin et al., 2011). Project findings suggest access to alcohol may be facilitated by In-Pensioner representation of the Royal Hospital, as many events to which they are invited provide alcoholic refreshments as part of the social engagement. The narrative indicates some In-Pensioners choose to avoid such events or decline invitations to events where fellow In-Pensioners who are known consume alcohol to excess are attending, which could add weight to the narrative that challenges with alcohol exist. It could be argued that the on-site Chelsea Pensioners Club (Appendix Y – In-Pensioner Handbook), a licensed social venue for In-Pensioners and guests, facilitates the relationship with alcohol, however as In-Pensioners have the freedom to socialise wherever they choose, and are able to consume alcohol in the Long Wards and in their own Berths, a negative influence linked specifically to the social club may be challenging to evidence.`

Nevertheless, staff are aware of the extant challenges with veteran's mental health, the relationship with alcohol, and the association to military culture, which places them in a good position to monitor the In-Pensioners they may be concerned about, thus providing opportunities to engage with them to encourage moderation or adopt healthy habits that are important facilitators to ageing well (Bowling & Dieppe, 2005; Wang et al., 2023). Moreover, as evidenced in the project findings, In-Pensioners regard each other as family, and as a result keep a watchful eye on each other and are comfortable

in raising concerns with the relevant members of staff. Wang et al. (2003) found engagement with peers may have a positive influence on health outcomes by contributing towards a reduction in harmful, or unhealthy, practises. In this cohort, the findings indicate that there appears to be the potential to develop a network of peer-led support to address these issues and encourage engagement.

In-Pensioner resilience and stoicism are evident throughout the project narrative, which arguably influences the quality-of-life findings, as In-Pensioners clearly demonstrate a 'can do' attitude and fiercely guard their independence. The impact of serving in the military is lifelong and instils learned behaviour as the training process breaks down the 'civilian self' and rebuilds the 'military self', which creates characteristics that are essential in times of operational need, whether that be day-to-day military life or on combat duties (Meyer, 2015; Spiro et al., 2016). These characteristics include resilience and stoicism, which may be protective factors during military and civilian life and be beneficial contributors towards overall wellbeing in later life (Burnell et al., 2017; Pietrzak et al., 2014; Spiro et al., 2016). However, they can also become barriers and prevent individuals from seeking support from healthcare services (Burnell et al., 2017; Meyer, 2015; Spiro et al., 2016). It may be considered that the military-style environment of the Royal Hospital may inadvertently motivate In-Pensioners to revert to the stoic and resilient characteristics developed during their military lives, and potentially contribute towards the reluctance to seek support. Equally however, the narrative undoubtedly evidences the peer-support and camaraderie that In-Pensioners share, which when combined with the level of health and social care provision available, and the safe and secure environment within which In-Pensioners live, I would argue provides a structure to enable In-Pensioners to seek support to overcome any challenges they may be facing.

6.6.5 On-site Rehabilitation

In-Pensioners have access to rehabilitation services, within the Royal Hospital's MTI following periods of illness or hospitalisation. This enables In-Pensioners to receive extra care in the form of recuperation, or respite, and facilitates a return to better health, which is particularly beneficial to those In-Pensioners who live independently within the Long Ward accommodation. It could be argued that access to this provision,

aligns with the UK government initiative to develop intermediate care services that advance hospital discharges (Allen & Glasby, 2013; Department of Health, 2002). Without access to the MTI, In-Pensioners may be subject to extended stays in hospital until they are considered well enough to go home. Therefore, it could be further argued that this provision has a direct impact on secondary care resources as hospital beds are vacated to support other patients, and In-Pensioners are able to recuperate within a familiar environment.

An additional benefit of this rehabilitation provision is the opportunity to increase awareness of the MTI. This alleviates the resistance to ageing that is clearly evident in the narrative as some In-Pensioners express fierce reluctance towards being considered 'old' and resist the notion of moving into the MTI and requiring nursing care, as they age and their health declines. Conversely, the narrative shows other In-Pensioners demonstrate a pragmatic attitude towards the ageing process recognising that ageing is an inevitable part of life. Irrespective of the paradoxical reluctance and acceptance, all In-Pensioners express levels of reassurance knowing that they are able to, if necessary, transition into a higher-needs facility that is within an environment with which they are familiar, and with staff who are known to them. Moreover, MTI residents are fellow In-Pensioners who are, as discussed previously, considered as 'family' and may well have been former neighbours when living on the Long Wards, further alleviating any apprehension relating to transition. I would argue that the opportunity for In-Pensioners to recuperate 'at home' or within a familiar environment clearly demonstrates that they are able to age in [the right] place and develop an understanding of what life may be like should their health decline to the extent that they move from the Long Ward accommodation into the MTI. As a result, this opportunity minimises the impact of a move later in life and at a time where individuals may be approaching end-of-life.

Similar transition options are available within some retirement communities including the Royal Alfred Seafarers Society (Table 7), and Whiteley Village (Mayhew et al., 2017), however some establishments are restricted to short stays where provision is limited to respite care only, resulting in those residents with higher needs needing to relocate to a new establishment to receive the appropriate level of care (Evans & Means, 2007). It could therefore be argued that the reassurance articulated by those In-Pensioners engaged in this project is likely to be experienced by those living in

these similar environments, however further research is needed to explore this assumption.

6.6.6 Delivering Effective Health and Social Care to Older Veterans

The project narrative clearly emphasises the collaborative and holistic way all staff work to ensure In-Pensioners remain at the heart of everything they do. This affords them opportunities to stay healthy, and as a result, experience positive health and quality-of-life outcomes. Moreover, it is evident from the findings that the embedded nature of health and social care support, and the village-style environment of the Royal Hospital, results in staff accessing areas frequented by In-Pensioners such as the café, shop, chapel, and Chelsea Pensioner Club. This develops relationships with In-Pensioners, creates a 360º approach to service provision, and facilitates early identification of any potential decline in an In-Pensioners wellbeing. Irrespective of their actual job role, all staff appear to assume this observational role which reaffirms the staff commitment to ensure In-Pensioners are well cared for. This may, as reflected in the narrative, be attributed to the staff awareness of the contribution In-Pensioners have made to society as a result of their military service.

Whilst it could be argued that veterans are essentially 'civilians', the impact of serving in the military can reverberate through an individual's life-course, bringing with it challenges that may exacerbate physical and mental health conditions including musculoskeletal issues, hearing loss, mental ill-health, sleep issues, and increased alcohol consumption (Fullwood, 2015; Kiernan et al., 2018; RBL, 2014; Spiro et al., 2016; Williamson et al., 2019b). However, Woodhead et al. (2011) found veterans engaged in national service were no more likely to experience challenges when compared against those who did not engage in military service. Moreover, as discussed earlier, veterans can also display a stoicism that can be a barrier towards them seeking assistance (Iversen et al., 2005; Randles & Finnegan, 2022). Spiro et al. (2016, p.6) suggest that the impact of military service influences health outcomes across the lifespan, and moreover, that healthcare delivery for older veterans should consider their life experiences pre and post military service to facilitate effective healthcare support, with military service being a *"hidden variable"* that may have a positive, negative, or no, impact on ageing.

Meyer (2015) suggests, the ability to deliver effective care to veterans requires an understanding of the mechanics and culture of the military, and military service, which I would argue is clearly visible in the project findings which indicate that exclusively supporting an older veteran population, enables staff to develop expert knowledge of this cohort. Subsequently, this enables focussed and appropriate support and early identification of those health conditions to which older veterans are more susceptible to. It may be considered that evidence of this expertise is supported by the quantitative data which clearly indicates positive In-Pensioner quality-of-life outcomes, suggesting the Royal Hospital's model of care and its delivery are effective.

Arguably, the Royal Hospital environment, the on-site health and social care provision, and the 360º level of monitoring afforded to In-Pensioners places them at an advantage over those in other residential establishments where it may not be possible to identify changes in health and wellbeing status early on. Notwithstanding the level of oversight staff have of residents, there are some In-Pensioners who express a preference to be supported by ex-military staff only, as discussed earlier (see 6.3.2), however there is no evidence to suggest the health and social care provision is negatively impacted by a combined workforce.

As Bacon et al. (2022), Fullwood (2015), and Meyer (2015) explain, there is a need to ensure that those delivering health related services to the Armed Forces Community have an awareness of military culture and the increased health challenges some veterans may face either as a direct, or indirect, result of their military service. Notwithstanding the development of training packages for healthcare staff in the United States, including the 'Have you ever served in the military?' and 'Joining Forces' initiatives (Cooper et al., 2016), and the more informal learning available to UK healthcare professionals via online resources, there appears to be a lack of formalised learning specific to veterans' health needs within clinical training environments such as colleges or universities (Cooper et al., 2016).

Of the training that is available, one UK programme provides an overview of the general characteristics of those who have served in the military is "The Military Human: Understanding Military Culture and Transition" which seeks to inform those who are engaged in supporting veterans across public, private and charitable sectors. However, this training is a more generalised insight into the idiosyncrasies of being a

veteran rather than being health focussed (Wood, 2016). Additionally, one initiative that aims to increase awareness of, and support for, veterans, from what could be argued is the 'front door' of health provision, is for General Practitioner (GP) medical practices in England to become 'veteran friendly' accredited practices, with 24% of GP practices currently in receipt of this accreditation (Armed Forces Covenant, 2022). This emphasises the importance of the need to establish whether a patient has served in the military, it helps improve staff knowledge, and may encourage individuals to declare their veteran status, and subsequently receive access to more appropriate support commensurate with their needs (Grant & Simpson, 2022). Additionally, part of the accreditation includes the nomination of a veteran's clinical lead which aims to ensure the practice remains aware of current issues and training requirements, disseminating information to the wider practice as required, potentially resulting in a more effective service for the veteran population (RCGP, 2023a). Unsurprisingly, the Royal Hospital medical centre became 'veteran friendly' accredited in November 2022 (RCGP, 2023b). Furthermore, veteran's health has been incorporated into the UK GP training curriculum and is currently active in England and Scotland (Armed Forces Covenant, 2022) suggesting recognition of the importance of ensuring those delivering healthcare to the veteran population is expanding.

The project findings suggest that, notwithstanding the progress outlined above, the lack of awareness of delivering healthcare services to older veterans presents opportunities for the Royal Hospital to share its expertise and knowledge with GP practices, healthcare professionals and veteran-specific residential establishments.

6.6.7 Section Summary

Staying healthy is an important contributor towards ageing well, however it is only one element of several factors which include maintaining social relationships, engagement in activities, and feeling safe in the environment in which you live (Allen & Glasby, 2013), which have been previously discussed and collectively influence the impact on quality-of-life experiences.

Project findings clearly demonstrate the Royal Hospital Chelsea's model of care offers its residents opportunities to remain healthy and achieve optimum health outcomes

whilst remaining within the same environment throughout their remaining life course, suggesting In-Pensioners are able to age well, and arguably, age in the [right] place.

Exploring ways to navigate the stoic attitude of some In-Pensioners, may encourage In-Pensioners to engage in support for health issues that may be detrimental to overall health outcomes, such as mental health and alcohol consumption.

The project narrative identified the widely held opinion that In-Pensioners live longer as a result of living at the Royal Hospital, however the project was unable to directly evidence this. Further research is needed to explore the variables of the model of care to substantiate this assumption and enable comparisons to be made with similar establishments.

Access to the embedded medical centre and the resultant health and social care provision, alongside the 360º support from all staff, results in early identification of health and wellbeing issues which ultimately impacts positively on In-Pensioner quality-of-life outcomes. Supporting older military veterans enables staff to develop expert knowledge in caring for this specific cohort of the population, which undoubtedly contributes towards In-Pensioner outcomes, and is knowledge that could be shared with other healthcare providers to benefit those living outside of the Royal Hospital Chelsea environment.

Arguably, the Royal Hospital Chelsea model of care clearly supports In-Pensioners to stay healthy, age well, and age in [the right] place, meeting the WHO definition:

> *"Meeting the desire and ability of people, through the provision of services and assistance, to remain living relatively independently in the community in his or her current home or an appropriate level of housing. Ageing in place is designed to prevent or delay more traumatic moves to a dependent facility, such as a nursing home."* (WHO, 2004, p.9).

This section highlights that opportunities to stay healthy enable In-Pensioners to maintain positive health and wellbeing outcomes, with these outcomes supported by the quality-of-life data, suggesting In-Pensioners have high levels of life satisfaction as a result of living at the Royal Hospital.

6.7 Strengths and Limitations

This project has several strengths and limitations that should be considered and reflected on. Evaluating mixed methods research is challenging, therefore, to ensure data integrity and methodological rigor, the project applied the minimum evaluation criteria as suggested by Creswell and Clark (2017).

Table 24. Minimum criteria for evaluating mixed methods research (Creswell & Clark, 2017)

Criteria for evaluating mixed methods research:	**Section(s)**
Collects and analyses both qualitative and quantitative data rigorously in response to research questions and hypotheses	4.7; 4.8
Intentionally integrates (or mixes or combines) the two forms of data and their results	4.8
Organises these procedures into specific research designs that provide the logic for conducting the study, *and*	3.2; 4.2
Frames these procedures within theory and philosophy	2.2; 3.2

This project evidenced these criteria by developing a mixed methods approach that also considered the most appropriate theoretical framework, focussing on two theories of ageing, namely ageing well, and ageing in [the right] place to address the research aims. The project used Pragmatist positioning which is recognised as supporting mixed methods enquiry and places the importance of answering the research phenomenon above one preferred research methodology (Ritchie et al., 2013; Hall, 2013). Mixed methods enquiry enabled this project to collect data from three participant cohorts that were engaged in either qualitative, quantitative, or a combination of both, methodologies. This approach facilitates a coalescence of the data that enables a broader, more inclusive, interpretation of the findings. The non-traditional convergent design enabled these multiple data collection methods, and facilitated the simultaneous collection of qualitative data ahead of quantitative data which was an important consideration as the qualitative data held more dominance in this project, and not all participants were engaged in quantitative data collection. The data collection and analysis of the combined results followed a reflexive thematic analysis process which, to ensure consistency, transparency, rigor, and integrity, was

supported by researcher triangulation (Carter et al., 2014; Tracy, 2010), and regular appraisal with project supervisors.

Researcher engagement with the Royal Hospital Chelsea's Health and Wellbeing Oversight Committee, and the Research Oversight Committee, further strengthened the integrity of the project as regular updates generated constructive dialogue and transparent oversight of the overall progress of the project, which is an important element of applied 'real world' research, as collaboration is imperative.

The inclusion of both Key Staff and In-Pensioner participants strengthened the project as opportunities to explore the views of both groups ensured a balanced opinion of the Royal Hospital Chelsea model of care, from both service provider and service user perspectives. Furthermore, these opinions were analysed as one dataset to facilitate a focus on the model of care rather than a 'compare and contrast' presentation of the findings between the participant cohorts.

Researcher positioning, as previously reflected on in section (3.4), as a veteran, created an 'insider/outsider' perspective which added strength to the project, as the shared military experience meant there was an understanding of military terminology, characteristics, and culture, which helped mitigate any misunderstandings and reduce communication barriers. Disclosure of the researcher's veteran status was made at an appropriate time to ensure it did not influence In-Pensioner participation, engagement, or interview content. However, sharing the veteran status had a positive impact on the process as it developed a level of understanding and respect, and put In-Pensioners at ease which was evident in comments such as *'you get it'* or *'well, you know what it's like',* inferring an assumption of understanding around what it means to have served in the military. Researcher objectivity and mitigation of potential bias was maintained by applying rigor to the participant selection process, transparency throughout the data analysis process and regular researcher triangulation, and supervision sessions. The 'outsider' perspective was two-fold, firstly the researcher position as a veteran of the Royal Air Force, juxtaposed with all In-Pensioner residents being British Army veterans, resulted in some cultural differences as, notwithstanding the shared attributes as discussed earlier, each branch of the Armed Forces retains their own idiosyncrasies and cultural references specific to their force, with a 'professional rivalry' and 'banter' present across all Armed Forces. Secondly, not being

an In-Pensioner, and being ineligible to become one, resulted in experiencing the Royal Hospital from the outset of the project as an observer and being 'on the outside looking in'. It was critical to reflect on this through reflexive processes throughout my PhD journey to consider the potential impact of my insider/outsider experiences on the study as a whole.

The project had several limitations, one of which was establishing a coherent and consistent definition of 'residential care'. The numerous living options, combined with varying levels of care available within each option presented challenges throughout the project when critiquing the Royal Hospital Chelsea model of care. The lack of veteran-specific establishments with independent living options added further challenge. Many of the establishments identified throughout this study support veterans with higher needs or nursing care, which would align more with the MTI rather than the Long Ward living environment. These challenges required researcher vigilance when critiquing the findings to ensure selected empirical evidence concerned residential establishments that were principally comparable to the Royal Hospital Chelsea independent living option to prevent inappropriate misrepresentation of the evidence.

A further study limitation is the exclusion of those In-Pensioners living in the MTI, however the limited timeframe of the project required a decision on whether to navigate a potentially protracted NHS ethical approval process as this would have been required for inclusion of the MTI. Arguably, the findings from this project have relevance to those In-Pensioners living in the MTI as some are likely to still engage in the services available at the Royal Hospital, however omitting MTI residents does result in those In-Pensioner voices being unheard, and the inability to examine similarities and/or differences between the two models of care.

Project design and timescales meant extant quality-of-life questionnaires were used rather than the creation of a bespoke measure, which may be considered a limitation of the project. However, the use of empirically recognised quality-of-life questionnaires facilitated the presentation of reliable data, enabled empirical comparisons, and added rigor to the findings.

The decision to use the ICECAP-A quality of life questionnaire in preference to the ICECAP-O questionnaire may be considered a limitation, as the former is designed

for adults of working age, and the latter for adults 65 years of age and older (Baji et al., 2021). In their study to compare differences between the ICECAP-A and ICECAP-O quality-of-life questionnaires, Baji et al. (2021) found increased differences between ICECAP-O and ICECAP-A scores as participant capability decreased and age increased, which may indicate the ICECAP-O could have been a more appropriate measure. Conversely, the ICECAP-A may be effective for those older persons who are beyond retirement age and still engaged in employment-like activities (Baji et al., 2021), which reflects the representational role of the In-Pensioners, whilst recognising that this role does not result in financial reward.

Furthermore, Baji et al. (2021) found both measures to be comparable, in their cohort of adults aged 50-70 years of age, with differences influenced primarily by an individual's health positioning or work status rather than the participant's age. Therefore, arguably, the use of the ICECAP-A, rather than the ICECAP-O measure, for a population group aged 65 years and older who are engaged in employment-like activities may be considered appropriate for the In-Pensioner and New In-Pensioner population.

A further limitation is the disconnect between the In-Pensioner quantitative data and the Key Staff narrative, particularly when referring to mental health challenges, as In-Pensioners indicated no issues when answering the quality-of-life questions and the Key Staff narrative contradicting this. However, it is possible that Key Staff findings demonstrate a panoptic view of the In-Pensioner population, which contrasts with the personal view of the In-Pensioner participants.

Excluding In-Pensioner age and length of military service as part of the participant selection process may be considered a limitation, however neither factor influenced the length of time an In-Pensioner had lived at the Royal Hospital which was a key consideration of the selection criterion. Furthermore, the project did not aim to explore the impact age or length of time served in the Army had on the In-Pensioner experience, therefore it could be argued that the impact of these exclusions was minimal. Similarly, not capturing the age and length of military service of the New In-Pensioner cohort may be considered a limitation, with the omission of age-related data reducing the transferability of the quality-of-life findings.

Additionally, not capturing the extant health status of the In-Pensioner and New In-Pensioner cohorts may be considered a limitation, specifically regarding the New In-Pensioner cohort, where the change in living environment may have impacted on changes to health status. The project focus was on the influence of the whole model of care on the In-Pensioner experience of living at the Royal Hospital, however it could be argued that the collection of health status data may have added an additional dimension to the project findings, and informed the supposition that In-Pensioners live longer as a result of living at the Royal Hospital, therefore if the project were to be repeated, the collection of health status data would be a consideration.

The self-selected nature of the In-Pensioner participants may be considered a limitation, as the project findings only represent the experience of approximately 10% of the In-Pensioner population. There is, therefore, the potential that those participants who chose to engage, were those with a positive bias towards living at the Royal Hospital. However, participation was voluntary and open to all In-Pensioner's living within the Long Wards, therefore opportunities existed for any resident living independently to engage, irrespective of a potential bias for or against the Royal Hospital. Additionally, a further limitation is the targeted selection of Key Staff participants, who were invited to take part depending on their job role, and who may, therefore, have felt an obligation to contribute. However, participation was voluntary, and several staff members did not engage in the project, demonstrating that the option to decline was acted on by some.

The number of female In-Pensioner participants engaged in the project was small, which may be considered a limitation. Four percent of the In-Pensioner participants were female which compares with the overall female In-Pensioner population at the time of the project, being 5.81% (see 6.4.5) Furthermore, a higher percentage of New In-Pensioner participants were female, at 12.5%. Whilst recognising that this representation is smaller than that found in non-veteran specific establishments, where female residents are more prevalent, the project demographic is more reflective of the population balance in veteran-specific residences (Lemke & Moos, 1989; Montross et al., 2006). Furthermore, the project steering group was supported by a female In-Pensioner, which increased the engagement of females in the overall project

Generalisation of the project findings are most relevant to two areas, namely representational transferability, and inferential transferability, with the former applying to the wider population group from which the study participants belong, and the latter more relevant to similar environments (Ritchie et al., 2013; Braun & Clarke, 2022a).

The In-Pensioner participant selection process ensured a balanced representation of In-Pensioner residents, therefore the project findings have representational transferability, as they have relevance to the wider population of the Royal Hospital Chelsea. Furthermore, some project findings have inferential transferability, particularly in relation to veteran-specific establishments, as arguably, several findings could be replicated within these residences due to the mutual characteristics that those who have served in the military share.

Notwithstanding the unique characteristics of the Royal Hospital, for example wearing uniform, several project findings have inferential transferability, including the impact of resident civic engagement, the importance of place-attachment, access to activities, and social engagement, with these findings, if implemented, potentially delivering similar outcomes in other residential establishments.

However, the small quantitative data sample size limits the generalisability of the quality-of-life findings. Collectively, 42 In-Pensioners and New In-Pensioners completed questionnaires, however in isolation, numbers were 25 and 17 respectively. Several elements need to be considered when determining sample sizes (Fugard & Potts, 2015) and for this project, qualitative data assumed primacy and data collection methods were different for each participant cohort. In-Pensioner and New In-Pensioner participant numbers determined the amount of quantitative data available, however, the maximum amount of data possible was collected from these two participant groups. Furthermore, the quantitative findings aimed to create a quality-of-life evidence baseline to facilitate further data gathering of the wider In-Pensioner population, therefore current data findings are arguably more relevant to the Royal Hospital Chelsea than the wider audience.

The final limitation of this project is researcher interpretation and potential bias as a result of being a veteran. Personal experience of military life alongside ongoing engagement with the veteran community undoubtedly influences knowledge of military veteran culture, however attention has been paid when analysing and interpreting the

data to ensure an impartial view has been maintained. Nevertheless, reflexive thematic analysis assumes researcher subjectivity as part of the analytical process, therefore an element of researcher bias is anticipated.

6.8 Researcher Reflections

This section will aim to provide a reflection on my positioning within this research and the rationale that influenced the methods, data collection, and analysis of the project.

Perhaps the greatest personal influence on this PhD has been my own positioning as a military veteran, as this held weight from the outset and informed my decision to submit my proposal to undertake this research. An awareness of the Royal Hospital Chelsea, and its iconic Chelsea Pensioners meant I felt elements of privilege and responsibility to undertake this research, recognising the commitment that would be required to deliver a credible piece of research that would hopefully add value to the Royal Hospital.

My experience of the military is that of having served in the Royal Air Force, but not as someone who is defined by their service, as it was a ‘part of my life’ rather than ‘my whole life’. As a result, I brought into this PhD, an assumption that the majority of Chelsea Pensioners were likely to fall into the latter category, thus more likely to be defined by their service and considered the Army to have been ‘their whole life’, and therefore happy to assume a quasi-military position in their later life, as epitomised by the wearing of their uniform and living to quasi-military rules. This contradictory perspective forced me to maintain a balanced viewpoint of the project as I held a curiosity around what it was that made Army veterans choose to become Chelsea Pensioners and voluntarily return to a military-style way of life, which appeared juxtaposed to a lifestyle I would choose for myself.

As discussed earlier, my position as an RAF veteran situated me ‘outside’ of the In-Pensioner environment. This enabled me to adopt a more objective and almost neutral perspective as some elements of Army life were unfamiliar such as the nuances between Army regiments, units and rank structure, which meant I needed to remain focussed and engaged as I could not assume an in-depth knowledge of Army parlance.

My lived experience influenced several areas of the PhD, not least during the In-Pensioner recruitment process where I unconsciously adopted a peer-led recruiting position and was able to establish rapport early on, as revealing my veteran status removed communication barriers and opened up opportunities for participants to initiate 'banter', particularly as I 'belonged' to a different branch of the Armed Forces.

Furthermore, as a student of 'advancing years', I believe my age also helped foster rapport with participants as, in my opinion, it afforded me a level of respect and credibility that may not have been evident had I been younger. This belief is subjective as I have no evidence to endorse this, however the ease at which I was able to engage with participants throughout the project informed this belief.

My lived experience further influenced the project as it undoubtedly guided the literature review, the development of the semi-structured interview questions, the interview process, and the data analysis, as I was able to use my knowledge and experience to challenge findings more effectively and explore evidence in more depth whilst self-critiquing throughout. However, it is also possible that my experience may have resulted in some information being overlooked during the interviews as the '*well, you know what it's like'* approach by some participants may have unconsciously prevented the further exploration of the topic being discussed, as there was the assumption of shared knowledge and understanding.

Maintaining a reflexive journal throughout the project was an essential element of the reflexive thematic analysis process, providing an insight and historical record of my thought processes. This was particularly important during theme development where initial thoughts shifted as the analysis deepened.

This project has impacted on me personally as it has highlighted the importance of being in control of where to live in later life, in selecting an appropriate living environment that meets my needs and affords sufficient time in which to develop an attachment to my new surroundings, which as this project evidences, is often lost as people move as a result of increasing needs, rather than through choice.

The Covid-19 pandemic did not impact negatively on the overall project, therefore it is not included within the limitations section. The pandemic began during the first year of the project, where the focus was on obtaining project, and ethical, approval, conducting the literature review, and developing the participant information

documentation, therefore this work could take place with minimal impact. The pandemic did impact on the Key Staff interviews as they were carried out using digital platforms, however as most of the staff were both conversant and comfortable with this method of communication, this impact was minimal.

On reflection, the opportunity to undertake an ethnographic study of the Royal Hospital may have elicited a deeper understanding (Myers, 1999) of the In-Pensioner experience and the influence the model of care has on their health and social care outcomes, however time constraints and the Covid-19 pandemic would have made this choice of methodology impractical.

In addition to reflecting on my own positioning within the research, and the influence this had throughout the project, my philosophical approach has also been reflected on. The applied, 'real world' research nature of this project meant selecting the most appropriate methodology was important. A mixed-methods approach was agreed early on in this project as it was evident that quantitative and qualitative data needed to be collected, and the findings integrated, to address the project aims. This methodology was supported by a Pragmatist philosophical positioning as it enabled the research question to assume prominence over 'how' the question was addressed and offered researcher flexibility by removing the need to explore the phenomenon using one particular 'worldview'. I believe applying this methodology to the project enabled the research aims to be addressed in the most effective way, and importantly, aligns with my own philosophical Pragmatist positioning.

6.9 Original Contribution to Knowledge

This project provides original contribution to knowledge in several ways, not least by meeting the project aims of providing the Royal Hospital Chelsea with its first evidence-based understanding of its model of care, and the influence this has on the health and social care outcomes of the In-Pensioner residents. This evidence-based knowledge will subsequently inform current and future service provision and influence the Royal Hospital's decision-making processes.

Contribution to military veteran's research is enhanced, as this project provides further understanding of the ageing veteran, specifically those who choose to live in veteran-

specific residential establishments and demonstrates how the impact of military service is lifelong and how this evidence can be utilised through service delivery to help contribute towards positive quality-of-life outcomes. This project builds on the existing evidence identified in the literature review, specifically the impact of accessing to activities when living in residential establishments, by adding new knowledge to inform the 'so what', or the impact engaging in activities has on resident outcomes, evidence of which is currently limited. Furthermore, this project evidences the influence identity has, with the wearing of uniform, having a representational role, and reconnecting with a military-style environment, positively impacting on life satisfaction.

For providers of veteran-specific residential care, these project findings offer evidence of the contributing factors that influence positive health and social care outcomes which they may choose to implement to enhance the veteran experience. Equally, non-veteran specific residential establishments are offered an insight into the elements that are evidenced as being important for this population group which may support future service design and delivery.

The impact of civic engagement within residential establishments is clearly evidenced within this project and adds to the limited knowledge.

These project findings add to the existing ageing well and ageing in [the right] place knowledge, by evidencing a correlation between making a proactive decision to relocate to a more supported living environment and quality-of-life outcomes. Furthermore, the Royal Hospital Chelsea model of care demonstrates the positive impact of living in an environment that supports as specific population group, namely older military veterans, to remain in the same place, for the remainder of their lives with the reassurance that the environment, and access to health and social care provision, will support them from later life to end-of-life.

6.10 Implications for Future Research

This project has revealed numerous possibilities for future research. Firstly, the findings highlight areas the Royal Hospital may wish to consider exploring further ahead of any strategic or operational changes.

The concept of the Royal Hospital diverging from its core mission of providing a home to older British Army veterans, to considering expansion to other branches of the British Armed Forces, was met with both resistance and acceptance, therefore further research into the impact this would have on current and future In-Pensioners, the historical fabric, and the identity of the Royal Hospital Chelsea would be required. A suggestion would be using Participatory Action Research or an ethnographic study to engage with an existing veteran-specific establishment that has tri-service residents, to explore their service provision and the nuances supporting a mixed service population creates.

Additionally, further research is recommended to assess the demand of future veterans who have experienced limb loss or have complex mental health challenges, to mitigate any unnecessary structural or operational changes, as arguably the Royal Hospital has supported In-Pensioners with these challenges since its inception. Engaging with younger generations of veterans impacted by limb loss, or complex mental health challenges, in the form of Participatory Action Research may inform this demand.

The changing demographics of military veterans requires the Royal Hospital to consider raising awareness of its inclusivity to broaden the diversity of the In-Pensioner population and ensure it doesn't inadvertently exclude marginalised veterans who may benefit from experiencing life at the Royal Hospital.

This project did not include those In-Pensioners living in the MTI, hence there is an integral part of the Royal Hospital that has not been researched. Therefore, exploring this provision using Case Study methodology, would enable the Royal Hospital to assess the impact transitioning from the Long Wards to the MTI has on the In-Pensioner experience, and would contribute additional evidence on the concept of ageing in [the right] place, and support future service provision.

The participant narrative indicated a widely held belief that In-Pensioners enjoy longer life as a result of living at the Royal Hospital, however this was not directly evidenced in the project findings. Therefore, the Royal Hospital may wish to consider undertaking future research, for example a Randomised Control Trial, to enable more accurate comparisons with similar establishments, and to identify any cause and effect the model of care may have on In-Pensioner longevity.

Establishing a quality-of-life evidence base presents the Royal Hospital with indications on the impact moving in has on new In-Pensioner residents over a 6-month period. It is suggested that this evidence is expanded further by inviting all new residents to complete the questionnaires on arrival, and at the 6-month and 12-month points, with annual questionnaires thereafter. Furthermore, it may be beneficial to consider a longitudinal study to gain an in-depth understanding of the ongoing impact of the In-Pensioner experience, which may also identify individual and/or service provision challenges promptly.

There were clear challenges to succinctly identify the Royal Hospital and its blended model of care. Arguably, members of the Armed Forces Community, and those living within the London area, are aware of who the Chelsea Pensioners are and what they represent. However, the lack of clarity may be worthy of further investigation to minimise any ambiguity and raise awareness of the purpose and relevance of the Royal Hospital in the wider population. Research in the form of Survey's or Questionnaires may help identify levels of awareness of the Royal Hospital and inform next steps.

The impact taking part in civic and intergenerational activities has on an individual's sense of purpose, identity, usefulness, and quality of life is clearly evidenced by this project's findings. Furthermore, there is clear evidence of a willingness to engage. However, there is a paucity of evidence on the impact of civic engagement in residential establishments, therefore it is suggested that further qualitative research is needed, to build on this evidence and inform future service provision. For service providers, it is suggested that initiatives are explored to introduce civic and intergenerational engagement opportunities for those living in residential establishments, to reduce barriers of engagement, create more inclusive communities and enhance the quality-of-life outcomes of residents.

The positive impact on resident health and social care outcomes, and the ability to age well and in [the right] place, as a result of access to an embedded medical centre and social care team, has been clearly evidenced in this project. Plainly, this level of provision may not be economically or practically viable for many residential establishments, however it is suggested that similar provision be considered where appropriate, whether stand-alone or a shared service, to facilitate better resident

outcomes. Additionally, further multi-disciplinary research, including engagement with health economists, is required to evidence the health benefits and economic impact this holistic approach to delivering health and social care has on those in residential care establishments.

Undoubtedly, there will be military veterans living in residential establishments across the UK who are ‘hidden’ if they have not declared their veteran status, or if the place in which they live is not engaged with the Armed Forces Community. Therefore, these individuals may be ‘missing out’ on opportunities to live within veteran-specific establishments such as the Royal Hospital Chelsea, and potentially not experiencing the benefits living within such a community brings. It is suggested that research, in the form of a Survey, takes place to identify this ‘hidden’ population and establish whether there is a demand or need for individuals to consider relocating to veteran-specific establishments, recognising that this option may not be the preferred choice for some. Furthermore, it is suggested that there is the potential for the Royal Hospital to engage with this veteran population as part of its developing outreach programme, to bring together those with shared experiences and further expand the Royal Hospital community.

The project findings indicate that In-Pensioners benefit from being supported by a staff group who have also served in the military, and therefore share similar experiences. This impact may benefit from further research, in the form of mixed methods research, or by Quantitative measures only using Questionnaires, to explore whether other veteran-specific establishments have a veteran staff contingent, and what impact this has on resident outcomes. Also worthy of further exploration, perhaps using Participatory Action Research, is the impact this peer-support working environment has on the veteran member of staff, as arguably there are mutual benefits. It is suggested that findings may indicate a cohort of veterans who themselves have experienced challenges with transitioning from their military service and wish to maintain some connection to their former lives, or conversely, it may simply denote a desire to support fellow veterans.

The In-Pensioner population clearly identify with their previous military service which enhances their sense of identity and belonging and is further increased by the wearing of uniform, and the military-style environment in which they live. Service providers may

wish to examine whether the sense of identity and belonging is evident in similar veteran-specific establishments, and whether elements of the Royal Hospital Chelsea model of care can be replicated to elicit similar health and social care outcomes.

The project findings evidence the sense of home, or place attachment, experienced by In-Pensioners and the positive impact this has on their sense of belonging and quality-of-life outcomes, however empirical evidence demonstrates this is found to be lacking in other residential establishments. It is suggested that further research, for example using Participatory Action Research or Case Study research, explores ways to facilitate place attachment in residential establishments to alleviate the upset and instability caused by a move into higher needs living and improve opportunities for individuals to age well.

Finally, the Royal Hospital may wish to consider engaging with other establishments, veteran and non-veteran specific, to share best practices which may benefit the wider community of older people living in residential establishments.

6.11 Conclusion

This project has established an evidence base for the Royal Hospital Chelsea model of care and informed on the impact this had on the health and social care outcomes of its residents, namely the In-Pensioners. To achieve this, a mixed methods approach was applied which generated primary qualitative and quantitative evidence.

Integrated analysis presented four areas that were central to the model of care and the In-Pensioner outcomes: *'the environment'*, *'identity'*, *'staying active'*, and *'staying healthy'*, with each one dependent on the other.

These project findings will be of interest to providers of both veteran and non-veteran residential care with several areas being relevant to the older population, irrespective of their previous occupation. Through the theoretical lenses of ageing well and ageing in [the right] place the findings evidence the Royal Hospital Chelsea presents opportunities for In-Pensioners to achieve both by offering a holistic health and social care package that provides support from the day they move in, which for some can extend beyond 30 years, to end of life. Challenges experienced by the general population when relocating from the home environment to higher needs care, are

removed as In-Pensioners simply relocate from their independent living accommodation to the MTI nursing facility, remaining within a familiar environment, and surrounded by friends and care staff who are known to them.

For providers of veteran-specific residential care, these findings offer an insight into what military-related influences contribute towards an individual's positive life experiences, some of which may be transferrable.

This project has provided the Royal Hospital Chelsea with empirical evidence of its model of care, in line with the project aims, and as a consequence has identified a number of areas that would benefit from additional research, the results of which may further influence the service provision of establishments that, for many of the older population, are the places in which they spend the final years of their lives, and should, arguably, be the places they choose to call 'home' as they age as well as possible, and in [the right] place.

6.12 Chapter Summary

Chapter 6 discussed the collective project findings, presented as pieces of a jigsaw, within four distinct areas namely: The Environment; Identity; Staying Active; and Staying Healthy. Together, these distinct areas represent the In-Pensioner experiences of living at the Royal Hospital Chelsea.

The Royal Hospital presented In-Pensioners with the opportunity to live in an environment resonant of that experienced whilst serving in the Army, which brought a sense of familiarity and security. This is complemented by a cohort of ex-military staff employed in quasi-military positions, which it is argued was mutually beneficial as these staff provided a peer-support-like service to the In-Pensioners. This was discussed through the theories of ageing 'well', and in [the right] place.

The identity of the Royal Hospital and that of the Chelsea Pensioner are mutually exclusive and beneficial. In-Pensioners enjoyed an elevated status as a result of living at the Royal Hospital. Equally, awareness of the Royal Hospital was maintained by the requirement of In-Pensioners to wear their Scarlet uniform. The blended accommodation options presented challenges to accurately identify the Royal Hospital Chelsea however this did not impact on the In-Pensioner experience. The apparent

lack of diversity may be reflective of the Army demographics for this generation of In-Pensioners and is likely to change over time. In-Pensioners displayed a propensity to primarily identify themselves as Chelsea Pensioner but were also keen to maintain an individual identity.

The ability to stay active enabled independence and fostered a sense of purpose. Social, or civic, engagement provided In-Pensioners with opportunities to engage in knowledge exchange across multiple generations and with a wide variety of people, in numerous situations. These opportunities positively impacted on In-Pensioner lives. However, the lack of evidence of the impact of civic engagement for those living in residential care presents opportunities for further research.

Expedited healthcare, onsite medical and social care, including respite and domiciliary care all contributed towards positive health outcomes for the In-Pensioner population. This provision was supported by a committed workforce of blended ex-military and civilian staff who considered In-Pensioner wellbeing their main priority. Challenges existed to overcome the stoicism and reluctance by some In-Pensioners to accept support.

Throughout the findings there was clear evidence that In-Pensioners considered themselves to be in a privileged position, as a result of living at the Royal Hospital, with both staff and In-Pensioners expressing an ideal that this level of privilege should be experienced by those outside of the Royal Hospital Chelsea.

These four key areas; The Environment, Identity, Staying Active, and Staying Healthy, were integral to the Royal Hospital Chelsea's model of care and influenced In-Pensioner health and social care outcomes, contributing towards positive quality-of-life outcomes as a result of residing at the Royal Hospital.

This chapter also outlined the project strengths and limitations, and the reflexive summary which presented a precis of researcher reflections throughout the duration of the project.

This chapter outlined the project's original contribution to knowledge, which included meeting the project aims by providing the Royal Hospital Chelsea with an evidence base for their model of care; adding to the knowledge base for veteran-specific residential care, and the wider population; and contributing towards the ageing 'well'

and ageing in [the right] place knowledge. Implications for future research outline areas for the Royal Hospital Chelsea, providers of care in similar residential facilities, and wider research opportunities.

Finally, this chapter presented the project conclusion.

APPENDICES

APPENDIX A

Professional Development Record

Domain A: Knowledge and intellectual skills		
Title	**Type**	**Date**
Teaching Qualitative Research online	Research Workshop/Seminar	15.04.2020
Conducting Qualitative Fieldwork during Covid-19	Research Workshop/Seminar	21.04.2020
NVivio Transcription - Integrate with NVivio Transcription for Faster Analysis	Professional Development	06.05.2020
Introduction to research data, data services and DataCite at the British Library (and beyond)	Professional Development	14.05.2020
EndNote Introduction	Professional Development	19.05.2020
Literature Searching and Planning	Professional Development	20.05.2020
Research Philosophies and Paradigms	Research Workshop/Seminar	21.05.2020
Research Data Management	Professional Development	04.06.2020
How to Develop Plan B	Research Workshop/Seminar	30.06.2020
How to Write a Great Research Paper, and Get it Accepted by a Scholarly Journal - Northumbria University	Professional Development	17.11.2020
Annual Progression - Preparing for Year 1 Submission QandA	Training Course	03.12.2020
Quality improvement in health and social care	Training Course	26.04.2021
Expectations of the Peer Review process	Research Workshop/Seminar	11.05.2021
Coproduction Workshop	Training Course	13.07.2021
Systematic Reviews training session	Research Workshop/Seminar	07.09.2021
Introduction to qualitative research and qualitative evidence synthesis	Research Workshop/Seminar	28.10.2021
Measuring research impact for literature reviews	Research Workshop/Seminar	29.10.2021
Storytelling - Visual Communications	Research Workshop/Seminar	11.11.2021
Influencing Policymakers Workshop	Research Workshop/Seminar	02.12.2021
Selecting studies and assessing methodological limitations	Research Workshop/Seminar	13.12.2021
Finding the right Journal	Training Course	07.01.2022
Social Impact	Professional Development	10.01.2022
Ensuring Visibility	Professional Development	11.01.2022
Qualitative Evidence Synthesis - Making Sense of Framework and Best Fit Framework Synthesis	Research Workshop/Seminar	20.01.2022
Coach Lane Research Conversation "To write or not to write - what, for whom, where and how to publish your research" with Professor Monique Lhussier	Webinar	21.01.2022
Qualitative Evidence Synthesis - Thematic Synthesis	Webinar	24.02.2022
Common Challenges in Thematic Analysis and how to avoid them, with Virginia Braun and Victoria Clarke	Webinar	11.08.2022
Domain B – Personal Effectiveness		
What you need to know right now about.... How actors build confidence	Research Workshop/Seminar	28.05.2020

Title	Type	Date
PGR women in academia: navigating the imposter phenomenon	Research Workshop/Seminar	23.02.2021
Policy and Care Seminar	Research Workshop/Seminar	04.03.2021
Science and Function Seminar	Conference **Attendance** or Contribution (online)	11.03.2021
Becoming an Early Career Researcher	Webinar	12.03.2021
Veterans Families and Covid Seminar	Conference **Attendance** or Contribution (online)	18.03.2021
How to write a thesis	Research Workshop/Seminar	23.03.2021
Substance Misuse and Gambling Seminar	Conference **Attendance** or Contribution (online)	25.03.2021
Making Generation R - Equality Matters "Building Resilience and overcoming adversity	Webinar	21.04.2021
Professor Renata Gomes Public Lecture 'Victory over blindness'	Lecture/Webinar	26.06.2021
Navigating the Progression Panel	Professional Development	02.07.2021
British Society of Gerontology Annual Conference	Conference **Attendance** or Contribution (online)	07.07.2021 – 09.07.2021
British Society of Gerontology Annual Conference - Presentation	Conference Attendance or **Contribution** (online)	08.07.2021
Tougher Minds	Conference Attendance or Contribution (online)	11.11.2021
Domain C – Research Governance and Organisation		
Ethics training	Professional Development	07.05.2020
PGR Drop-in Session Equality, Diversity, and Inclusivity	Webinar	27.04.2021
Basic Travel Security Awareness	Mandatory Training	08.11.2021
Annual Progression: Preparing for the Panel	Professional Development	23.11.2021
Intellectual Property for Research	Research Workshop/Seminar	12.01.2022
Domain D – Engagement, Influence, and Impact		
Care of the Ageing Population: Developing an Evidence Base for the Royal Hospital Chelsea model of care. Royal Hospital Chelsea Research Oversight Committee	Invited Presentation	14.10.2020
"Crafting the next Stirling Prize poster: A master class with Nadine Mirza"	Research Workshop/Seminar	16.12.2020
How to give a presentation	Research Workshop/Seminar	30.03.2021
Care of the Ageing Population: Developing an Evidence Base for the Royal Hospital Chelsea model of care. Royal Hospital Chelsea Research Oversight Committee	Invited Presentation	21.04.2021
What residential models of care exist for ageing military veterans, what are their characteristics, and what evidence exists to demonstrate their impact on health and social care outcomes? A Systematic Narrative Review.	Internal Peer-Reviewed Conference (Presentation)	15.06.2021
British Society of Gerontology Annual Conference 2021 -Presentation	Conference Attendance or **Contribution** (online)	08.07.2021

Title	Type	Date
Care of the Ageing Population: Developing an Evidence Base for the Royal Hospital Chelsea model of care. Royal Hospital Chelsea Research Oversight Committee	Invited Presentation	13.10.2021
COMMunity Research Launch	Research Workshop/Seminar	14.10.2021
North East Post Graduate Conference	Conference **Attendance** or Contribution (online)	01.11.2021
Ensuring Visibility	Research Workshop/Seminar	11.01.2022
Social Impact	Research Workshop/Seminar	11.01.2022
Becoming a Peer Reviewer	Research Workshop/Seminar	15.01.2022
Care of the Ageing Population: Developing an Evidence Base for the Royal Hospital Chelsea model of care. Forces in Mind Trust	Invited Presentation (Poster)	24.03.2022
Care of the Ageing Population: Developing an Evidence Base for the Royal Hospital Chelsea model of care. Royal Hospital Chelsea Research Oversight Committee	Invited Presentation	31.03.2022
Writing for Publishing	Research Workshop/Seminar	28.04.2022
Care of the Ageing Population: Developing an Evidence Base for the Royal Hospital Chelsea model of care. Ethics Committee, King Edward VII Hospital	Invited Presentation	11.05.2022
Introduction to Public Engagement - Academic Staff	Research Workshop/Seminar	14.06.2022
Evaluation of Public Engagement - Academic Staff	Research Workshop/Seminar	29.06.2022
British Society of Gerontology Annual Conference 2022 -Presentation	Conference Attendance or **Contribution** (online)	08.07.2022
Care of the Ageing Population: Developing an Evidence Base for the Royal Hospital Chelsea model of care. Royal Hospital Chelsea Public Engagement Team	Invited Presentation	24.08.2022
Care of the Ageing Population: Developing an Evidence Base for the Royal Hospital Chelsea model of care. Royal Hospital Chelsea Research Oversight Committee	Invited Presentation	29.09.2022
Care of the Ageing Population: Developing an Evidence Base for the Royal Hospital Chelsea model of care. Royal Hospital Chelsea Research Oversight Committee	Invited Presentation	12.04.2023
British Society of Gerontology Annual Conference 2023 -Presentation	Conference Attendance or **Contribution**	07.07.2023

APPENDIX B

Conference Abstracts

BSG conference 2021 - 'Ageing Past, Present and Future – Innovation and Change'

A global review of residential care models for the ageing military veteran population: What is available and what evidence exists to demonstrate their impact on health and social care outcomes?

Ms Helen Cullen[1], Dr Gemma Wilson[1]

[1]Northumbria University, Faculty of Health and Life Sciences, Department of Nursing, Midwifery, and Health, Newcastle upon Tyne, United Kingdom.

ABSTRACT

With ageing population numbers continuing to rise globally, a systematic narrative review of residential care provision in a non-hospitalised setting specifically for military veterans over 65 years of age was conducted. This unique employment group has access to residential care that is tailored to meet their needs, however little is known about the impact these settings have on resident outcomes, and whether there is a need for this exclusive provision.

After completing a systematic search strategy and removing all papers that did not meet inclusion criteria, a total of 14 peer-reviewed articles were included in the study. A grey-literature search also identified veteran specific residential options in 10 countries.

The review found the majority of establishments accepted residents from military and non-military backgrounds, and established there is little empirical evidence that identifies the health and social care outcomes of military veterans in non-hospital setting residential care. The majority of provision for veterans in the UK is facilitated by third sector military charities. Two residential care options identified in the USA warrant further investigation to assess the potential of implementation in other countries.

The considerable amount of provision available to UK veterans and lack of research invites further investigation to evidence health and social care outcomes, inform service development and identify whether this cohort of the ageing population benefits from tailored provision. These findings would benefit comparable global provision.

Abstract for 2022 BSG Conference

BSG conference 2022 - **'Better Futures for Older People – Towards Resilient and Inclusive Communities'**

Care of the ageing veteran population: Developing an evidence base for the Royal Hospital Chelsea model of care. PhD: Preliminary Findings

Ms Helen Cullen[1], Dr Gemma Wilson-Menzfeld[1]
[1]Northumbria University, Faculty of Health and Life Sciences, Department of Nursing, Midwifery, and Health, Newcastle upon Tyne, United Kingdom.

ABSTRACT

Royal Hospital Chelsea is home to 300 British Army Veterans, known as Chelsea Pensioners, who live in a unique community setting. Residents live independently within a communal setting, having the opportunity to 'age in place' with access to onsite medical facilities and a nursing home thereby removing the need to be relocated as their health deteriorates.
This setting aims to foster a sense of belonging, rekindle previous military comradeship and offer access to a multitude of activities from tending allotments and fishing to representing the Royal Hospital on formal occasions such as Remembrance Day Parades or less formal events including 'tea at the Ritz'.
This research project aimed to develop an evidence base for a way of life established in 1692 to support former soldiers. It examined the health and social care impact on Chelsea Pensioners and aimed to inform strategic direction to ensure the Royal Hospital remains viable for future generations of veterans. A mixed-method design was used to capture qualitative and quantitative data and identify areas of interest to support the research objectives.
Preliminary findings indicate enhanced quality of life, removal of financial burdens experienced 'outside' and reduced social isolation and loneliness. Some residents were averse to being regarded as 'old people' and felt they had a wealth of experience that could be better utilised by the Royal Hospital.
Further research is required to compare this setting to others, explore best-practice and offer a knowledge exchange which may inform health and social care policy.

BSG conference 2023 - **'Inclusive Participation Throughout Ageing: Creating a Society for all'**

Title:

The impact of life in a veteran-specific residential setting: Living at, and representing, the Royal Hospital Chelsea reinvigorates identity, sense of purpose and belonging, and enhances quality of life.

Ms Helen Cullen[1], Dr Gemma Wilson-Menzfeld[1]
[1]Northumbria University, Faculty of Health and Life Sciences, Department of Nursing, Midwifery, and Health, Newcastle upon Tyne, United Kingdom.

ABSTRACT

Military veterans have access to residential options that acknowledge their military service and tailor the environment in which they live to reflect their time in uniform. The Royal Hospital Chelsea is the largest veteran-specific residential establishment in the UK and has been home to British Army veterans, known as 'Chelsea Pensioners', since 1692.
Eligible veterans can live at the Royal Hospital from 66 years of age, remaining within the community for the rest of their lives, living semi-independently with access to on-site health and social support, and a nursing home as their health deteriorates.
A PhD research project developed an evidence base for the Royal Hospital Chelsea by exploring its model of care and the impact access to health and social care had on the Chelsea Pensioners. A mixed-methods design captured qualitative and quantitative data identifying areas that supported the research aims.
Representing the Royal Hospital Chelsea fostered a sense of belonging and contributed towards a sense of purpose and pride as Chelsea Pensioners integrated themselves and embraced the environment in which they lived. Wearing a military-style uniform reinforced the Chelsea Pensioner identity with the Royal Hospital, which brought recognition, respect, and an elevated social status. Access to a multitude of meaningful activities including hobbies and therapeutic 'jobs' within the Royal Hospital Chelsea contributed towards positive quality of life.
Findings suggest that living in a veteran-specific establishment offers individuals the opportunity to re-establish a sense of identity and purpose, lead meaningful lives, and enhance life satisfaction in older age.

APPENDIX C

Poster Presentation

Northumbria University NEWCASTLE

Care of the ageing veteran population

Developing an evidence base for the Royal Hospital Chelsea model of care

Helen Cullen (PhD Researcher); Dr Gemma Wilson-Menzfeld; Professor Matthew D Kiernan; Dr Alison Osborne (Supervisors)

Background

- The Royal Hospital Chelsea (RHC) has provided sheltered accommodation alongside integrated health and social care to retired British Army veterans since 1692
- Current population of Chelsea Pensioners is approximately n=300 with female veteran's resident since 2009 (currently n=17 female residents)
- Integrated living includes Independent Living in 'Long-Wards', on-site Medical Centre facilities and a Nursing Home (Margaret Thatcher Infirmary) supporting transition as Chelsea Pensioners [In-Pensioners] 'age in place'

AIM To gain an understanding of the Royal Hospital Chelsea model of care and inform future provision

Method

A mixed methods sequential[1] approach was utilised across four phases:

Phase 1 Systematic Narrative Review + **Phase 2** Qualitative Data Collection Key Staff + **Phase 3 (a,b)** Qualitative & Quantitative Data Collection - In-Pensioners* + **Phase 4** RHC Document Review**

1: Review Question: What residential models of care exist for ageing military veterans, what are their characteristics, and what evidence exists to demonstrate their impact on health and social care outcomes?

2: Semi-structured interviews with n=19 Key-Staff across Governance; Executive Management & Service Delivery roles – identified by job-role

3a: Semi-structured interviews with n=25 In-Pensioners & completion of Quality-of-Life Questionnaires (ICECAP-A[2]; WHOQOL-BREF[3])

3b: Quality of Life Questionnaires: approx. n=30 New In-Pensioners to create an evidence baseline (*data collection ongoing)

4: Review of selected Strategic & Operational documents supporting service delivery (**ongoing)

Findings: Phase 1

- A lack of outcomes evidence to inform the health and social care impact of ageing veteran's living in non-hospital residential care
- Residence occupancy is mixed – a hidden veteran population is likely to exist within non-veteran specific establishments
- n=10 countries indicated ageing veteran-specific residential care
- UK (England & Scotland) indicates the greatest military charity-led residential care options (n=11 providers; n=24 residences)
- USA indicated the greatest number of veteran-specific residential care options (n=7)
- Empirical findings dominated by two USA models of care – Medical Foster Home and Adult Foster Home - worthy of further investigation for potential implementation in other countries

Preliminary Findings: Phases 2 & 3

Preliminary Findings: Phases 2 & 3

- Combined ex-military and non-military workforce ensures RHC maintains its military ethos and delivers service in line with health and social care guidelines. However, there is a requirement for staff and In-Pensioners to recognise the value this combined knowledge and experience brings
- Independence is actively supported by a multi-disciplinary person-centered approach, including In-Pensioner peer support, which strengthens the comradeship ethos and enhances quality of life
- Transition from independent living to nursing/dementia care offers In-Pensioners reassurance that they can 'age in place' in what is considered by many as their 'last posting'
- Access to embedded medical services enables early identification of healthcare issues promoting continued independence and longevity
- The developing Outreach programme will broaden the reach of those benefits experienced by In-Pensioners to the wider ageing veteran community
- The perception that Chelsea Pensioners represent all members of the veteran community is worthy of further exploration to ensure clear messaging as the Outreach programme progresses
- Sustainability requires RHC to evolve to include the current diverse armed forces population and the recent generation of veterans with complex physical and mental health challenges
- With a decreasing defence force, RHC acknowledges the need to consider a tri-service offer to maintain its legacy and ensure it remains relevant to future generations of ageing veterans

Acknowledgements

This is a PhD project joint funded by Northumbria University and the Royal Hospital Chelsea

PhD Researcher: Helen Cullen
Supervisors:
Dr Gemma Wilson-Menzfeld
Professor Matthew D Kiernan
Dr Alison Osborne

Further Information

Project end date: February 2023

For further information following the conclusion of the project please contact:

PhD Researcher: Helen Cullen
Helen.cullen@northumbria.ac.uk
Tel: 07766 982904

References

1. Bowen, P., Rose, R. and Pilkington, A., 2017. Mixed methods-theory and practice. Sequential, explanatory approach. International Journal of Quantitative and Qualitative Research Methods, 5(3), pp.10-27.
2. Flynn, T.N., Huynh, E., Peters, T.J., Al-Janabi, H., Clemens, S., Moody, A., and Coast, J. (2015) 'Scoring the Icecap-a Capability Instrument. Estimation of a UK General Population Tariff'. Health Economics Vol. 24, pp.258-269. doi: 10.1002/hec.3014
3. Skevington, S., Lotfy, M. and O'Connell, K. (2004) 'The World Health Organization's WHOQOL-BREF quality of life assessment: Psychometric properties and results of the international field trial. A Report from the WHOQOL Group'. Quality of Life Research Vol. 13, pp.299–310.

APPENDIX D

Systematic Narrative Review Screening and Selection Tool

Review Question:	**Title:** A Systematic Narrative Review of International Residential care models for the ageing military veteran population: What residential models of care exist for ageing military veterans, and what evidence exists to demonstrate their impact on health and social care outcomes? **Aim:** To explore residential care options for the ageing military veteran in a non-hospitalised setting and identify evidence of resident outcomes on health and social care			
Inclusion Criteria using PICOS	**P**opulation - **Veteran** OR **Ex-servicemen** **I**ntervention - **Care-home, Residential-home OR Assisted living** **C**omparator - Not applicable		**O**utcomes – QoL, Longevity, Health Care impact, Social Care impact (Occupational therapy/rehabilitation), Pastoral Care **S**etting - Residential care-home facilities (for the over 65yrs only)	
Author Info/Article ID etc., Title:			**Date of Screening:**	**Journal:**
	Include		**Exclude**	
Population	☐ Adults over the age of 65 years ☐ Veterans who have served in the Armed Forces/military		☐ Adults under the age of 65 ☐ Children ☐ Non-military population	
Intervention	☐ Residential care (homes) ☐ Care homes ☐ Assisted Living (residential) ☐ Veteran-specific residential establishments (for those aged 65 years and older)		☐ Non-residential care ☐ Day care centres ☐ Home-nursing/care ☐ Rehabilitation centres ☐ Children's residential est. ☐ Hospitals (acute care) ☐ Book Chapters	☐ Specialised residential establishments (i.e., terminal/ neurological care; dementia/ mental-health/substance-misuse specific) ☐ Residential Treatment Programmes ☐ Homeless centres ☐ Service Reviews
Comparator	N/A			
Outcomes	☐ QoL ☐ Longevity	☐ Health Care impact ☐ Pastoral Care	☐ Social Care impact (Occupational therapy/rehabilitation)	
Study Design	☐ Peer Reviewed ☐ Grey Literature ☐ Website link/search	☐ Non-peer reviewed art. ☐ Residential Report ☐ Newspaper/online art.	☐ RCT ☐ Systematic Reviews ☐ Theses/Dissertations	
Overall Decision	**Included** ☐		**Excluded** ☐	

APPENDIX E

Empirical Papers Selected for Inclusion in Systematic Narrative Review

Empirical Papers Selected for Inclusion in Systematic Narrative Review				
Paper title	**Author(s)/Date**	**Journal**	**Overview of paper**	**Country Researched**
Assisted Living Pilot Program - Utilization and Cost Findings	Chapko, M.K., Manheim, L.M., Guihan, M., Sullivan, J.H., Zhou, X.H.A., Wang, L., Mambourg, F.J. and Hedrick, S.C., 2009.	Journal of aging and health, 21(1), pp.208-225.	This is one of three related papers on the Assisted Living Pilot Program (ALPP). This paper focuses on the financial aspect (cost evaluation of the pilot programme)	USA
Predicting Mortality of Older Residents in Long-Term Care Facilities	Chen, L.K., Peng, L.N., Lin, M.H., Lai, H.Y., Hwang, S.J. and Lan, C.F., 2010.	Journal of the American Medical Directors Association, 11(8), pp.567-571.	Paper focuses predicting end-of-life mortality rates in a long-term facility for veterans (the Banciao Veterans Care Home, Taiwan).	Taiwan
A qualitative exploration of veteran and family perspectives on medical foster homes	Gilman, C., Haverhals, L., Manheim, C. and Levy, C., 2018.	Home Health Care Services Quarterly, 37(1), pp.1-24.	Paper focuses on the Medical Foster Home programme and the experiences of veterans residing in MFH's and their families/guardians - part of a larger mixed-methods study (see the Pilot papers)	USA
Assisted Living Pilot Program - Background, Methods, Facility Characteristics	Guihan, M., Thomas, M.D., Mambourg, F.J., Wang, L., Chapko, M.K. and Hedrick, S.C., 2009.	Journal of aging and health, 21(1), pp.172-189.	This is one of three related papers on the Assisted Living Pilot Program (ALPP). This paper covers the Department of Veterans Affairs funding of Assisted Living, Adult Family Home and residential care within the Assisted Living Pilot Program (to support onward transition from VA funded access to medical care to Medicaid or self-funded care)	USA

Paper title	Author(s)/Date	Journal	Overview of paper	Country Researched
Caregivers Create a Veteran-Centric Community in VHA Medical Foster Homes	Haverhals, L.M., Manheim, C.E., Gilman, C.V., Jones, J. and Levy, C., 2016.	Journal of gerontological social work, 59(6), pp.441-457.	This paper focuses on the Medical Foster Home (MFH) (which provides care to 'end of life' and is considered a 'permanent' option of long-term care/home-nursing/assisted level care, but for those requiring 24 hr care. Paper focuses on the type of care backgrounds, the skills of the caregivers (in their own homes), caregiver motivations, how they function to support veterans.	USA
Characteristics of Residents and Providers in the Assisted Living Pilot Program (ALPP)	Hedrick, S., Guihan, M., Chapko, M., Manheim, L., Sullivan, J., Thomas, M., Barry, S. and Zhou, A., 2007.	The Gerontologist, 47(3), pp.365-377.	Assessment of the ALPP and service providers to capture characteristics	USA
Assisted Living Pilot Program - Health Outcomes	Hedrick, S.C., Guihan, M., Chapko, M.K., Sullivan, J., Zhou, X.H., Manheim, L.M., Forsberg, C.W. and Mambourg, F.J., 2009.	Journal of Aging and Health, 21(1), pp.190-207.	This is one of three related papers on the Assisted Living Pilot Program (ALPP). This paper covers health outcomes, including Assisted Daily Living (ADL) scores, psychiatric diagnoses, hospitalisation rates, onward admission to nursing homes, mortality rates.	USA
Residential Care and the Veterans Administration	Kenter, A., 1980.	American Health Care Association, 6(6), pp.30-30.	An article that summarises the USA VA Foster Home Program (started in 1951), the impact on veterans and the cost benefits to the VA foster home care -v- hospitalisation.	USA
Paper title	**Author(s)/Date**	**Journal**	**Overview of paper**	**Country Researched**

Life at the Extreme: Characteristics of Veteran Centenarians in Long-Term Care	Kheirbek, R.E., Fokar, Al., Wilson-Bell, L., DeGrote, S., 2018.	The annals of long-term care, 26(5), pp. E25–E32.	This paper presents findings on research into the long-term care of US veteran centenarians - from the Washington DC VA Medical Center, a 120-bed, 24 hr hospital-based skilled nursing care facility that includes long-term, restorative and short-term rehabilitative services plus inpatient palliative and hospice services.	USA
Ownership and Quality of Care in Residential Facilities for the Elderly	Lemke, S. and Moos, R.H., 1989.	The Gerontologist, 29(2), pp.209-215.	This paper researches the various types of residence in the USA: private; non-profit and veterans facilities run by the VA- nursing homes, residential facilities and congregate apartments. Includes veteran's facilities.	USA
Residential care services for older people in China: from state to market provisions?	Leung, J.C., 2010.	Social Development Issues (Follmer Group), 32(1).	Paper explores residential care in China, and the transition from state funded provision to private operators. Details China's 'honor homes' for those who have made significant contributions to the country during the civil war, family members of martyrs, or disabled ex-servicemen.	China
Paper title	**Author(s)/Date**	**Journal**	**Overview of paper**	**Country Researched**

A Qualitative Evaluation of a new Community Living Model: Medical Foster Homes	Levy, C.R., Jones, J., Haverhals, L.M. and Nowels, C.T., 2013.	Journal of nursing education and practice, 4(1), p.162.	Model of care for veterans as an alternative to nursing homes - the Medical Foster Home is for those eligible for nursing care but prefer to receive care in private homes (care is long-term and is aimed towards lifetime residence).	USA
Correlates of Self-rates successful aging among community dwelling older adults	Montross, L.P., Depp, C., Daly, J., Reichstadt, J., Golshan, S., Moore, D., Sitzer, D. and Jeste, D.V., 2006.	The American Journal of Geriatric Psychiatry, 14(1), pp.43-51.	This paper examines four USA community dwellings including one veteran establishment. Focus is on self-reported successful ageing	USA
Predictive Factors of Self-Care Capacity in Veterans' Care Institution Residents	Wu, L.F., 2002.	Journal of Nursing Research, 10(3), pp.195-204.	Paper focuses on factors that affect the self-care capacity of self-pay veterans in a veteran's care home in Taiwan	Taiwan

APPENDIX F

Grey Information - Countries Contacted for information residential provision for veterans				
Country	**Source of Information (e.g., organisation contacted)**	**Method of Communication**	**Response Received**	**Ageing Veteran Residential Provision Confirmed**
Australia	Multiple Organisations	Multiple	Yes	**Yes**
Canada	Multiple Organisations	Multiple	Yes	**Yes**
Czech Republic	Ministry of Defence of the Czech Republic	Direct email	Yes	**Yes**
France	Multiple Organisations	Multiple	Yes	**Yes**
Jordan	Jordanian Economic and Social Association for Retired Servicemen & Veterans (ESARSV)[1]	Contact Form via website	Yes	**Yes**
Netherlands	Bronbeek Royal Home for Retired Military Personnel	Multiple	Yes	**Yes**
New Zealand	Multiple Organisations	Multiple	Yes	**Yes**
Poland	Ministry of Defence	Direct email	Yes	**Yes**
Poland	Association of Combatants of the Polish Republic and Former Political Prisoners (ACPR & FPP)[1]	Contact Form via website	No	Not Known
UK	Multiple Organisations	Multiple	Yes	**Yes**
USA	Multiple Organisations	Multiple	Yes	**Yes**
Albania	Ministry of Defence, Republic of Albania	Direct email	Yes	No
Algeria	Algerian Ministry of National Defence	Direct email	No	Not Known
Angola	Association of War Disabled Ex-Servicemen of Angola (AMMIGA)[1]	Contact Form via website	No	Not Known
Argentina	War Veterans Federation of Lujan-Buenos Aires - Argentina[1]	Contact Form via website	No	Not Known
Austria	Federal Ministry for National Defence	Contact Form via website	No	Not Known
Austria	Austrian Association of Victims of War and Disabled (KOBV-Ö)[1]	Contact Form via website	No	Not Known
Belgium	Belgian Defence	Contact Form via website	Yes	No

Country	Source of Information (e.g., organisation contacted)	Method of Communication	Response Received	Ageing Veteran Residential Provision Confirmed
Bosnia & Herzegovina	Bosnia & Herzegovina Association of War Disabled Veterans (AWDV)[1]	Contact Form via website	No	Not Known
Bosnia & Herzegovina	United Veterans Organization - Veterans Union of Bosnia & Herzegovina (JOB - Unija Veterana BiH)[1]	Contact Form via website	No	Not Known
Brazil	Ministry of Defense	Direct email	No	Not Known
Bulgaria	Deputy Prime Minister for Public Order and Security and Minister of Defence	Direct email	No	Not Known
Croatia	Croatian War Veterans Association (UHRV)[1]	Contact Form via website	No	Not Known
Croatia	Union of Associations of Croatian Defence Force Veterans (AUCDFV)[1]	Contact Form via website	No	Not Known
Cyprus	Ministry of Defence	Direct email	No	Not Known
Denmark	Veterans of Denmark[1]	Contact Form via website	No	Not Known
Egypt	Egyptian Veterans and War Victims Association[1]	Contact Form via website	No	Not Known
Estonia	Ministry of Defense	Direct email	No	Not Known
Finland	Disabled War Veterans Association of Finland[1]	Contact Form via website	No	Not Known
Finland	Finnish War Veterans Federation[1]	Contact Form via website	No	Not Known
Georgia	Ministry of Defence of Georgia	Direct email	No	Not Known
Germany	German Federal Ministry of Defence	Direct email	Yes	No
Greece	Greek Ministry of National Defence	Direct email	No	Not Known
Hungary	Ministry of Defence	Direct email	Yes	No
India	Department of Ex-Servicemen Welfare	Direct email	Yes	No
Iran	Veterans and War Victims Foundation of Iran[1]	Contact Form via website	No	Not Known
Ireland	Organisation of National Ex-Service Personnel (ONE)	Direct email	Yes	No
Israel	Israeli Defence Force	Direct email	Yes	No

Country	Source of Information (e.g., organisation contacted)	Method of Communication	Response Received	Ageing Veteran Residential Provision Confirmed
Israel	Israel Defence Forces Veterans of War Association (TZEVET)[1]	Contact Form via website	No	Not Known
Italy	National Association of War Disabled (ANMIG)[1]	Contact Form via website	No	Not Known
Italy	National Association of War Veterans and Repatriated Soldiers (ANCR)[1]	Contact Form via website	No	Not Known
Japan	Japan Veterans Association[1]	Contact Form via website	No	Not Known
Kuwait	Ministry of Defence of Kuwait	Direct email	No	Not Known
Latvia	Ministry of Defense of the Republic of Latvia	Direct email	Yes	No
Lithuania	Lithuanian Government Portal	Direct email	No	Not Known
Luxembourg	Ministry of Homeland Security	Direct email	No	Not Known
Malaysia	Malaysian Armed Forces Veterans Council[1]	Contact Form via website	No	Not Known
Malta	Ministry for Home Affairs, National Security and Law Enforcement	Direct email	Yes	No
Mexico	Mexico - Secretariat of National Defence[1]	Direct email	No	Not Known
Montenegro	Ministry of Defence	Direct email	No	Not Known
Nigeria	Nigerian Legion[1]	Contact Form via website	No	Not Known
North Macedonia	Ministry of Defence, Republic of North Macedonia	Direct email	No	Not Known
Norway	Norwegian Veterans Association for International Operations	Direct email	Yes	No
Pakistan	Pakistan Armed Services Board (PASB)[1]	Contact Form via website	No	Not Known
Philippines	Veterans Federation of the Philippines (VFP)[1]	Contact Form via website	No	Not Known
Portugal	General Secretariat of the Ministry of National Defense	Direct email	No	Not Known
Portugal	Ligue des Combattants[1]	Contact Form via website	No	Not Known
Qatar	Government Communications Office, Council of Ministers	Direct email	No	Not Known

Country	Source of Information (e.g., organisation contacted)	Method of Communication	Response Received	Ageing Veteran Residential Provision Confirmed
Republic of Kosovo	Ministry for Kosovo Security Force (MKSF)	Direct email	No	Not Known
Republic of Congo	National Office of Veterans and War Victims of the Republic of Congo (ONAC-VG)[1]	Contact Form via website	No	Not Known
Romania	Minister of National Defence	Direct email	No	Not Known
Serbia	Serbian War Veterans[1]	Contact Form via website	No	Not Known
Singapore	Singapore Armed Forces Veterans' League (SAFVL)[1]	Contact Form via website	No	Not Known
Slovakia	Ministry of Defence	Direct email	No	Not Known
Slovenia	Ministry of Labor, Family, Social Affairs & Equal Opportunities	Direct email	Yes	No
South Africa	Council of Military Veterans' Organization of the Republic of South Africa (CMVO)	Contact Form via website	No	No
South Africa	Department of Military Veterans	Direct email	No	Not Known
South Africa	South African National Military Veterans Association (SANMVA)	Contact Form via website	No	No
Spain	Spanish Ministry of Defence	Direct email	Yes	No
Sweden	Swedish Veterans Federation (SVF)[1]	Contact Form via website	Yes	No
Switzerland	Switzerland Federal Department of Defence, Civil Protection and Sport (DDPS)	Direct email	Yes	Not Applicable
Thailand	War Veterans Association of Thailand (WVO)[1]	Contact Form via website	No	Not Known
Turkey	Presidency of the Republic of Turkey	Direct email	No	Not Known
Ukraine	All Ukrainian Union of War Veterans (VSUV)[1]	Contact Form via website	No	Not Known
Vietnam	Veterans Association of Vietnam (VAVN)[1]	Contact Form via website	No	Not Known

[1]World Veterans Federation Member

APPENDIX G

Empirical Studies Participant Characteristics							
Paper title/Author(s)	**Participant Gender**		**Participant Numbers**	**Client Group Included in Study**			**Client Age (years)**
	Male Only	**Mixed**		**Veteran**	**Non-Veteran**	**Family**	
Assisted Living Pilot Program - Utilization and Cost Findings (Chapko, et al. 2009)	X		n=393[(1)] n=259 (comparison group)	X[(1)]			*X*=69.3
Predicting Mortality of Older Residents in Long-Term Care Facilities (Chen, et al. 2010)	X		n=559	X			*X*=80.9
A qualitative exploration of veteran and family perspectives on medical foster homes (Gilman, et al. 2018)		X	n=62	X (n=35)		X (n=27)	n/s
Assisted Living Pilot Program - Background, Methods, Facility Characteristics (Guihan, et al. 2009)		X	n=743[(1)]	X[(1)]			n/s
Caregivers Create a Veteran-Centric Community in VHA Medical Foster Homes (Haverhals, et al. 2016)		X	n=20	n/a[(3)]			n/s
Characteristics of Residents and Providers in the Assisted Living Pilot Program (ALPP) (Hedrick, et al. 2007)		X	n=743[(1)]	X[(1)]			28-96 years
Assisted Living Pilot Program - Health Outcomes (Hedrick, et al. 2009)		X	n=393[(1)]	X[(1)]			*X*=69.3
Residential Care and the Veterans Administration (Kenter, 1980)	n/a		n/a[(1)]	X[(1)]			n/a
Life at the Extreme: Characteristics of Veteran Centenarians in Long-Term Care (Kheirbek, et al. 2018)		X	n=6 male[(1)] n=2 female [(1)]	X			over 100 years

Paper title/Author(s)	Participant Gender		Participant Numbers	Client Group Included in Study			Client Age (years)
	Male Only	Mixed		Veteran	Non-Veteran	Family	
Ownership and Quality of Care in Residential Facilities for the Elderly (Lemke and Moos, 1989)	n/a		n/a	X[2]			*X*=70
Residential care services for older people in China: from state to market provisions? (Leung, 2010)	n/a		n/a	X[1]			n/a
A Qualitative Evaluation of a new Community Living Model: Medical Foster Homes (Levy, et al. 2013)		X	n=35	X (n=2)	X[4] (n=26)	X (n=7)	n/s
Correlates of Self-rates successful aging among community dwelling older adults (Montross, et al. 2006)		X	n=201	X (n=25)	X (n=176)		(mean=80.4)
Predictive Factors of Self-Care Capacity in Veterans' Care Institution Residents (Wu, 2002)	X		n=404[1]	X[1]			68-93 years

[1] Retrospective analysis of data - participants not interviewed as part of the study
[2] Facility types and ownership reviewed - participants not interviewed as part of the study
[3] Service providers interviewed n=20
[4] Stakeholders also interviewed n=26
n/a - not applicable
n/s - not specified

APPENDIX H

Empirical Studies Residency Characteristics

Paper title/Author(s)	Residence/Facility Population Group		Residence/Facility Type [1] (with number of facilities if available)								Size of Residence/ Facility (e.g., number of rooms/ apartments)	Residency Room Type		Residence/Facility Organisation Type			Funding		
	Veteran Only	Mixed/ Non-Veteran	RCF	AFH	MFH	ALF	NH	RES	ALR	VAFH		Private Single Room	Shared Room	For Profit	Non-Profit	Defence /State Funded	Self	Defence/ State	Mixed
Assisted Living Pilot Program - Utilization and Cost Findings (Chapko, et al. 2009)	n/s		n/s								n/s	n/s		n/s				X	
Predicting Mortality of Older Residents in Long-Term Care Facilities (Chen, et al. 2010)	X		X								n/s	n/s		n/s			n/s		
A qualitative exploration of veteran and family perspectives on medical foster homes (Gilman, et al. 2018)	X[2]				X						n/s [2]	n/s		X					X
Assisted Living Pilot Program - Background, Methods, Facility Characteristics (Guihan, et al. 2009)	X	X	X (n=43)	X (n=41)		X (n=47)					RCF (mean=20.7) AFH (mean=6.0) ALF (mean=66.2)	X	X	X	X		n/a		
Caregivers Create a Veteran-Centric Community in VHA Medical Foster Homes (Haverhals, et al. 2016)	X[2]				X						n/a	n/a		X					X
Characteristics of Residents and Providers in the Assisted Living Pilot Program (ALPP) (Hedrick, et al. 2007)	X[2]	X	X (n=46)	X (n=58)		X (n=56)					ALF (mean=66.0) AFH (mean=5.9) RCF (mean=22.0)	AFH - 85% ALF - 91.7% RCF - 38.9%	AFH - 15% ALF - 8.3% RCF - 61.1%	X			n/s		
Assisted Living Pilot Program - Health Outcomes (Hedrick, et al. 2009)	n/s		X	X		X					(mean=30.3)	X	X	n/s				X	
Residential Care and the Veterans Administration (Kenter, 1980)	X[2]									X	n/a	n/s		n/a			n/a		

Paper title/Author(s)	Residence/Facility Population Group		Residence/Facility Type [1] (with number of facilities if available)								Size of Residence/ Facility (e.g., number of rooms/ apartments)	Residency Room Type		Residence/Facility Organisation Type			Funding		
	Veteran Only	Mixed/ Non-Veteran	RCF	AFH	MFH	ALF	NH	RES	ALR	VAFH		Private Single Room	Shared Room	For Profit	Non-Profit	Defence /State Funded	Self	Defence/ State	Mixed
Life at the Extreme: Characteristics of Veteran Centenarians in Long-Term Care (Kheirbek, et al. 2018)	X						X				(mean=120)	n/s				X		X	
Ownership and Quality of Care in Residential Facilities for the Elderly (Lemke and Moos, 1989)		X	X				X	X			Veteran (mean=103) Other (mean=120)	n/s		X	X	X	n/s		
Residential care services for older people in China: from state to market provisions? (Leung, 2010)	n/a		n/a								n/a	n/a		n/a			n/a		
A Qualitative Evaluation of a new Community Living Model: Medical Foster Homes (Levy, et al. 2013)	X[(2)]				X						n/s [(2)]	n/s		X					X
Correlates of Self-rates successful aging among community dwelling older adults (Montross, et al. 2006)	X	X						X	X		n/a	n/s		n/s			n/s		
Predictive Factors of Self-Care Capacity in Veterans' Care Institution Residents (Wu, 2002)	X		X								n/s	X		n/s			n/s		

[1]RCF: Residential Care Facility; AFH: Adult Foster Home; MFH: Medical Foster Home; ALF: Assisted Living Facility (Residential); NH: Nursing Home; RES: Residential (Community Independent Living); ALR: Assisted Living (Residential Facility); VAFH: Veterans Affairs Foster Home

[2] Medical Foster Homes have a maximum of n=3 veteran residents, however it is unclear if this is the maximum number of residents in each establishment

n/s[2] - not specified - refer to point 2

n/s - not specified

n/a - not applicable

APPENDIX I

Empirical Studies Participant Outcomes								
Paper title	**Author(s)/Date**	**Quality of Life (QoL)**	**Longevity**	**Physical Health**	**Social Engagement**	**Environment**	**Pastoral Care**	**Reason for Leaving Residence**
Assisted Living Pilot Program - Utilization and Cost Findings	Chapko, et al. 2009			X				X
Predicting Mortality of Older Residents in Long-Term Care Facilities	Chen, et al. 2010			X				X
A qualitative exploration of veteran and family perspectives on medical foster homes	Gilman, et al. 2018					X		
Assisted Living Pilot Program - Background, Methods, Facility Characteristics	Guihan, et al. 2009	X			X			
Caregivers Create a Veteran-Centric Community in VHA Medical Foster Homes	Haverhals, et al. 2016					X		
Characteristics of Residents and Providers in the Assisted Living Pilot Program (ALPP)	Hedrick, et al. 2007			X				
Assisted Living Pilot Program - Health Outcomes	Hedrick, et al. 2009			X				X
Residential Care and the Veterans Administration	Kenter, 1980					X		
Life at the Extreme: Characteristics of Veteran Centenarians in Long-Term Care	Kheirbek, et al. 2018	X	X	X	X		X	X
Ownership and Quality of Care in Residential Facilities for the Elderly	Lemke and Moos, 1989				X	X		X
Residential care services for older people in China: from state to market provisions?	Leung, 2010							
A Qualitative Evaluation of a new Community Living Model: Medical Foster Homes	Levy, et al. 2013	X				X		
Correlates of Self-rates successful aging among community dwelling older adults	Montross, et al. 2006.	X		X	X		X	
Predictive Factors of Self-Care Capacity in Veterans' Care Institution Residents	Wu, 2002				X			

APPENDIX J

Grey Information: Residency Characteristics – UK Provision												
Service Provider	**Number of Residential Properties**	**Resident Age Group**		**Residency Population Group**			**Residency Type**		**Size of Facility**	**Residency Type**	**Funding**
		Over 65 yrs. only	**Any age - needs assessed**	**Veteran Only**	**Veteran/Spouse /Widow/Partner**	**Mixed (Veteran/ non-Veteran)**	**Residential Care Home with/without Nursing Care**	**Assisted Living/ Sheltered Accommodation**		**Not-for-Profit (Military Charity)**	**Self-Pay & State Funded**
Blind Veterans UK	n=1		X	X			X		n=77	X	X
Broughton House	n=1	X		X			X		n=35	X	n/s
Defence Business Services, Veterans UK	n=1	X			X		X		n=98	n/s	n/s
Erskine Hospital	n=4		X		X		X		n=339	X	X
Royal British Legion	n=6		X		X		X		n=477	X	X
Royal British Legion Industries (RBLI)	n=3		X		X		X	X	n=105	X	X
Royal Hospital Cheslea	n=1	X		X			X	X	n=300	X	X

Service Provider	Number of Residential Properties	Resident Age Group		Residency Population Group			Residency Type		Size of Facility	Residency Type	Funding
		Over 65 yrs. only	Any age - needs assessed	Veteran Only	Veteran/Spouse /Widow/Partner	Mixed (Veteran/ non-Veteran)	Residential Care Home with/without Nursing Care	Assisted Living/ Sheltered Accommodation		Not-for-Profit (Military Charity)	Self-Pay & State Funded
The Royal Alfred Seafarers Society	n=2	n/s			X		X	X	n=90	X	X
The Royal Cambridge Home	n=1	X				X	X		n=30	X	X
Royal Naval Benevolent Trust	n=2	X			X		X		n=121	X	X
Royal Star and Garter	n-3		X		X		X		n=60	X	X

APPENDIX K

Grey Information Data - Residency Characteristics - Rest of the World (Part a)							
Country of Residence	**Service Provider**	**Number of Residential Care Properties**	**Resident Age Group**		**Residency Population Group**		
			Over 65 yrs. only	**Any age - needs assessed**	**Veteran Only**	**Veteran/Spouse/ Widow/Partner**	**Mixed (Veteran/ non-Veteran)**
Australia	Multiple	n=32	n/s				X
Canada	Multiple	n=17	n/s		X n=1 (n/s n=8)	X n=1	X n=7
Czech Republic	Ministry of Defence of the Czech Republic	n=2	n/s		X		
France	1. National Office for Veterans & War Victims; 2. [French] Foreign Legion Control; 3. Independent Provider	n=3		X	X n=2		X n=1
Jordan	Ministry of Social Development	n/s	n/s		n/s		
Netherlands	Dutch Ministry of Defence	n=1		X	X		

Country of Residence	Service Provider	Number of Residential Care Properties	Resident Age Group		Residency Population Group		
			Over 65 yrs. only	Any age - needs assessed	Veteran Only	Veteran/Spouse/ Widow/Partner	Mixed (Veteran/ non-Veteran)
New Zealand	Multiple	n=5				X n=1	X n=4
Poland	Polish Local Authorities	n=23	X		X		
USA [(1)]	State Veterans Home (Kentucky Department of Veterans Affairs)	Multiple (n=4 in Kentucky)	n/s		X	X	
	Assisted Living Facility (Florida Department of Veterans Affairs)	Multiple (n=1 in Florida)		X	X		
	Adult Foster Home (Multiple Independent providers)	Multiple		X			X
	Medical Foster Home Multiple Independent providers	Multiple	n/s				X
	Community Living Centre (model) [(2)]	Multiple	n/s		n/s		
	Community Nursing Home (model) [(2)]	Multiple	n/s		n/s		
	Community Residential Care (model) [(2)]	Multiple	n/s		n/s		

Grey Information Data - Residency Characteristics - Rest of the World (Part b)								
Country of Residence	**Residency/Facility Type**		**Size of Facility**	**Residency/Organisation Type**		**Funding**		
	Residential Care Home with/without nursing care	**Assisted Living**		**For Profit**	**Not-for-Profit (+/- Military Charity)**	**Defence/ State Funded**	**Defence/ State**	**Self-Pay & State Funded**
Australia	X n=32		n=3924	X n=25	X n=7			X
Canada	X n=17		n=1754	X n=5	X n=2	X n=2		X n=17
Czech Republic	X		n=35			X	n/s	
France	X n=3		n=201 (n=2 residences) N/S (n=1 residence)		X n=1	X n=2	n/s n=2	X n=1
Jordan	X		n/s			X	X	
Netherlands	X		n=50			X	X	
New Zealand	X n=5		n=214	X n=1	X n=3		n/s n=1	X n=4
Poland	X		n=23			X		X

Country of Residence	Residency/Facility Type		Size of Facility	Residency/ Organisation Type		Funding		
	Residential Care Home with/without nursing care	Assisted Living		For Profit	Not-for-Profit (+/- Military Charity)	Defence/ State Funded	Defence/ State	Self-Pay & State Funded
USA [(1)] State Veterans Home (Kentucky Department of Veterans Affairs)	X		n=120			X		X
Assisted Living Facility (Florida Department of Veterans Affairs)		X	n=150			X		X
Adult Foster Home (Multiple Independent providers)		X	n=6 (Maximum 6 residents)	X				X
Medical Foster Home Multiple Independent providers		X	n/s (max n=3 veterans)	X				X
Community Living Centre (model) [(2)]			n/s	n/s				X
Community Nursing Home (model) [(2)]			n/s	n/s				X
Community Residential Care (model) [(2)]		X[(3)]	n/s	n/s				X

(1) the USA has several veteran care models. Represented here are examples of the care available

(2) indicates other models of care available to eligible US veterans

(3) care is delivered across multiple care settings

n/s - not specified; n/a - not applicable

APPENDIX L

Northumbria University NEWCASTLE

HOME OF THE CHELSEA PENSIONERS

Research Project: Care of the ageing veteran population: Developing an evidence base for the Royal Hospital Chelsea model of care

Quality of Life Questionnaire

Participant UIN:	
Date Completed:	

Thank you for agreeing to take part in the above research project. Part of the project involves collecting responses regarding how you feel about your quality of life.

To do this, we would be grateful if you could answer the following questions by ticking the answer that closely matches how you have been feeling **over the past two weeks.**

Your answers are confidential and will only be seen by the researcher. All data will be anonymised to ensure you cannot be identified.

When you have completed the questionnaire, please return it to the researcher in the pre-paid envelope provided, or hand it to them at the end of your interview.

Please note that there are 2 questionnaires, however they have been combined into one document to make it easier to complete.

If you have any questions, please do not hesitate to speak to the researcher either at the time of your interview, or by calling Helen Cullen on 07766 982904.

Thank you

Researcher Use Only:	
Date Received:	
Date Data recorded:	

APPENDIX L

UIN:	

ICECAP-A

ABOUT YOUR OVERALL QUALITY OF LIFE

Please indicate which statements best describe your overall quality of life at the moment by placing a tick in ONE box for each of the five groups below.

1. Feeling settled and secure	✓	
I am able to feel settled and secure in all areas of my life		4
I am able to feel settled and secure in many areas of my life		3
I am able to feel settled and secure in a few areas of my life		2
I am unable to feel settled and secure in any areas of my life		1

2. Love, friendship and support	✓	
I can have a lot of love, friendship and support		4
I can have quite a lot of love, friendship and support		3
I can have a little love, friendship and support		2
I cannot have any love, friendship and support		1

3. Being independent	✓	
I am able to be completely independent		4
I am able to be independent in many things		3
I am able to be independent in a few things		2
I am unable to be at all independent		1

4. Achievement and progress	✓	
I can achieve and progress in all aspects of my life		4
I can achieve and progress in many aspects of my life		3
I can achieve and progress in a few aspects of my life		2
I cannot achieve and progress in any aspects of my life		1

5. Enjoyment and pleasure	✓	
I can have a lot of enjoyment and pleasure		4
I can have quite a lot of enjoyment and pleasure		3
I can have a little enjoyment and		2
I cannot have any enjoyment and pleasure		1

APPENDIX L

UIN:	

The following set of questions have been reproduced with permission from the WHO Press Permission Team, Geneva, World Health Organization (WHO), (2020). WHO does not endorse any specific companies, products or services.

Instructions:

This questionnaire asks how you feel about your quality of life, health, and other areas of your life. **Please answer all the questions**. If you are unsure about which response to give to a question, please **choose the one** that appears most appropriate. This can often be your first response.

Please keep in mind your standards, hopes, pleasures and concerns. We ask that you think about your life in the **last two weeks**.

For example, thinking about the last two weeks, a question might ask:

Do you get the kind of support from others that you need?				
Not at all	Not Much	Moderately	A Great Deal	Completely
1	2	3	4	5

You should circle the number that best fits how much support you got from others in the last two weeks. So, you would **circle number 4** if you got **a great deal** of support from others.

You would **circle number 1** if you **did not get any support at all** from others.

If you would like to discuss anything before starting the questionnaire, please speak to the researcher. If you are completing this questionnaire at home, call Helen (Cullen) on 07766 982904

Please read each question, assess your feelings (over the last two weeks), and circle the number on the scale for each question that gives the best answer for you.

		Very poor	Poor	Neither poor nor good	Good	Very good
1	How would you rate your quality of life?	1	2	3	4	5

		Very dissatisfied	Fairly Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
2	How satisfied are you with your health?	1	2	3	4	5

The following questions ask about **how much** you have experienced certain things in the **last two weeks**.

		Not at all	A Little	A Moderate amount	A great deal	An Extreme amount
3	To what extent do you feel that physical pain prevents you from doing what you need to do?	1	2	3	4	5
4	How much do you need any medical treatment to function in your daily life?	1	2	3	4	5
5	How much do you enjoy life?	1	2	3	4	5
6	To what extent do you feel your life to be meaningful?	1	2	3	4	5

		Not at all	A Little	A Moderate Amount	Very	Extremely
7	How well are you able to concentrate?	1	2	3	4	5
8	How safe do you feel in your daily life?	1	2	3	4	5

9	How healthy is your physical environment?	1	2	3	4	5

The following questions ask about **how completely** you experience or were able to do things **in the last two weeks**

		Not at all	A Little	Moderately	Mostly	Completely
10	Do you have enough energy for everyday life?	1	2	3	4	5
11	Are you able to accept your bodily appearance?	1	2	3	4	5
12	Have you enough money to meet your needs?	1	2	3	4	5
13	How available to you is the information you need in your day-to-day life?	1	2	3	4	5
14	To what extent do you have the opportunity for leisure activities?	1	2	3	4	5

		Not at all	Slightly	Moderately	Very	Extremely
15	How well are you able to get around physically?	1	2	3	4	5

The following questions ask you to say how **good or satisfied** you have felt about various aspects of your life over the over the **last two weeks**

		Very Dissatisfied	Fairly Dissatisfied	Neither Satisfied nor Dissatisfied	Satisfied	Very satisfied
16	How satisfied are you with your sleep?	1	2	3	4	5
17	How satisfied are you with your ability to perform your daily living activities?	1	2	3	4	5

18	How satisfied are you with your capacity for work	1	2	3	4	5
19	How satisfied are you with yourself?	1	2	3	4	5
20	How satisfied are you with your personal relationships?	1	2	3	4	5
		Very Dissatisfied	Fairly Dissatisfied	Neither Satisfied nor Dissatisfied	Satisfied	Very satisfied
21	How satisfied are you with your sex life?	1	2	3	4	5
22	How satisfied are you with the support you get from your friends?	1	2	3	4	5
23	How satisfied are you with the conditions of your living place?	1	2	3	4	5
24	How satisfied are you with your access to health services?	1	2	3	4	5
25	How satisfied are you with your transport?	1	2	3	4	5

The following question refers to **how often** you have felt or experienced certain things **in the last two weeks**

		Never	Seldom	Quite Often	Very Often	Always
26	How often do you have negative feelings such as blue mood, despair, anxiety or depression?	1	2	3	4	5

Thank you for completing this questionnaire. Please return it to the researcher in the pre-paid envelope provided, or hand it to them at the end of your interview.

Thank you

APPENDIX M

Northumbria University Ethics

Research Ethics: Your submission has been approved

EthicsOnline@Northumbria <EthicsOnline@Northumbria>

Sun 23/08/2020 08:03

To: helen.cullen <helen.cullen@northumbria.ac.uk>

Cc: Gemma Wilson-Menzfeld <gemma.wilson-menzfeld@northumbria.ac.uk>

Dear helen.cullen,

Submission Ref: 24587

Please note that at the current time, all research projects involving interaction with human participants are required to use remote methods (e.g., videoconferencing) or postpone their research until the University lifts this restriction. Current guidance is available

Following independent peer review of the above proposal*, I am pleased to inform you that **APPROVAL** has been granted on the basis of this proposal and subject to continued compliance with the University policies on ethics, informed consent, and any other policies applicable to your individual research. You should also have current Disclosure & Barring Service (DBS) clearance if your research involves working with children and/or vulnerable adults.

* Note: Staff Low Risk applications are auto-approved without independent peer review.

The University's Policies and Procedures are here

All researchers must also notify this office of the following:

- Any changes to the study design, by submitting an 'Ethics Amendment Form'
- Any incidents which have an adverse effect on participants, researchers or study outcomes, by submitting an 'Ethical incident Form'
- Any suspension or abandonment of the study.

Please check your approved proposal for any Approval Conditions upon which approval has been made.

Use this link to view the submission: View Submission

Research Ethics Home: Research Ethics Home

Please do not reply to this email. This is an unmonitored mailbox. If you are a student, queries should be discussed with your Module Tutor/Supervisor. If you are a member of staff please consult your Department Ethics Lead.

Camberwell St Giles Research Ethics Committee Approval Documents

From: camberwellstgiles.rec@hra.nhs.uk <noreply@harp.org.uk>
Sent: 22 January 2021 12:57
To: Gemma Wilson <gemma.wilson@northumbria.ac.uk>; helen.cullen <helen.cullen@northumbria.ac.uk>
Cc: Laura Hutchinson <laura.hutchinson2@northumbria.ac.uk>
Subject: IRAS 288952. Status Update - Provisional Opinion

Dear Dr Wilson,

Following the review meeting I am pleased to provide the following update regarding the status of your application. The Research Ethics Committee reviewed the application on 15 January 2021 and issued a Provisional Opinion. Please provide the following information in order for a final ethical opinion to be issued:

No.	Action Required	Response from the applicant
1	Please explain how you will correlate anonymised hospital records with participants' answers to the questionnaires.	It is not intended to correlate the data from the Margaret Thatcher Infirmary (MTI) to the In-Pensioner Quality of Life questionnaires or the Qualitative Interviews, as the two sets of information/results are independent of each other. The anonymised data received from the MTI will look to capture admission data for all Royal Hospital Chelsea In-Pensioners (approximately n=300) and will form findings for Phase 2 of the project (review of Royal Hospital Chelsea Documentation).
2	The IRAS form states that the study will not be registered on a public database on confidentiality grounds but as research should be registered wherever possible and the study data will be anonymised, please find an appropriate public database on which the study will be registered and advise which this will be, or provide adequate justification for not registering the study.	11.02.2021 – The project has been registered on the ClinicalTrials.gov database and is currently in the approval stages (Northumbria University then ClinicalTrials.gov). A copy of the acknowledgement email is attached for reference.
3	The letter of invitation to staff should rephrase 'the interpretation of organisational policy alongside the perceptions of care delivery and the sustainability of the model of care' so that it will be readily understood by all staff.	Letter of invitation has been revised

4	<u>Pensioners information sheets</u> a. These should state that if the participant loses mental capacity, their data up to the time of incapacity will be kept and used in the study. b. Under 'Why is this study being carried out?', ".....300 years, however.." should be changed to ".....300 years. However…". c. The heading 'What will happen to my results?' should read 'What will happen to the results of the study?' and the second paragraph under this heading should be removed. d. The second paragraph under 'Why is this study being carried out?' should read 'The study aims to find out the influence Royal Hospital Chelsea has on the lives of its current generation of In-Pensioners, how your care is delivered, and how the environment in which you live contributes to your overall health and quality of life'.	All Participant Information Sheets revised: • In-Pensioners • New In-Pensioners • Key Staff
5	<u>Quality of life questionnaire</u> 'I can have' in questions 2 and 5 should read 'I have'.	Questions 2 and 5 amended. In addition: Q5: final statement – the word 'cannot' has been replaced with 'do not': I **do not** have any enjoyment and pleasure

The Committee delegated authority to the Chair/Vice Chair and Dr Lavender

A response should be submitted by no later than 21 February 2021.

- Please provide a response to the requested information through IRAS by referring to the instructions on how to submit a response to provisional opinion electronically.
- Please provide your answers in the table above and then submit this, with revised documentation where appropriate, underlining, tracking or otherwise highlighting the changes which have been made and giving revised version numbers and dates.
- Do not make any changes to the IRAS application form unless you have been specifically requested to do so.

Membership of the Committee: London - Camberwell St Giles Research Ethics Committee
Attendance at Committee meeting on 15 January 2021

Committee Members:

Name	*Profession*	*Present*	*Notes*
Ms Joanna Bagshaw	Research Facilitator	Yes	
Dr Geok Mei Chong	Industry Partnerships and Commercialisation Officer	No	
Mr Thomas Gale	Freelance Translator	No	
Ms Susan Harrison	Retired Health and Social Services Manager	Yes	
Dr Hilary Anne Lavender	General Medical Practitioner	Yes	
Dr Michael Millar	Consultant in Infection (Barts Health)	Yes	
Mrs Larissa Revill	Laboratory Manager/Researcher: Women's Health	Yes	
Mr John Richardson	Retired Director of COREC: former Ecumenical Officer for Churches Together in South London	Yes	Chair
Ms Lois Rogers (BREAK IN SERVICE)	Journalist	No	
Dr Mark Tanner	Consultant Psychiatrist	Yes	
Mr James Uwalaka	Regulatory Compliance Officer	Yes	

Name	*Position (or reason for attending)*
Ms Anna Gorczyca	Pharmacist
Elaine C Hutchings	Approvals Officer
Natalie Wilson	Approvals Manager

If you have any queries, please do not hesitate to contact me.

Kind regards,

Elaine Hutchings

Approvals Officer

Ground Floor | Temple Quay House | Health Research Authority | BS1 6PN

T. 0207 1048 007

E. camberwellstgiles.rec@hra.nhs.uk

W. www.hra.nhs.uk

NHS
Health Research Authority

London - Camberwell St Giles Research Ethics Committee

Ground Floor Temple Quay House
2 The Square
Bristol BS1 6PN

Please note: This is the favourable opinion of the REC only and does not allow

you to start your study at NHS sites in England until you receive HRA Approval

Telephone: 0207 104 8340

18 February 2021

Dr Gemma Wilson
Vice Chancellor's Research Fellow in Applied Health
University of Northumbria at Newcastle
Faculty of Health & Life Sciences
Department of Nursing, Midwifery & Health
Coach Lane Campus, Newcastle Upon Tyne
NE7 7XE

Dear Dr Wilson

Study title:	**Care of the ageing veteran population: Developing an evidence base for the Royal Hospital Chelsea model of care**
REC reference:	**21/LO/0058**
IRAS project ID:	**288952**

Thank you for your revised documentation received on the 17th February 2021, responding to the Research Ethics Committee's (REC) request for further information on the above research.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation [as revised], subject to the conditions specified below.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Copies of materials calling attention of potential participants to the research [IRAS Ref 288952 Recruitment Coffee Morning Poster v.Final2 15.12.2020]	Final2	15 December 2020
Copies of materials calling attention of potential participants to the research [IRAS Ref 288952 Participant Recruitment Leaflet v.Final3 15.12.2020]	Final3	15 December 2020
Copies of materials calling attention of potential participants to the research [IRAS 288952 Recruitment Leaflet New In-Pensioner v.Final3 15.12.2020]	Final3	15 December 2020
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [University of Northumbria Insurance EL PL 2020-21 50m]	1.0	17 September 2020
Interview schedules or topic guides for participants [Interview Schedule RHC In-Pensioner]	Final	03 September 2020
Interview schedules or topic guides for participants [Interview Schedule RHC Key Staff]	Final	03 September 2020
IRAS Checklist XML [Checklist_17022021]		17 February 2021
Letters of invitation to participant [Key Staff covering email re Research Project]	Final	03 September 2020
Letters of invitation to participant [Key Staff Introduction to Research Project Letter]	v.RECRevisionFinal 1.2 CLEAN	17 February 2021
Other [University of Northumbria Insurance PI 2020-21]	1.0	17 September 2020
Other [NU Internal Approval Form Signed by all parties]	1.5	25 September 2020
Other [In-Pensioner Participant Personal Details Form]	Final	16 September 2020
Other [IRAS Ref 288952 WHO QOL BREF pg15-18 v.1.0 15.12.2020]	1.0	15 December 2020
Other [IRAS Ref 288952 Helen Cullen CV v.1.0 17.09.2020]	1.0	17 September 2020
Other [IRAS Ref 288952 In-Pensioner Personal Details Form v.Final2 15.12.2020]	Final2	15 December 2020
Other [IRAS Ref 288952 ICECAP-A Patient Quality of Life Questionnaire Validated Measure v.1.0 15.12.2020]	RECRevision Final 1.0	25 January 2021
Other [REC Panel email Provisional Opinion with Updates]	RECRevision Final 1.0	11 February 2021
Other [REC Panel Revisions Table]	v.1.2	11 February 2021
Other [IRAS Ref 288952 ICECAP-A Patient Quality of Life Questionnaire Validated Measure v.1.0 15.12.2020]	v.RECRevisionFinal 1.1 CLEAN	13 February 2021
Other [IRAS 288952 ClinicalTrials.gov Registration email v.1.0]	v.1.0	11 February 2021
Participant consent form [IRAS Ref 288952 Consent Form RHC In-Pensioner v.Final2 15.12.2020]	Final2	15 December 2020
Participant consent form [IRAS Ref 288952 Consent Form RHC Key Staff v.Final2 15.12.2020]	Final2	15 December 2020
Participant consent form [IRAS Ref 288952 Consent Form RHC New In-Pensioner v.Final2 15.12.2020]	Final2	15 December 2020
Participant information sheet (PIS) [Participant Information Sheet RHC Key Staff]	RECRevision Final 1.0	25 January 2021
Participant information sheet (PIS) [Participant Information Sheet RHC New In-Pensioner]	RECRevision Final 1.0	25 January 2021
Participant information sheet (PIS) [Participant Information Sheet RHC In-Pensioner]	v.RECRevisionFinal1.1 CLEAN	13 February 2021
Participant information sheet (PIS) [Participant Information Sheet RHC Key Staff]	v.RECRevisionFinal 1.1 CLEAN	13 February 2021

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality- assurance/

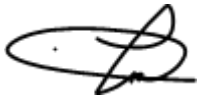
HRA Learning

We are pleased to welcome researchers and research staff to our HRA Learning Events and online learning opportunities– see details at: https://www.hra.nhs.uk/planning-and-improving- research/learning/

IRAS project ID: 288952	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this

project. Yours sincerely



PP

Dr Mark Tanner
Chair

Email: camberwellstgiles.rec@hra.nhs.uk

Enclosures: "After ethical review – guidance for researchers"

Copy to: Mrs Laura Hutchinson

APPENDIX N

Northumbria University NEWCASTLE

HOME OF THE CHELSEA PENSIONERS

Northern Hub for Veterans and Military Families Research

Terms of Reference

"Care of the Veteran population: Developing an evidence base for the Royal Chelsea Hospital's Care Model"

Project Steering Group

The following Terms of Reference (TORs) set out the role, purpose, and structure of the Steering Group for the above project.

The Project

This project is being carried out by researchers at Northumbria University's Northern Hub for Veterans and Military Families Research in partnership with Royal Hospital Chelsea (RHC) and is part of a post-graduate research study.

The project aims to evaluate Royal Hospital Chelsea's current service provision, inform the future direction of RHC, and address the gap in evidence-based research to demonstrate the impact of its model of care.

To do this, the project aims to:

- Evidence the influence RHC has on In-Pensioner health outcomes and the wider social care provision
- Reflect on the contribution the environment has on its In-Pensioners, their health outcomes and quality of life
- Inform future care provision by mapping current services, the future need and sustainability of the model, and projecting these findings to inform the growth of existing services

Role of the Steering Group

The role of the Steering Group is to provide advice, input, and direction on the project by discussing their thoughts and opinions but will not be a decision-making body. The Steering

Group will provide different and valuable perspectives to the research, ensuring the researcher is not missing any key areas of concern.

As the research is focussed on RHC staff and its residents, the Steering Group will ensure that both groups are represented by providing feedback and input as to the direction of the project.

The Steering Group will act as project 'Champions' to help raise awareness of the project and act as a link between RHC and the researcher.

The Steering Group will be asked to support any events that highlight the progress of the project where possible (i.e., participant recruitment coffee morning(s), end-of-project feedback sessions).

The Steering Group will meet with the researcher 4 times over a 2-year period.

The researcher, Helen Cullen, will act as Chair for the meetings and as the note-taker and will disseminate minutes after each meeting.

Practicalities

Each session will be kept to 1 hour maximum.

Due to the restrictions associated with COVID-19 the meetings will be virtual, either over Zoom or Microsoft Teams (to be mutually agreed upon and guidance will be provided). When and if it is safe to do so, **in line with RHC Covid-19 guidelines**, the final meeting(s) may take place in person at an appropriate venue within RHC.

The researcher would welcome the ability to record these sessions, however, the researcher will only do this if everyone consents before the start of each session.

An overview of the project and its progress will be provided to the Steering Group at the beginning of each meeting.

Purpose

The purpose of the Steering Group is to collectively oversee and collaborate on progress with the project. The purpose and goals of each Steering Group meeting are set out below.

Meeting	Date	Goals
1	March 2021	• Introductions • The researcher will present an overview of the project and aims of the Steering Group • A discussion about the recruitment of staff and In-Pensioners for interview, the timeline and logistics. Steering Group members to provide thoughts and opinions on this, ahead of interviews commencing in April/May 2021 • 'Pilot' interviews – call for Steering Group volunteers (x2) • Review/Feedback on project templates • Identify any key issues and potential challenges the researcher may have overlooked

2	February 2022	• Researcher to present a progress update • Steering Group to discuss any feedback or challenges they have experienced since last meeting • Interviews (Data collection) will be complete, and the researcher will give feedback on the process and present initial findings (all data is anonymised and remains confidential) • Members to discuss these findings and provide thoughts and opinions on the initial 'themes' that are emerging and help develop these themes further • Identify any key issues and potential challenges the researcher may have overlooked
3	September 2022	• Researcher to present a progress update to include progress on the development of identified themes • Steering Group to discuss any feedback or challenges they have experienced since last meeting • Members to provide input on the dissemination of the findings
4	February 2023	• To share final report/Executive Summary with the group • Discuss any 'next steps' following the end of the project • Thank members for their help and support • To close the Steering Group

Structure and Membership

The Steering Group consists of representatives from:

- Northumbria University (Researcher)
- RHC Staff (maximum 3) including:
    - Captains of Invalids (maximum 1)
    - Staff (maximum 2)
- RHC In-Pensioners including:
    - In-Pensioners (maximum 2)

Terms of Membership

Steering Group members are appointed by mutual agreement for the duration of the project. Members may leave and additional members may be appointed, and as the project evolves over time. However, to allow for continuity and when agreed, members stepping down before the end of the project will remain on the Steering Group as a representative of the association.

APPENDIX O

Date:

Research Project: Care of the ageing veteran population: Developing an evidence base for the Royal Hospital Chelsea model of care

Dear (*insert name*)

Royal Hospital Chelsea have commissioned Northumbria University to undertake a 3 year research project to develop an evidence base to demonstrate the influence Royal Hospital Chelsea has on the lives of its current generation of In-Pensioners, how the health and social care delivered, and the environment in which they live, contributes to their overall health outcomes and quality of life.

The findings of the study will look to inform the strategic direction of Royal Hospital Chelsea as it continues to deliver care to current and future generations of veterans and may also contribute to national health and social care policy.

As a key member of staff engaged in contributing to the strategic direction and/or the delivery of the Royal Hospital Chelsea model of care, both of which impact on the In-Pensioner experience, it is important for the project to gather your thoughts on the organisation's structure (including its policies and procedures), your views on the way in which care is delivered and received from your own perspective and, if possible, that of the In-Pensioners. It is also important to hear your views on how Royal Hospital Chelsea can continue to deliver care effectively to its residents.

The attached Participant Information Sheet gives detailed information on what it means for you should you agree to take part in the study. If, after reading the attached information sheet, you are willing to participate, I would be grateful if you could reply to my email or contact me directly on 07766 982904. I will then send you an Information Pack containing a consent form which needs to be signed and returned to me.

If you have any questions, please do not hesitate to contact me. I look forward to hearing from you.

Yours sincerely

Helen Cullen

Researcher

APPENDIX O

Northumbria University NEWCASTLE

HOME OF THE CHELSEA PENSIONERS

A call for participants to take part in a study on life at Royal Hospital Chelsea – a chance for you to share your story!

Research Project: Care of the ageing veteran population: Developing an evidence base for the Royal Hospital Chelsea model of care

Northumbria University is conducting a research project looking at the influence Royal Hospital Chelsea has on the lives of its In-Pensioners, how the health and social care offered, and the environment in which you live, contributes to your overall health and quality of life. The project has the full support of Royal Hospital Chelsea but is being carried out independently by Northumbria University.

We are looking for 25 in-pensioners to participate in the project by taking part in a confidential face-to-face interview and completing a questionnaire about your quality of life.

What does this mean for you?

If you agree to participate, you will be invited to take part in a recorded interview which will last up to 1.5 hours, and will include breaks. The interview will focus on your experience of living at Royal Hospital Chelsea and is an opportunity for you to tell your story in a confidential conversation. The quality of life questionnaire will be completed on the same day as your interview. Your recorded interview will be deleted when it has been typed up, and the transcript will be anonymised to prevent you from being identified.

Interviews will take place at Royal Hospital Chelsea between July 2021 and February 2022

If you are interested in taking part, or would like to discuss the project in more detail please contact Helen Cullen on 07766 982904

This project has the support of Northumbria University and Royal Hospital Chelsea and has received ethical approval from Northumbria University, IRAS (for health and social care/community care research)

APPENDIX O

Northumbria University NEWCASTLE

HOME OF THE CHELSEA PENSIONERS

A call for new In-Pensioners to take part in a study on life at Royal Hospital Chelsea

Research Project: Care of the ageing veteran population: Developing an evidence base for the Royal Hospital Chelsea model of care

Northumbria University is conducting a research project looking at the influence Royal Hospital Chelsea has on the lives of its In-Pensioners, how the health and social care offered, and the environment in which you live, contributes to your overall health and quality of life. The project has the full support of Royal Hospital Chelsea but is being carried out independently by Northumbria University.

We are asking all new in-pensioners to participate in the project by completing 2 questionnaires about your quality of life – 1 when you first arrive and 1 when you have been at Royal Hospital Chelsea for 6 months.

What does this mean for you?

If you agree to participate, you will be asked to complete 2 quality of life questionnaires. The first should be completed shortly after you first arrive at Royal Hospital Chelsea, and the second should be completed 6 months later.

You will be given pre-paid envelopes to return your questionnaires directly to the researcher, and your responses are confidential.

You will receive an information pack from the admissions officer containing more information about the project and the first questionnaire.

If you would like to discuss the project in more detail please contact Helen Cullen on 07766 982904

This project has the support of Northumbria University and Royal Hospital Chelsea and has received ethical approval from Northumbria University, IRAS (for health and social care/community care research)

APPENDIX O

Northumbria University NEWCASTLE

HOME OF THE CHELSEA PENSIONERS

Date:

Research Project: Care of the ageing veteran population: Developing an evidence base for the Royal Hospital Chelsea model of care

Dear

Thank you for agreeing to participate in the above research project and for sending me your signed Consent Form. Please find enclosed a copy for your own records.

The next stage of your participation is to take part in a recorded interview with myself. This will take place at Royal Hospital Chelsea, in a private space to ensure confidentiality.

The interviews are scheduled to take place between April 2021 and June 2021. I will contact you to arrange a date and time that is suitable to you.

As a reminder, you will find full details of the project within the Participant Information Sheet which was part of the Information Pack you received earlier. If you have any questions regarding your participation, please do not hesitate to contact me either by telephone (07766 982904) or via
email: helen.cullen@northumbria.ac.uk

Thank you for agreeing to take part in this project. I look forward to meeting you.

Yours sincerely

Helen Cullen

Researcher

APPENDIX O

Northumbria University NEWCASTLE

HOME OF THE CHELSEA PENSIONERS

Date:

Research Project: Care of the ageing veteran population: Developing an evidence base for the Royal Hospital Chelsea model of care

Dear

Thank you for agreeing to participate in the above research project and for sending me your signed Consent Form. Please find enclosed a copy for your own records.

The next stage of your participation is to take part in a recorded interview with myself. This will take place at Royal Hospital Chelsea, in a private space to ensure confidentiality. You will also be asked to complete a Quality of Life questionnaire at the start of the interview.

The interviews are scheduled to take place between July 2021 and February 2022. I will contact you to arrange a date and time that is suitable to you.

As a reminder, you will find full details of the project within the Participant Information Sheet which was part of the Information Pack you received earlier. If you have any questions regarding your participation, please do not hesitate to contact me either by telephone (07766 982904) or via
email: helen.cullen@northumbria.ac.uk

Thank you for agreeing to take part in this project. I look forward to meeting you.

Yours sincerely

Helen Cullen

Researcher

APPENDIX O

Northumbria University NEWCASTLE

HOME OF THE CHELSEA PENSIONERS

Date:

Research Project: Care of the ageing veteran population: Developing an evidence base for the Royal Hospital Chelsea model of care

Dear

Thank you for agreeing to participate in the above research project and sending me your signed Consent Form. Please find enclosed a copy for your own records.

Also, thank you for sending me your completed Quality of Life Questionnaire, which has been received.

The Admissions Officer at Royal Hospital Chelsea will ensure you receive a further Information Pack containing a second questionnaire in 6 months' time, when you have had chance to settle into your new home.

The second questionnaire is the same as the first one and your responses for each will be compared to see if there have been any changes to your quality of life. Please be reassured that your responses are confidential, and the results will be anonymised to ensure you cannot be identified.

As a reminder, you will find full details of the project within the Participant Information Sheet which was part of the Information Pack you received earlier. If you have any questions regarding your participation please do not hesitate to contact me either by telephone (07766 982904) or via
email: helen.cullen@northumbria.ac.uk

Thank you for agreeing to participate in this project.

Yours sincerely

Helen Cullen

Researcher

APPENDIX O

Northumbria University NEWCASTLE

HOME OF THE CHELSEA PENSIONERS

Research Project: Care of the ageing veteran population: Developing an evidence base for the Royal Hospital Chelsea model of care

Thank you for taking part in today's interview, we appreciate your time and the valuable contribution you are making to the project.

Should you feel that you would like to speak to someone following today's interview, please do not hesitate to contact the Researcher (Helen Cullen) either by telephone 07766 982904 or via email: helen.cullen@northumbria.ac.uk

If you would prefer to speak to someone other than the Researcher then please contact Royal Hospital Chelsea's Director of Health & Wellbeing on 020 7881 5259.

If you would like independent information about this project, please contact:

- Professor Tracy Finch (Northumbria University, Health & Life Sciences Departmental Research & Innovation Lead)
  Email: tracy.finch@northumbria.ac.uk Tel: 0191 215 6477

Thank you

APPENDIX O

Northumbria University NEWCASTLE

HOME OF THE CHELSEA PENSIONERS

Research Project: Care of the ageing veteran population: Developing an evidence base for the Royal Hospital Chelsea model of care

Thank you for taking part in today's interview, we appreciate your time and the valuable contribution you are making to the project.

Should you feel that you would like to speak to someone following today's interview, please do not hesitate to contact the Researcher (Helen Cullen) either by telephone 07766 982904 or via email: helen.cullen@northumbria.ac.uk

If you would prefer to speak to someone other than the Researcher then please contact Royal Hospital Chelsea's Director of Health & Wellbeing on 020 7881 5259.

Alternatively, you may wish to talk to a military charity such as SSAFA (0800 731 4880), the Royal British Legion (0808 802 8080), or your Regimental Association.

If you would like independent information about this project, please contact:

- Professor Tracy Finch (Northumbria University, Health & Life Sciences Departmental Research & Innovation Lead)
  Email: tracy.finch@northumbria.ac.uk Tel: 0191 215 6477

Thank you

APPENDIX O

Northumbria University NEWCASTLE

HOME OF THE CHELSEA PENSIONERS

Date:

Research Project: Care of the ageing veteran population: Developing an evidence base for the Royal Hospital Chelsea model of care

Dear

I trust my letter finds you keeping well.

It was good to meet you at our interview and I wanted to take this opportunity to thank you for agreeing to take part in this research project.

It is a privilege to carry out the research and hearing your experience as a key member of staff has given me a valuable insight into Royal Hospital Chelsea, what it takes to maintain service delivery, the strategic vision and of course what it means to the In-Pensioners who live there.

I will spend the remaining part of the project writing up my findings with an estimated completion date of February 2023.

A copy of the final report will be sent to you when it has been completed.

If you have any questions regarding your participation please do not hesitate to contact me either by telephone (07766 982904) or via email: helen.cullen@northumbria.ac.uk

If you feel you need support following your participation and would like to talk to someone other than myself then please contact Royal Hospital Chelsea's Director of Health & Wellbeing on
020 7881 5259.

Once again, thank you for taking part in this research.

Yours sincerely

Helen Cullen

Researcher

APPENDIX O

Northumbria University NEWCASTLE

HOME OF THE CHELSEA PENSIONERS

Date:

Research Project: Care of the ageing veteran population: Developing an evidence base for the Royal Hospital Chelsea model of care

Dear

I trust my letter finds you keeping well.

It was good to meet you at our interview and I wanted to take this opportunity to thank you for agreeing to take part in the above research project.

It is a privilege to carry out the research and hearing your experience of life as a Chelsea Pensioner has given me a valuable insight into Royal Hospital Chelsea and what it means to those who live there.

I will spend the remaining part of the project writing up my findings with an estimated completion date of February 2023.

A copy of the final report will be sent to you when it has been completed.

If you have any questions regarding your participation please do not hesitate to contact me either by telephone (07766 982904) or via email: helen.cullen@northumbria.ac.uk

If you feel you need support following your participation and would like to talk to someone other than myself then please contact Royal Hospital Chelsea's Director of Health & Wellbeing on 020 7881 5259. Alternatively, you may wish to talk to a military charity such as SSAFA (0800 731 4880), the Royal British Legion (0808 802 8080), or your Regimental Association.

Once again, thank you for taking part in this research project. I wish you good health and happiness as you continue your life at Royal Hospital Chelsea.

Yours sincerely

Helen Cullen

Researcher

APPENDIX O

Northumbria University NEWCASTLE

HOME OF THE CHELSEA PENSIONERS

Date:

Research Project: Care of the ageing veteran population: Developing an evidence base for the Royal Hospital Chelsea model of care

Dear

I trust my letter finds you well.

As you have completed your two Quality of Life Questionnaires, your part in the project is now complete and I wanted to take this opportunity to thank you for agreeing to take part.

It is a privilege to carry out this research, which will continue as I interview a number of key members of staff and In-Pensioners and is due to be completed in February 2023.

If you would like a copy of the final report then please do let me know and I will arrange for you to receive a copy when it is available.

If you have any questions regarding your participation please do not hesitate to contact me either by telephone (07766 982904) or via email: helen.cullen@northumbria.ac.uk

If you feel you need support following your participation and would like to talk to someone other than myself then please contact Royal Hospital Chelsea's Director of Health & Wellbeing on 020 7881 5259. Alternatively, you may wish to talk to a military charity such as SSAFA (0800 731 4880), the Royal British Legion (0808 802 8080), or your Regimental Association.

Once again, thank you for taking part in this research. I wish you good health and happiness as you continue your life at Royal Hospital Chelsea.

Yours sincerely

Helen Cullen

Researcher

APPENDIX O

Northumbria University NEWCASTLE

HOME OF THE CHELSEA PENSIONERS

Date:

Research Project: Care of the ageing veteran population: Developing an evidence base for the Royal Hospital Chelsea model of care

Dear (*insert name*)

I trust my letter finds you well.

Further to our recent conversation, I wanted to write to thank you for registering your interest to take part in the above project.

We had a wonderful response from those wishing to take part and following a process to make sure we had a balanced 'cross-section' of In-Pensioners, which included age, how long people have been a resident at Royal Hospital Chelsea and Army service career history, we now have the numbers needed for the project to take place.

As the numbers for the project are quite small, this means we have been unable to include you in the project on this occasion.

As we discussed when we spoke, we will keep your details on file for the duration of the project and contact you should a space on the project become available. The project is due to be completed in February 2023.

If you have any questions please do not hesitate to contact me either by telephone 07766 982904 or via email: helen.cullen@northumbria.ac.uk

Once again, thank you for registering your interest to take part in this research.

I wish you good health and happiness as you continue your life at Royal Hospital Chelsea.

Yours sincerely

Helen Cullen

Researcher

APPENDIX P

Northumbria University NEWCASTLE

HOME OF THE CHELSEA PENSIONERS

In-Pensioner Residency Details

Project Title: Care of the ageing veteran population: Developing an evidence base for the Royal Hospital Chelsea model of care

Principal Investigator: Helen Cullen

Royal Hospital Chelsea In-Pensioner – Register of Interest to take part in the above study	
Participant Name	
Date of Birth	
Regiment(s) Served	
Date of Enlistment (all dates for multiple service)	
Date of Discharge (all dates for multiple service)	
Length of Service (*researcher to calculate*)	
Date joined Royal Hospital Chelsea	

Researcher use:				
Date completed:				
Date Participant Information Pack sent/handed out:				
Date Consent Form Received:				
Participant included in Study?	**Yes**		**No***	
*If 'No' give reasons for exclusion				
*If 'No' – date call made to participant to advise them:				
*If 'No' – date letter sent to Participant to notify them & thank them for engaging in the study:				

APPENDIX Q

Northumbria University NEWCASTLE

HOME OF THE CHELSEA PENSIONERS

Participant Information Pack

Research Project: Care of the ageing veteran population: Developing an evidence base for the Royal Hospital Chelsea model of care

Thank you for expressing an interest in taking part in the above research project.

Within this information pack you will find the following:

- Participant Information Sheet
- Consent Form
- Pre-paid envelope (to return the Consent Form to the researcher)

Please take some time to read the enclosed documents before making your decision to participate in the project.

If you have any questions you are encouraged to speak to a member of the research team:

- Helen Cullen (Researcher) helen.cullen@northumbria.ac.uk 07766 982904
- Dr Gemma Wilson Gemma.wilson@northumbria.ac.uk 0191 215 6054

If you would like independent information about this project, please contact:

- Professor Tracy Finch (Departmental Research & Innovation Lead) tracy.finch@northumbria.ac.uk 0191 215 6477

This project has the support of Northumbria University and Royal Hospital Chelsea and has received ethical approval from Northumbria University and IRAS (for health and social care/community care research)

APPENDIX Q

Northumbria University NEWCASTLE

HOME OF THE CHELSEA PENSIONERS

Participant Information Pack

Research Project: Care of the ageing veteran population: Developing an evidence base for the Royal Hospital Chelsea model of care

Thank you for expressing an interest in taking part in the above research project.

Within this information pack you will find the following:

- Participant Information Sheet
- Project Information Leaflet
- Consent Form
- Pre-paid envelope (to return the Consent Form to the researcher)

Please take some time to read the enclosed documents before making your decision to participate in the project.

If you have any questions you are encouraged to speak to a member of the research team:

- Helen Cullen (Researcher) helen.cullen@northumbria.ac.uk 07766 982904
- Dr Gemma Wilson Gemma.wilson@northumbria.ac.uk 0191 215 6054

If you would like independent information about this project, please contact:

- Professor Tracy Finch (Departmental Research & Innovation Lead) tracy.finch@northumbria.ac.uk 0191 215 6477

This project has the support of Northumbria University and Royal Hospital Chelsea and has received ethical approval from Northumbria University and IRAS (for health and social care/community care research)

APPENDIX Q

Northumbria University NEWCASTLE

HOME OF THE CHELSEA PENSIONERS

Participant Information Pack

Research Project: Care of the ageing veteran population: Developing an evidence base for the Royal Hospital Chelsea model of care

As someone who has just joined Royal Hospital Chelsea, we would like you to consider taking part in the above research project.

Please note that this study is not part of your arrival process at Royal Hospital Chelsea, and you are free to choose whether or not to take part.

Within this information pack you will find the following:

- Participant Information Sheet
- Consent Form
- Quality of Life Questionnaire
- Pre-paid envelope (to return the Consent Form to the researcher)
- Pre-paid envelope (to return the completed Questionnaire to the researcher)

Please take some time to read the enclosed documents before making your decision to participate in the project. Please remember that taking part is up to you.

If you have any questions you are encouraged to speak to a member of the research team:

- Helen Cullen (Researcher) helen.cullen@northumbria.ac.uk 07766 982904
- Dr Gemma Wilson Gemma.wilson@northumbria.ac.uk 0191 215 6054

If you would like independent information about this project, please contact:

- Professor Tracy Finch (Departmental Research & Innovation Lead) tracy.finch@northumbria.ac.uk 0191 215 6477

This project has the support of Northumbria University and Royal Hospital Chelsea and has received ethical approval from Northumbria University and IRAS (for health and social care/community care research)

APPENDIX Q

Northumbria University NEWCASTLE

HOME OF THE CHELSEA PENSIONERS

Participant Information Pack

Research Project: Care of the ageing veteran population: Developing an evidence base for the Royal Hospital Chelsea model of care

Thank you for agreeing to take part in the above research project and for completing your first Quality of Life Questionnaire 6 months' ago. I hope you are settling into your new home well.

Within this second information pack, you will find the following:

- Quality of Life Questionnaire
- Pre-paid envelope (to return the completed Questionnaire to the researcher)

I would be grateful if you could please complete the questionnaire and return it to me in the envelope provided.

If you have any questions, please do not hesitate to contact me:

- Helen Cullen helen.cullen@northumbria.ac.uk 07766 982904

Thank you

This project has the support of Northumbria University and Royal Hospital Chelsea and has received ethical approval from Northumbria University and IRAS (for health and social care/community care research)

APPENDIX Q

Northumbria University NEWCASTLE

HOME OF THE CHELSEA PENSIONERS

Participant Information Sheet

Royal Hospital Chelsea Key Staff

Care of the ageing veteran population: Developing an evidence base for the Royal Hospital Chelsea model of care

You have been invited to be part of a study evaluating the Royal Hospital Chelsea model of care. Before agreeing to be involved in this project it is important that you understand why it is taking place and what taking part would mean for you. Please take the time to read this information leaflet. If you have any questions you are encouraged to speak to a member of the research team (contact details at the end of this document).

Study title:

Care of the ageing veteran population: Developing an evidence base for the Royal Hospital Chelsea model of care

Why is this study being carried out?

As a key member of staff you will be aware that Royal Hospital Chelsea is a unique establishment that has been supporting veterans of the British Army for over 300 years. However there is a lack of evidence into this support and the way Chelsea Pensioners are cared for.

The study aims to find out the influence Royal Hospital Chelsea has on the lives of its current generation of In-Pensioners, how the health and social care delivered, and how the environment in which they live, contributes to their overall health outcomes and quality of life.

The findings of the study will look to inform the strategic direction of Royal Hospital Chelsea as it continues to deliver care to current and future generations of veterans and may also contribute to decisions on national health and social care policy.

Part of the study involves interviewing a number of In-Pensioners and key staff at Royal Hospital Chelsea. This will help gain an understanding of the way in which the care is delivered and the experiences of those who receive the care. The study will also review Royal Hospital Chelsea's policy documentation to give an all-round view of the care it delivers.

Who is carrying out this study?

The study is being carried out by Helen Cullen who is a PhD student at Northumbria University.

Why have I been invited to participate?

You have been invited to participate in this study because, as a key member of staff, you are engaged in contributing to the strategic direction and/or the delivery of the Royal Hospital Chelsea model of care both of which impact on the In-Pensioner experience.

Your engagement in the study will help gather information on the interpretation of organisational policy alongside the perceptions of care delivery and the sustainability of the model of care.

Do I have to take part?

No. It is up to you whether you wish to take part in the study. This information leaflet will help you make that decision, and you are encouraged to discuss participation with others (including your family, friends, or other members of staff).

If you decide to participate but then change your mind, you can choose to withdraw from the study at any point, without telling us why. Choosing whether to participate or not will have no implications for you.

What will this mean for me if I choose to participate?

If you choose to participate, you will be asked to take part in a face-to-face interview which will last approximately 1 hour. All interviews will be recorded using a voice recorder.

If the situation regarding Covid-19 prevents a physical face-to-face meeting, the interview will take place via a video conference call which the researcher will arrange either directly with you or via a member of Royal Hospital Chelsea staff.

Interviews will take place in a private space within Royal Hospital Chelsea and will be confidential. If the interviews are via a video conference call the researcher will also be in a private space to ensure confidentiality is maintained.

The interview is an opportunity to hear about your experience of working at Royal Hospital Chelsea, your observations on how organisational policy is developed, interpreted and delivered to the In-Pensioners via the model of care. Your thoughts on the sustainability of the model of care, what you feel is being done well and areas that you feel could be improved will also be topics included in the interview.

As a member of staff in a key role we recognise that there is the potential risk of being identified, therefore extra care will be taken to ensure your feedback remains anonymous. Where specific references are made, staff will be referred to within their 'staff groups' for example 'a Commissioner' or 'a member of the Executive Board' or 'a member of the Heads of Care' or 'a member of Care Delivery'. Additional reference may be made to 'a member of senior management' or 'a member of service delivery' to prevent identification.

The Researcher will take all necessary steps to protect the identity of those taking part in the project however participants should be aware that there is a small risk of identification.

Will information collected in this study be kept confidential and anonymous?

All information collected in this study will be kept confidential and anonymous. Only the researcher will have access to information that can identify you. The recorded interview will be destroyed as soon as it has been written up, and all names and places will be changed to ensure that you cannot be identified. You will be allocated a unique Participant Number and only the researcher will know that this number refers to you.

Everything you say is confidential unless you tell us something that indicates you or someone else is at risk of harm. Should this happen, the researcher will discuss this with you and let you know the steps they need to take to inform those responsible for safeguarding matters.

What will happen to the results of the study?

Results of this study will inform the future direction of Royal Hospital Chelsea and may inform national policy. The findings will also be reported in a scientific journal or presented at a research conference. It is important to remember that all information within the findings will be anonymous and unidentifiable.

Consent given prior to death, is believed to extend beyond death (HRA, 2019). Therefore, if a participant dies after participating in an interview their information will remain as part of the study, unless a family member wishes this is be withdrawn. The family members will be given this opportunity, and if they wish to remove it, information will be removed from the study and destroyed.

Loss of mental capacity

If you experience a loss of mental capacity during your participation with the study, the information you have shared with the researcher up to the time of your incapacity will be kept and used in the study. You will be withdrawn from the study from the time of your incapacity and no further information will be requested from you.

How will my information be stored and how long will it be stored for?

All information relating to you will be kept confidential by the researcher and retained in password protected files within a Northumbria University secured

drive accessible via a password protected computer. Any paper records will be stored securely in a locked filing cabinet.

Your interview recording will be destroyed once it has been typed up. Your consent form will be stored securely in a locked filing cabinet. All transcribed interview information, and routinely collected information will be password protected and stored on a password protected computer.

All information will be stored in accordance with University guidelines, the Data Protection Act 2018, and General Data Protection Regulations 2018 (GDPR). All documentation will be destroyed 7 years after project completion.

What is the legal basis for processing personal information?

The legal basis for processing the personal information required for the purposes of this study is that the research is being conducted in the public interest.

What categories of personal information will be collected and processed in this study?

We will record your name, contact details, job role and date of appointment in the role. The only other information we will collect is the information you share during the interview. All information will be anonymised and made non-identifiable prior to analysis.

Who are the recipients or categories of recipients of personal information, if any?

Only the researcher at Northumbria University will see personal data.

What are my rights as a participant in this study?

We will be using information from you in order to undertake this study. Northumbria University is located within the United Kingdom, is the sponsor for this study and will act as the data (information) controller for this study. This means that we are responsible for looking after your information and

using it properly. Northumbria University will keep identifiable information about you for 7 years after the study has finished.

Your rights to see, change or move the information we have about you are limited, as we need to manage your information to ensure the research remains reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained, but will not obtain any new information. To protect your rights, we will use the minimum amount of personally identifiable information possible.

You can find out more about how we use your information by contacting the Data Protection Officer at dp.officer@northumbria.ac.uk. A copy of the Research Participant Privacy Notice is available on request.

Where can I get support if I need to speak to someone?

If you feel you need support during and after your participation and would like to talk to someone other than the Researcher then please contact Royal Hospital Chelsea's Director of Health & Wellbeing, Professor Deborah Sturdy.

Who has reviewed this study?

This study has been approved by:

- Northumbria University Ethics Online System *(Reference Number: 24587)*
- Integrated Research Application System (IRAS) (for health and social care/community care research) *(Reference Number: 288952)*

Contact details for further information:

- Helen Cullen helen.cullen@northumbria.ac.uk 07766 982904
- Dr Gemma Wilson Gemma.wilson@northumbria.ac.uk 0191 215 6054

If you would like independent information about this project, please contact:

- Professor Tracy Finch (Departmental Research & Innovation Lead) tracy.finch@northumbria.ac.uk 0191 215 6477

APPENDIX Q

Northumbria University NEWCASTLE

HOME OF THE CHELSEA PENSIONERS

Participant Information Sheet

Royal Hospital Chelsea In-Pensioner

Care of the ageing veteran population: Developing an evidence base for the Royal Hospital Chelsea model of care

You have been invited to be part of a study evaluating the Royal Hospital Chelsea model of care. Before agreeing to be involved in this project it is important that you understand why it is taking place and what taking part would mean for you. Please take the time to read this information leaflet. If you have any questions you are encouraged to speak to a member of the research team (contact details at the end of this document).

Study title:

Care of the ageing veteran population: Developing an evidence base for the Royal Hospital Chelsea model of care

Why is this study being carried out?

As a Chelsea Pensioner, you will be aware that Royal Hospital Chelsea is a unique establishment that has been supporting veterans of the British Army for over 300 years. However there is a lack of evidence to support the way Chelsea Pensioners are cared for and the impact it has on you.

The study aims to find out the influence Royal Hospital Chelsea has on the lives of its current generation of In-Pensioners, how your care is delivered, and how the environment in which you live, contributes to your overall health and quality of life.

The findings of the study will help Royal Hospital Chelsea make decisions on delivering care to current and future generations of veterans. It may also contribute to decisions on national government health and social care policy.

Part of the study involves interviewing a number of In-Pensioners and key staff at Royal Hospital Chelsea. This will help gain an understanding of the way in which the care is delivered and the experiences of those who receive the care. The study will also review Royal Hospital Chelsea's policy documentation to give an all-round view of the care it delivers.

Who is carrying out this study?

The study is being carried out by Helen Cullen who is a PhD student at Northumbria University.

Why have I been invited to participate?

You have been invited to participate in this study because you are an In-Pensioner at Royal Hospital Chelsea and sharing your experience of life as a Chelsea Pensioner will be an invaluable contribution to the study.

Do I have to take part?

No. It is up to you whether you wish to take part in the study. This information leaflet will help you make that decision, and you are encouraged to discuss participation with others (including your family, friends or Royal Hospital Chelsea staff).

If you decide to participate but then change your mind, you can choose to withdraw from the study at any point, without telling us why. Choosing whether to participate or not will have no implications for you.

What will this mean for me if I choose to participate?

If you choose to participate, you will be asked to take part in a face-to-face interview which may take up to 1.5 hours to complete. There will be the opportunity to pause the interview for rests or comfort breaks if needed. A second meeting can be arranged to finish the interview if it cannot be completed in one session. All interviews will be recorded using a voice recorder. You will also be asked to complete a Quality of Life questionnaire at the time of your interview.

If the situation regarding Covid-19 prevents a physical face-to-face meeting, the interview will take place via a video conference call which the researcher will arrange with Royal Hospital Chelsea staff. The Quality of Life questionnaire will be sent to you for completion along with a pre-stamped envelope for you to return it to the researcher. You will be given a unique participant number which will be on the questionnaire to ensure you cannot be identified, should the questionnaire get misplaced within the postal system.

Interviews will take place in a private space within Royal Hospital Chelsea and will be confidential. If the interviews are via a video conference call the researcher will also be in a private space to ensure confidentiality is maintained.

The interviews are to hear about your experience of living at Royal Hospital Chelsea and will explore areas such as why you chose to become a Chelsea Pensioner, what you think about the care you receive, the social aspect and impact the environment has on your life.

Will information collected in this study be kept confidential and anonymous?

All information collected in this study will be kept confidential and anonymous. Only the researcher will have access to data that can identify you. The recorded interview will be destroyed as soon as it has been written up, and all names and places will be changed to ensure that you cannot be identified.

The results of the Quality of Life Questionnaire will also be anonymised. You will be given a unique Participant Number and only the researcher will know that this number refers to you.

Everything you say is confidential unless you tell us something that indicates you or someone else is at risk of harm. Should this happen, the researcher will discuss this with you and let you know the steps they need to take to inform those responsible for dealing with these matters.

The Researcher will take all necessary steps to protect the identity of those taking part in the project, by giving everyone unique Participant Numbers, changing the names of places, people and events and anonymising all information, however participants should be aware that there may be a small risk of identification.

What will happen to the results of the study?

Results of this study will help Royal Hospital Chelsea make decisions for the future and may contribute to decisions on national government policy. The findings will also be reported in a scientific journal or presented at a research conference. It is important to remember that all information within the findings will be anonymous and unidentifiable.

Consent given prior to death, is believed to extend beyond death (HRA, 2019). Therefore, if a participant dies after participating in an interview their information will remain as part of the study, unless a family member wishes this is be withdrawn. The family members will be given this opportunity, and if they wish to remove it, information will be removed from the study and destroyed.

Loss of mental capacity

If you experience a loss of mental capacity during your participation with the study, the information you have shared with the researcher up to the time of your incapacity will be kept and used in the study. You will be withdrawn from the study from the time of your incapacity and no further information will be requested from you.

How will my information be stored and how long will it be stored for?

All information relating to you will be kept confidential by the researcher and retained in password protected files within a Northumbria University secured drive accessible via a password protected computer. Any paper records will be stored securely in a locked drawer.

Your interview recording will be destroyed once it has been typed up. Your consent form will be stored securely in a locked filing cabinet. All typed up interview information, and routinely collected information will be password protected and stored on a password protected computer. All information will be stored in accordance with University guidelines, the Data Protection Act 2018 and General Data Protection Regulations 2018 (GDPR). All documentation will be destroyed 7 years after project completion.

What is the legal basis for processing personal information?

The legal basis for processing the personal information required for the purposes of this study is that the research is being conducted in the public interest.

What categories of personal information will be collected and processed in this study?

We will record personal details including your name, age, place of birth, date of joining Royal Hospital Chelsea, service details including which Regiment/Branch of the British Army you served in, duration of service, reason for leaving and service rank at time of discharge. We will collect the results from the Quality of Life questionnaire. The only other information we will collect is the information you share during the interview. All information will be anonymised and made non-identifiable before any analysis takes place.

Who are the recipients or categories of recipients of personal information, if any?

Only the researcher at Northumbria University will see personal information.

What are my rights as a participant in this study?

We will be using information from you in order to undertake this study. Northumbria University is located within the United Kingdom, is the sponsor for this study and will act as the data (information) controller for this study. This means that we are responsible for looking after your information and using it properly. Northumbria University will keep identifiable information about you for 7 years after the study has finished. This information will be destroyed after this period of time.

Your rights to see, change or move the information we have about you are limited, as we need to manage your information to make sure the research remains reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained, but we will not obtain any new information. To protect your rights, we will use the minimum amount of personally identifiable information possible.

You can find out more about how we use your information by contacting the Data Protection Officer at dp.officer@northumbria.ac.uk. A copy of the Research Participant Privacy Notice is available on request.

Where can I get support if I need to speak to someone?

If you feel you need support during and after your participation and would like to talk to someone other than the Researcher then please contact Royal Hospital Chelsea's Director of Health & Wellbeing, Professor Deborah Sturdy.

Alternatively, you may wish to talk to a military charity such as SSAFA (0800 731 4880), the Royal British Legion (0808 802 8080), or your Regimental Association.

Who has reviewed this study?

This study has been approved by:

- Northumbria University Ethics Online System *(Reference Number: 24587)*

- Integrated Research Application System (IRAS) (for health and social care/community care research) *(Reference Number: 288952)*

Contact details for further information:

- Helen Cullen helen.cullen@northumbria.ac.uk 07766 982904
- Dr Gemma Wilson Gemma.wilson@northumbria.ac.uk 0191 215 6054

If you would like independent information about this project, please contact:

- Professor Tracy Finch (Departmental Research & Innovation Lead) tracy.finch@northumbria.ac.uk 0191 215 6477

APPENDIX Q

Northumbria University NEWCASTLE

HOME OF THE CHELSEA PENSIONERS

Participant Information Sheet

Royal Hospital Chelsea - New In-Pensioner

Care of the ageing veteran population: Developing an evidence base for the Royal Hospital Chelsea model of care

You have been invited to be part of a study evaluating the Royal Hospital Chelsea model of care. Before agreeing to be involved in this project it is important that you understand why it is taking place and what taking part would mean for you. Please take the time to read this information leaflet. If you have any questions you are encouraged to speak to a member of the research team (contact details at the end of this document).

Please note that this study is not part of your arrival process at Royal Hospital Chelsea, and you are free to choose whether or not to take part.

Study title:

Care of the ageing veteran population: Developing an evidence base for the Royal Hospital Chelsea model of care

Why is this study being carried out?

As someone who has just become a Chelsea Pensioner, you will be aware that Royal Hospital Chelsea is a unique establishment that has been supporting veterans of the British Army for over 300 years. However there is a lack of evidence to support the way Chelsea Pensioners are cared for.

The study aims to find out the influence Royal Hospital Chelsea has on the lives of its current generation of In-Pensioners, how your care is delivered, and how the environment in which you live, contributes to your overall health and quality of life.

The findings of the study will help Royal Hospital Chelsea make decisions on delivering care to current and future generations of veterans. It may also contribute to decisions on government national health and social care policy.

The study is asking new In-Pensioners to complete 2 anonymous questionnaires that asks questions about their Quality of Life.

The study will also be interviewing a number of staff and In-Pensioners to help gain an understanding of the way in which the care is delivered and the experiences of those who receive the care. The study will also review Royal Hospital Chelsea's policy documentation to give an all-round view of the care it delivers.

Who is carrying out this study?

The study is being carried out by Helen Cullen who is a PhD student at Northumbria University.

Why have I been invited to participate?

You have been invited to participate in this study because you are a new In-Pensioner which gives us a unique opportunity to obtain information on how you feel about your Quality of Life on arrival at your new home, and again 6 months later when you have had chance to settle into your new surroundings. This will help the study collect Quality of Life information, something that cannot be done with those who have lived at Royal Hospital Chelsea for a long time.

Do I have to take part?

No. It is up to you whether you wish to take part in the study. This information leaflet will help you make that decision, and you are encouraged to discuss

participation with others (including your family, friends, or Royal Hospital Chelsea staff).

If you decide to participate but then change your mind, you can choose to withdraw from the study at any point, without telling us why. Choosing whether to participate or not will have no implications for you.

What will this mean for me if I choose to participate?

If you choose to take part we will ask you to complete 2 Quality of Life Questionnaires – one shortly after your arrival at Royal Hospital Chelsea, and the second, 6 months later, when you have become settled into your new environment. You will be given a pre-paid envelope to return the questionnaire to the researcher when you have completed it.

You will be allocated a Participant Number which will be used on the questionnaires, rather than your name, which means your responses are confidential and you cannot be identified by anyone other than the researcher.

The Admissions Officer at Royal Hospital Chelsea will give you the first questionnaire at some point during your first week of arrival. They will also give you the second questionnaire 6 months later.

The Information Pack contains a Consent Form for you to complete and return to the researcher using a separate pre-paid envelope which will be provided.

Will information collected in this study be kept confidential and anonymous?

All information collected in this study will be kept confidential and anonymous. The Royal Hospital Chelsea Admissions Officer will have access to blank Consent Forms and will allocate your Participant Number however they will not see your completed Consent Form or questionnaires – as these will be returned directly to the researcher so will not be seen by anyone else.

The information collected from your questionnaires will be anonymised so you cannot be identified.

What will happen to the results of the study?

Results of this study will help Royal Hospital Chelsea make decisions for the future and may contribute to decisions on government national policy. The findings will also be reported in a scientific journal or presented at a research conference. It is important to remember that all information within the findings will be anonymous and unidentifiable.

Consent given prior to death, is believed to extend beyond death (HRA, 2019). Therefore, if a participant dies after participating in an interview their information will remain as part of the study, unless a family member wishes this is be withdrawn. The family members will be given this opportunity, and if they wish to remove it, information will be removed from the study and destroyed.

Loss of mental capacity

If you experience a loss of mental capacity during your participation with the study, the information you have shared with the researcher up to the time of your incapacity will be kept and used in the study. You will be withdrawn from the study from the time of your incapacity and no further information will be requested from you.

How will my information be stored and how long will it be stored for?

All information relating to you will be kept confidential by the researcher and retained in password protected files within a Northumbria University secure drive accessible via a password protected computer. Any paper records will be stored securely in a locked drawer.

Your consent form will be stored securely in a locked filing cabinet. All routinely collected information will be password protected and stored on a password protected computer. All information will be stored in accordance with University guidelines, the Data Protection Act 2018, and General Data Protection Regulations 2018 (GDPR). All documentation will be destroyed 7 years after project completion.

What is the legal basis for processing personal information?

The legal basis for processing the personal information required for the purposes of this study is that the research is being conducted in the public interest.

What categories of personal information will be collected and processed in this study?

We will record your name, age, and date of joining Royal Hospital Chelsea. We will collect the results from the Quality of Life questionnaire. All information received will be anonymised and made non-identifiable.

Who are the recipients or categories of recipients of personal information, if any?

Only the researcher at Northumbria University will see personal information.

What are my rights as a participant in this study?

We will be using information from you in order to undertake this study. Northumbria University is located within the United Kingdom, is the sponsor for this study and will act as the data (information) controller for this study. This means that we are responsible for looking after your information and using it properly. Northumbria University will keep identifiable information about you for 7 years after the study has finished, and it will be destroyed after this period of time.

Your rights to see, change or move the information we have about you are limited, as we need to manage your information to make sure the research remains reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained, but will not obtain any new information. To protect your rights, we will use the minimum amount of personally identifiable information possible.

You can find out more about how we use your information by contacting the Data Protection Officer at dp.officer@northumbria.ac.uk. A copy of the Research Participant Privacy Notice is available on request.

Where can I get support if I need to speak to someone?

If you feel you need support during and after your participation and would like to talk to someone other than the Researcher then please contact Royal Hospital Chelsea's Director of Health & Wellbeing, Professor Deborah Sturdy.

Alternatively, you may wish to talk to a military charity such as SSAFA (0800 731 4880), the Royal British Legion (0808 802 8080), or your Regimental Association.

Who has reviewed this study?

This study has been approved by:

- Northumbria University Ethics Online System *(Reference Number: 24587)*
- Integrated Research Application System (IRAS) (for health and social care/community care research) *(Reference Number: 288952)*

Contact details for further information:

- Helen Cullen helen.cullen@northumbria.ac.uk 07766 982904
- Dr Gemma Wilson Gemma.wilson@northumbria.ac.uk 0191 215 6054

If you would like independent information about this project, please contact:

- Professor Tracy Finch (Departmental Research & Innovation Lead) tracy.finch@northumbria.ac.uk 0191 215 6477

APPENDIX Q

Northumbria University NEWCASTLE

HOME OF THE CHELSEA PENSIONERS

Consent form

Project Title: Care of the ageing veteran population: Developing an evidence base for the Royal Hospital Chelsea model of care

Chief Investigator: Dr Gemma Wilson
PhD Student Researcher: Helen Cullen

Royal Hospital Chelsea Key Staff	**Yes (please tick)**
I have read and understand the Information Sheet and have had the opportunity to ask questions which have been answered to my satisfaction.	
I understand that I do not have to take part. If I do take part and change my mind, I may withdraw at any time, without giving reason.	
I agree to take part in an interview and I understand this interview will be recorded and subsequently destroyed after it has been typed up/transcribed.	
I understand that everything I say/report is confidential unless I tell you something that indicates I/or someone else is at risk of harm. This will be discussed this with me before telling anyone else.	
I agree to take part in this study	

Name of Participant:	**Date:**	**Signature:**
Name of Researcher:	**Date:**	**Signature:**
Helen Cullen		

Please ensure you read and sign the 'Statement of Confirmation' (overleaf).

This project has the support of Northumbria University and Royal Hospital Chelsea and has received ethical approval from Northumbria University, IRAS (for health and social care/community care research)

Statement of confirmation:

Your information will be held and processed for the following purpose(s):

Care of the ageing veteran population: Developing an evidence base for the Royal Hospital Chelsea model of care

I agree to the University of Northumbria at Newcastle recording and processing this information about me. I understand that this information will be used only for the purpose(s) set out in the information sheet supplied to me, and my consent is conditional upon the University complying with its duties and obligations under the Data Protection Act 2018 which incorporates General Data Protection Regulations (GDPR). You can find out more about how we use your information here: https://www.northumbria.ac.uk/about-us/leadership-governance/vice-chancellors-office/legal-services-team/gdpr/gdpr---privacy-notices/

Participant Name:

_____

Signature: _____Date: _____

Should you wish to make a complaint about the conduct of this research, you should contact Professor Tracy Finch, Health & Life Sciences Departmental Research & Innovation Lead, tracy.finch@northumbria.ac.uk Tel: 0191 215 6477

One copy of this consent form must be given to the participant, and one copy is to remain on file at Northumbria University.

APPENDIX Q

Northumbria University NEWCASTLE

HOME OF THE CHELSEA PENSIONERS

Consent form

Project Title: Care of the ageing veteran population: Developing an evidence base for the Royal Hospital Chelsea model of care

Chief Investigator: Dr Gemma Wilson
PhD Student Researcher: Helen Cullen

Royal Hospital Chelsea In-Pensioner	**Yes (please tick)**
I have read and understand the Information Sheet and have had the opportunity to ask questions which have been answered to my satisfaction.	
I understand that I do not have to take part. If I do take part and change my mind, I may withdraw at any time, without giving reason.	
I agree to take part in an interview and I understand this interview will be recorded and subsequently destroyed after it has been typed up/transcribed	
I understand that everything I say/report is confidential unless I tell you something that indicates I/or someone else is at risk of harm. This will be discussed this with me before telling anyone else.	
I agree to take part in this study	

Name of Participant:	**Date:**	**Signature:**
Name of Researcher:	**Date:**	**Signature:**
Helen Cullen		

Please ensure you read and sign the 'Statement of Confirmation' (overleaf).

This project has the support of Northumbria University and Royal Hospital Chelsea and has received ethical approval from Northumbria University, IRAS (for health and social care/community care research)

Statement of confirmation:

Your information will be held and processed for the following purpose(s):

Care of the ageing veteran population: Developing an evidence base for the Royal Hospital Chelsea model of care

I agree to the University of Northumbria at Newcastle recording and processing this information about me. I understand that this information will be used only for the purpose(s) set out in the information sheet supplied to me, and my consent is conditional upon the University complying with its duties and obligations under the Data Protection Act 2018 which incorporates General Data Protection Regulations (GDPR). You can find out more about how we use your information here: https://www.northumbria.ac.uk/about-us/leadership-governance/vice-chancellors-office/legal-services-team/gdpr/gdpr---privacy-notices/

Participant Name:

_____

Signature: _____Date: _____

Should you wish to make a complaint about the conduct of this research, you should contact Professor Tracy Finch, Health & Life Sciences Departmental Research & Innovation Lead, tracy.finch@northumbria.ac.uk Tel: 0191 215 6477

One copy of this consent form must be given to the participant, and one copy is to remain on file at Northumbria University.

APPENDIX Q

Northumbria University NEWCASTLE

HOME OF THE CHELSEA PENSIONERS

Consent form

Project Title: Care of the ageing veteran population: Developing an evidence base for the Royal Hospital Chelsea model of care

Chief Investigator: Dr Gemma Wilson
PhD Student Researcher: Helen Cullen

Royal Hospital Chelsea New In-Pensioner	**Yes (please tick)**
I have read and understand the Information Sheet and have had the opportunity to ask questions which have been answered to my satisfaction.	
I understand that I do not have to take part. If I do take part and change my mind, I may withdraw at any time, without giving reason.	
I agree to complete 2 Quality of Life Questionnaires and understand that my answers will be made anonymous so I cannot be identified.	
I agree to take part in this study	

Name of Participant:	**Date:**	**Signature:**
Name of Researcher:	**Date:**	**Signature:**
Helen Cullen		

Please ensure you read and sign the 'Statement of Confirmation' (overleaf).

This project has the support of Northumbria University and Royal Hospital Chelsea and has received ethical approval from Northumbria University, IRAS (for health and social care/ community care research)

Statement of confirmation:

Your information will be held and processed for the following purpose(s):

Care of the ageing veteran population: Developing an evidence base for the Royal Hospital Chelsea model of care

I agree to the University of Northumbria at Newcastle recording and processing this information about me. I understand that this information will be used only for the purpose(s) set out in the information sheet supplied to me, and my consent is conditional upon the University complying with its duties and obligations under the Data Protection Act 2018 which incorporates General Data Protection Regulations (GDPR). You can find out more about how we use your information here: https://www.northumbria.ac.uk/about-us/leadership-governance/vice-chancellors-office/legal-services-team/gdpr/gdpr---privacy-notices/

Participant Name:

_____

Signature: _____Date: _____

Should you wish to make a complaint about the conduct of this research, you should contact Professor Tracy Finch, Health & Life Sciences Departmental Research & Innovation Lead, tracy.finch@northumbria.ac.uk Tel: 0191 215 6477

One copy of this consent form must be given to the participant, and one copy is to remain on file at Northumbria University.

APPENDIX R

Northumbria University NEWCASTLE

Risk Assessment Form

Date: 27/07/2021	**Assessor:**	Department of Nursing, Midwifery and Health ethical reviewers
Area/Activity: Data collection	**Assessment Title:** PhD research study	

Item No.	Activity, Equipment, Materials, etc.	Hazard7	Persons at risk	Severity	Likelihood	Risk Rating H 20-36 M 12-18 L 1-10	Control Measures Required	**Final Result***
1	***Please use this format as an example.***	***Unknown medical conditions leading to illness/collapse***	***Participants who are not medically fit***	*5*	*1*	***5 (L)***	• ***Medical details will be taken when the participant joins the club and details of any conditions shared with coaches*** • ***Any member with a serious medical condition must not train unsupervised***	***5x1=*** *5 (L)*

	All activity							
1	**Participant face-to-face Interview**	**Potential risk to Covid-19**	**In-Pensioner Participants & Researcher**	**5**	**3**	**15 (M)**	• **Ensure that each participant has had both Covid-19 vaccinations** • **Researcher has had both Covid-19 vaccinations** • **Researcher will undertake a Lateral Flow Test each day before interviews commence** • **Researcher will be temperature checked by RHC security each day** • **Face mask(s) to be worn if requested to do so by participant and/or RHC** • **Frequent hand-washing will take place** • **Hand sanitizer will be available and used frequently** • **A Royal Hospital Chelsea (RHC) Risk Assessment will be carried out to ensure their requirements are met and that they approve on-site face-to-face research**	
2	**Participant face-to-face Interview**	**Interview room – inadequate space, cleanliness and ventilation**	**In-Pensioner Participants & Researcher**	**3**	**2**	**6 (L)**	• **Ensure the room at RHC is large enough to accommodate the participant and researcher with sufficient space to enable adequate social distancing** • **Ensure there is adequate ventilation by booking a room with windows that open to allow fresh air to circulate** • **Ensure there is adequate distance (1m+) between the participant and researcher during the interview**	

							• **Table, chair and touch points will be cleaned after each participant interview** • **Hand-sanitiser will be available** • **Face-masks will be worn if requested to do so by participant and/or RHC**	
3	**Participant face-to-face Interview**	**Extremely clinically vulnerable participants – increased risk of Covid-19**	**In-Pensioner Participants**	**1**	**3**	**3 (L)**	• **Researcher to confirm with participant that they do/do not fall into the extremely clinically vulnerable category prior to scheduling the interview** • **Any extremely clinically vulnerable participants will be interviewed using digital online platform (Zoom)** • **Support will be given by RHC to secure a meeting room with digital facilities and help set the equipment up**	
4	**Participant face-to-face Interview**	**Potential risk to Covid-19 due to either no or only n=1 Covid-19 vaccination**	**In-Pensioner Participants**	**1**	**3**	**3 (L)**	• **Researcher to confirm that the participant has either not had any Covid-19 vaccination or is not fully vaccinated prior to scheduling the interview** • **Participants will be interviewed using a digital online platform (Zoom)** • **Support will be given by RHC to secure a meeting room with digital facilities and help set the equipment up**	

5	**Participant face-to-face Interview**	**Researcher is asked to self-isolate prior to or during interview(s)**	**Researcher**	**3**	**3**	**9 (L)**	• **Researcher will self-isolate as instructed via the NHS Covid-19 app or following a positive lateral flow test** • **Interviews will be rescheduled**	
6	**Participant face-to-face Interview**	**Participant is asked to self-isolate prior to interview**	**In-Pensioner Participant**	**3**	**3**	**9 (L)**	• **Regular Covid-19 testing takes place for all In-Pensioners** • **Participant to notify researcher if tested positive (NB. Participation is confidential. RHC staff are unaware of who is taking part in the project therefore it is the responsibility of the participant to notify the researcher)** • **Interview will be rescheduled**	

Does this Risk Assessment Require Further Specific Risk Assessment:					
Manual Handling: N Please list reference No:	COSHH: N? Please list reference No:	PUWER: N? Please list reference No:	DSEAR: N Please list reference No:	Young Persons: N Please list reference No:	New & Expectant Mothers: N Please list reference No:

To be completed by the person undertaking the risk assessment

Name: **Helen Cullen** **Job Title: PhD Student**

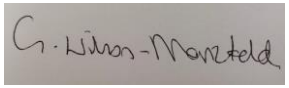
Signature: 

Date: 27 July 2021

To be completed by the Line Manager

I consider this risk assessment to be suitable and sufficient to control the risks to the health & safety of both employees undertaking the tasks and any other person who may be affected by the activities.

Name: Dr Gemma Wilson-Menzfeld **Job Title: Senior Lecturer**

Signature:  **Date: 27th July 2021**

NB – If Line Managers do not agree that the risk assessment is suitable and sufficient then the assessment must be reviewed and amended accordingly.

To ensure we are consistent in managing safety risks across the UNN please answer the following question and take any appropriate action: -

1. **Can this risk assessment be shared and labelled as Generic to the University i.e. is the activity carried out within another faculty or department?** Y/ N
2. **Is there a related risk assessment that may require review and update following completion of this risk assessment?** Y/N

Calculating the risk rating

Risk = Likelihood x Severity

Likelyhood			x	Severity		
Remote	=	1		Near miss	=	1
Unlikely	=	2		Minor injury	=	2
Possible	=	3		Lost time	=	3
Likely	=	4		Major injury	=	4
Very Likely	=	5		Fatality	=	5
Certain	=	6		Multiple fatality	=	6

Severity 1 to 6

Likelihood 1 to 6

	Near miss	Minor injury	Lost time	Major injury	Fatality	Multiple fatality
Remote	1	2	3	4	5	6
Unlikely	2	4	6	8	10	12
Possible	3	6	9	12	15	18
Likely	4	8	12	16	20	24
V Likely	5	10	15	20	25	30
Certain	6	12	18	24	30	36

Acceptable region: no need to do more

Tolerable region: Reduce risk as low as reasonably practicable

Unacceptable region: MUST reduce risk to at least tolerable

Royal Hospital Chelsea Risk Assessment Form

Covid 31 – RESEARCHER F2F INTERVIEWS

Risk Assessment Form

Location/Dept: Health & Wellbeing (Maggie Kufeldt)	**Date Assessed: 09 Aug 21**	**Assessed by: Mark Evans**
Task/ Activity: Clerical & Administration Northumbria University/RHC Research Project: In-Pensioner Face to Face Interviews by Researcher (Helen Cullen)	**Review Date: 22 Aug 21**	**Reference Number: COVID - 32**

Hazard	Person at Risk	Risk	Controls in place	Severity (1-5)	Likelihood (1-5)	Risk/ Priority	Additional controls required / Notes
Entering Site	In-Pensioner(s) and Researcher	Disease transfer and Infection	• Any PPE worn to travel to the RHC is to be discarded at the gate, if personal masks have been worn, they are not to be worn on site, a fresh mask will be issued and worn on site if required.	3	2	6	
Entering Buildings	In-Pensioner(s) and Researcher	Disease transfer and Infection	• Access to LW23 / 24 Basement is to be via North Front steps and fire exit. • Wren House - front door.	3	1	3	
Participant face-to-face Interviews **Vaccinated Pensioners**	In-Pensioner(s) and Researcher	Disease transfer and Infection	• Ensure that each participant and researcher has had both Covid-19 vaccinations • Researcher will undertake a Lateral Flow Test each day before interviews commence • Face mask(s) to be worn if requested to do so by participant and/or RHC • Hand sanitizer is available and is to be used when entering any buildings. Hand washing facilities are available across the site. • Interview rooms are well ventilated. • Rooms are large enough to facilitate 1m+ distancing.	3	2	6	• **DHW to ensure adequate sanitation wipes and hand sanitiser are provided.**

			• Table, chair, and touch points will be cleaned after each participant interview • Any extremely clinically vulnerable participants will be interviewed using digital online platform (Zoom) •				
Participant face-to-face Interviews **Not vaccinated Pensioners**	In-Pensioner Participants	Disease transfer and Infection	• Physical Face to Face interview not to take place, interview to take place via digital platform - ZOOM.	2	1	2	
Positive LFT / PCR result	Researcher	Disease transfer and Infection	• Researcher will not be allowed on site and should isolate in line with Government direction. • IPs will be placed in Disease isolation and RHC track and trace protocol will be followed. • Interview area will be deep cleaned. • Interviews will be rescheduled	3	3	9	
Participant face-to-face Interviews **Infection Control**	In-Pensioner Participant	Participant is asked to self-isolate prior to interview	• Regular Covid-19 testing takes place for all In-Pensioners. • In-Pensioner Participant to notify researcher if tested positive (NB. Participation is confidential. RHC staff are unaware of who is taking part in the project therefore it is the responsibility of the participant to notify the researcher)	3	3	9	• **Participation is confidential. RHC staff are unaware of who is taking part in the project therefore it is the responsibility of the participant to notify the researcher)**

Review Record

SER	DATE	REASON	REVIEWED BY	REMARKS
1	09 Aug 21	Initial Assessment	Mark Evans	
2				

Risk/Priority Indicator Key

Severity (Consequence)
1. Negligible – (No Injury/ no damage)
2. Slight (minor injury- 1ST Aid Required / damage / interruption)
3. Moderate (lost time, major injury, illness, damage, lost business)
4. High (major injury / damage, lost time business interruption, disablement)
5. Very High (fatality / business closure)

Likelihood
1. Improbable / very unlikely
2. Unlikely
3. Even chance / may happen
4. Likely
5. Almost certain / imminent

RISK / PRIORITY INICATOR MATRIX

LIKELIHOOD						
	5	5	10	15	20	25
	4	4	8	12	16	20
	3	3	6	9	12	15
	2	2	4	6	8	10
	1	1	2	3	4	5
		1	2	3	4	5
		SEVERITY (CONSEQUENCE)				

Summary		Suggested Timeframe
12-25	High	As soon as possible
7 -11	Medium	Within next 3-6 months
1-6	Low	Whenever viable to do so

APPENDIX S

Northumbria University NEWCASTLE

HOME OF THE CHELSEA PENSIONERS

Interview schedule – Key Staff

Care of the ageing veteran population: Developing an evidence base for the Royal Hospital Chelsea model of care

Semi-structured interviews will take place. The questions will be formulated following the findings from the relevant phases (Phases 1 & 2 will form the questions for Key Staff; Phases 1-3 will form the questions for In-Pensioners). Therefore, for the purpose of ethical review, discussion points are provided but these will be further developed and refined following data collection in
Phases 1-3.

Introduction

- Verbal confirmation of the consent process and reassurance that the interview will be recorded and confidential
- Verbal reminder that the interview is confidential unless the participant shares something that indicates that the participant or someone else is at risk of harm, and the steps that will be taken to report this
- General introductions and outline the purpose of the interview

Topics for discussion with Key Staff - Board of Commissioners & Executive Board:

- Brief discussion on their role at Royal Hospital Chelsea
- What do they consider is the 'Unique Selling Point' of Royal Hospital Chelsea?
- What influences the strategic direction of Royal Hospital Chelsea? (i.e. priorities)
- Policy development – are staff engaged in the development of organisational policies and procedures?
- What challenges do the Board of Commissioners & Executive Board face when implementing organisational policies and procedures?
- What areas work well, and which areas work less well?
- What are the challenges for the sustainability of the model of care?
- In their opinion, what does the future look like for Royal Hospital Chelsea?

Topics for discussion with Key Staff – Heads of Care & Care Delivery:

- Brief discussion on their role at Royal Hospital Chelsea
- Contribution to Health Outcomes (including longevity and Quality of Life)
- Policy interpretation – delivery of frontline services (clear vision?)
- Impact of organisational policies & procedures on service delivery
- Challenges in service delivery
- What works well?
- What areas would they look to improve/grow/reduce?

- What do they consider is the 'Unique Selling Point' of Royal Hospital Chelsea?
- In their opinion, what does the future look like for Royal Hospital Chelsea?

Closing Comments

- Is there anything else you wish to discuss?
- Advise on the next steps of their involvement in the project
- Give an opportunity for the participant to ask any questions
- Hand participant the 'end of interview' information leaflet
- Thank the participant for their time

APPENDIX S

Northumbria University NEWCASTLE

HOME OF THE CHELSEA PENSIONERS

Interview schedule – In-Pensioner

Care of the ageing veteran population: Developing an evidence base for the Royal Hospital Chelsea model of care

Semi-structured interviews will take place. The questions will be formulated following the findings from the relevant phases (Phases 1 & 2 will form the questions for Key Staff; Phases 1-3 will form the questions for In-Pensioners). Therefore, for the purpose of ethical review, discussion points are provided but these will be further developed and refined following data collection in
Phases 1-3.

Introduction

- Verbal confirmation of the consent process and reassurance that the interview will be recorded and confidential
- Verbal reminder that the interview is confidential unless the participant shares something that indicates that the participant or someone else is at risk of harm, and the steps that will be taken to report this
- General introductions and outline the purpose of the interview
- Completion of the Quality of Life Questionnaire before the recorded interview starts

Topics for discussion:

- Brief discussion on their Army career
- Key driver for their decision to become an In-Pensioner at Royal Hospital Chelsea
    - i.e. social isolation; health security as they age; sense of belonging; absence of camaraderie since leaving the Army; appeal of the 'institution' or regimental ethos
- What life is like for them, living at Royal Hospital Chelsea
- Access/use of social care provision and the impact this has on their day-to-day living and quality of life/life satisfaction
- Accessibility to medical support (i.e. Infirmary and on-site Medical Practice & it's facilities) and the impact this has on their day-to-day living and quality of life

- Their opinion on the environment in which they live
    - i.e. the historical buildings, the public engagements they may attend
- Their opinion on what areas of Royal Hospital Chelsea work well and what areas could be improved

Closing Comments

- Is there anything else you wish to discuss?
- Advise on the next steps of their involvement in the project
- Give an opportunity for the participant to ask any questions
- Hand participant the 'end of interview' information leaflet
- Thank the participant for their time

APPENDIX T

Northumbria University NEWCASTLE

HOME OF THE CHELSEA PENSIONERS

Research Project: Care of the ageing veteran population: Developing an evidence base for the Royal Hospital Chelsea model of care

Thank you for agreeing to take part in an informal interview to share your thoughts about life at the Royal Hospital Chelsea. You'll find information below about the topics the interviewer/researcher will ask you about.

If you have any questions, then please do not hesitate to contact the Researcher, Helen Cullen, on 07766 982904

Topic to be discussed:	A chance for you to:
Introduction	Tell me a little about your decision to move to the Royal Hospital
Covid-19 Impact	Share your thoughts about living at the Royal Hospital during the Covid-19 pandemic
Staff engagement	Share your thoughts on the support you receive from the staff at the Royal Hospital
Challenges/Barriers	Share your thoughts on any challenges you feel you face living at Royal Hospital
Health Care Needs	Share your thoughts on the health care support you receive
Social Care Needs	Share your thoughts on the social care support you receive, for example, your wellbeing, day to day living and social interaction with other In-Pensioners and staff.
Quality of Life	Share your thoughts on the quality of life you have at the Royal Hospital
Families	Share your thoughts on how the Royal Hospital includes families in supporting you as you live at the Royal Hospital
The future of RHC	Share your thoughts on what you think the future of the Royal Hospital will/should look like
Outreach Programme	Share your thoughts on the outreach programme that is being developed at the Royal Hospital
Environment	Share your thoughts on what it is like living in such historic buildings and grounds

Please remember that this is an informal interview and is taking place to give you the chance to talk about your life at the Royal Hospital Chelsea.

There are no right or wrong answers but your opinion and thoughts count!

APPENDIX U

Helen Cullen
PhD Student
c/o Ms Nicola Seccombe
Quality Assurance & Clinical Compliance
Royal Hospital Chelsea
Royal Hospital Road
London SW3 4SR

Date: 27 June 2022

Research Project: Care of the ageing veteran population: Developing an evidence base for the Royal Hospital Chelsea model of care

Dear xxx

I would like to take this opportunity to offer my sincere condolences following the passing of your *father/mother/brother etc.,*

As a Chelsea Pensioner, xxxxx kindly agreed to take part in the above research project, which is a collaboration between the Royal Hospital and Northumbria University.

The project is looking to gain an understanding of life at the Royal Hospital and the impact this has on Chelsea Pensioners including their health outcomes and quality of life. It will also look to contribute towards the future direction of the Royal Hospital to ensure it continues to support future generations of ageing veterans

Taking part in the project involved a face-to-face interview and the completion of a 'quality of life' questionnaire. All information collected is treated anonymously which means xxxx will not be identified by name in any documents or reports produced as part of the project.

As part of the ethical requirements of the project and as a member of xxxx's family, you do have the opportunity to request that the information collected be removed from the project. I have included a copy of the Participant Information Sheet which gives full details of the project. I can confirm that xxxx received and read this information before signing the consent form and agreeing to take part.

If you decide to withdraw xxxx's information from the project I would be grateful if you could let me know by contacting me either by telephone (07766 982904) or email: helen.cullen@northumbria.ac.uk

If I do not receive a reply from you by 30 July 2022, I will assume that you agree to xxxx's information remaining within the project.

Xxxx's contribution has been invaluable, and I am very grateful to them for agreeing to take part in this important work. I will ensure that you receive a copy of the Executive Summary when the project is completed at the end of February 2023.

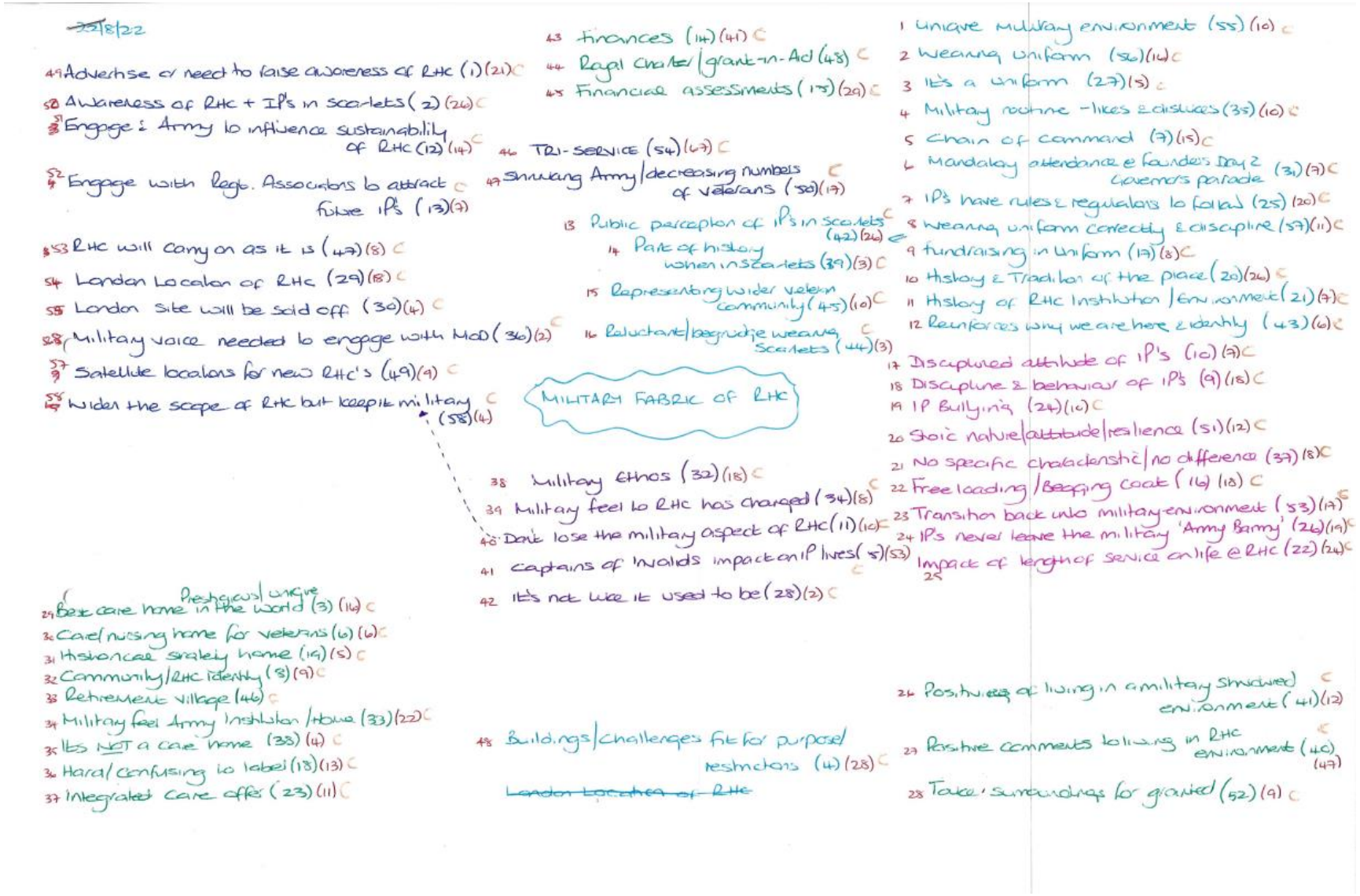
Please do not hesitate to contact me if you have any questions regarding the project or about xxxx's involvement.

Yours most sincerely

Helen Cullen

Researcher

APPENDIX V **Thematic Analysis Mind Map**



APPENDIX W

ICECAP-A ANOVA tests for statistical significance

ANOVA Testing

The following tables indicate no significant difference between all three datasets when compared against each other.

Question 5 violated the assumption of homogeneity of variance. Further statistical analysis using a one-way ANOVA, applying the Welch test was carried out for this question. A one-way ANOVA test was carried out on all other ICECAP-A questions which did not violate the assumption of homogeneity of variances.

All Questions – Levene's Test

Tests of Homogeneity of Variances

		Levene Statistic	df1	df2	Sig.
Q1	Based on Mean	3.010	2	55	.057
	Based on Median	1.513	2	55	.229
	Based on Median and with adjusted df	1.513	2	48.963	.230
	Based on trimmed mean	3.009	2	55	.058
Q2	Based on Mean	.045	2	55	.956
	Based on Median	.104	2	55	.901
	Based on Median and with adjusted df	.104	2	52.952	.901
	Based on trimmed mean	.130	2	55	.879
Q3	Based on Mean	1.083	2	55	.346
	Based on Median	.255	2	55	.776
	Based on Median and with adjusted df	.255	2	53.180	.776
	Based on trimmed mean	.741	2	55	.481
Q4	Based on Mean	1.965	2	55	.150
	Based on Median	.921	2	55	.404
	Based on Median and with adjusted df	.921	2	52.191	.404
	Based on trimmed mean	1.810	2	55	.173
Q5	Based on Mean	3.564	2	55	.035
	Based on Median	.163	2	55	.850
	Based on Median and with adjusted df	.163	2	44.915	.850
	Based on trimmed mean	2.250	2	55	.115

Question 5: One Way ANOVA applying the WELCH test

Descriptives

Q5

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
In-Pensioner	25	3.52	.510	.102	3.31	3.73	3	4
New In-Pensioner Part1	17	3.53	.800	.194	3.12	3.94	2	4
New In-Pensioner Part 2	16	3.63	.500	.125	3.36	3.89	3	4
Total	58	3.55	.597	.078	3.39	3.71	2	4

ANOVA

Q5

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	.120	2	.060	.163	.850
Within Groups	20.225	55	.368		
Total	20.345	57			

Robust Tests of Equality of Means

Q5

	Statistic[a]	df1	df2	Sig.
Welch	.219	2	31.529	.804

a. Asymptotically F distributed.

All questions: One Way ANOVA

ANOVA

		Sum of Squares	df	Mean Square	F	Sig.
Q1	Between Groups	1.382	2	.691	1.513	.229
	Within Groups	25.118	55	.457		
	Total	26.500	57			
Q2	Between Groups	1.707	2	.853	1.941	.153
	Within Groups	24.173	55	.440		
	Total	25.879	57			
Q3	Between Groups	.164	2	.082	.255	.776
	Within Groups	17.715	55	.322		
	Total	17.879	57			
Q4	Between Groups	2.806	2	1.403	3.388	.041
	Within Groups	22.780	55	.414		
	Total	25.586	57			
Q5	Between Groups	.120	2	.060	.163	.850
	Within Groups	20.225	55	.368		
	Total	20.345	57			

APPENDIX X

WHOQOL-BREF ANOVA tests for statistical significance

ANOVA Testing

The following tables indicate no significant difference between all three datasets when compared against each other.

Domain 2 demonstrated statistically significant variances which were Post Hoc re-tested using Games-Howell with results indicating no significant difference.

All Domains

ANOVA

		Sum of Squares	df	Mean Square	F	Sig.
Domain_1	Between Groups	211.756	2	105.878	.412	.664
	Within Groups	14387.755	56	256.924		
	Total	14599.511	58			
Domain_2	Between Groups	221.398	2	110.699	.632	.536
	Within Groups	9815.961	56	175.285		
	Total	10037.359	58			
Domain_3	Between Groups	297.442	2	148.721	.689	.506
	Within Groups	12080.147	56	215.717		
	Total	12377.589	58			
Domain_4	Between Groups	115.384	2	57.692	.533	.590
	Within Groups	6060.966	56	108.232		
	Total	6176.350	58			

All Domain Post-Hoc test using Tukey

Multiple Comparisons

Tukey HSD

Dependent Variable	(I) Group	(J) Group	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval Lower Bound	95% Confidence Interval Upper Bound
Domain_1	In Pensioner	New IP 1	-.46218	5.03886	.995	-12.5936	11.6692
		New IP 2	-4.34874	5.03886	.666	-16.4801	7.7826
	New IP 1	In Pensioner	.46218	5.03886	.995	-11.6692	12.5936
		New IP 2	-3.88655	5.49785	.760	-17.1230	9.3499
	New IP 2	In Pensioner	4.34874	5.03886	.666	-7.7826	16.4801
		New IP 1	3.88655	5.49785	.760	-9.3499	17.1230
Domain_2	In Pensioner	New IP 1	4.58431	4.16200	.517	-5.4360	14.6046
		New IP 2	1.00588	4.16200	.968	-9.0144	11.0262
	New IP 1	In Pensioner	-4.58431	4.16200	.517	-14.6046	5.4360
		New IP 2	-3.57843	4.54112	.712	-14.5115	7.3546
	New IP 2	In Pensioner	-1.00588	4.16200	.968	-11.0262	9.0144
		New IP 1	3.57843	4.54112	.712	-7.3546	14.5115
Domain_3	In Pensioner	New IP 1	3.42157	4.61713	.740	-7.6945	14.5376
		New IP 2	-2.46078	4.61713	.855	-13.5768	8.6553
	New IP 1	In Pensioner	-3.42157	4.61713	.740	-14.5376	7.6945
		New IP 2	-5.88235	5.03770	.477	-18.0109	6.2462
	New IP 2	In Pensioner	2.46078	4.61713	.855	-8.6553	13.5768
		New IP 1	5.88235	5.03770	.477	-6.2462	18.0109
Domain_4	In Pensioner	New IP 1	.01934	3.27045	1.000	-7.8545	7.8931
		New IP 2	-3.07993	3.27045	.616	-10.9537	4.7939
	New IP 1	In Pensioner	-.01934	3.27045	1.000	-7.8931	7.8545
		New IP 2	-3.09926	3.56835	.662	-11.6903	5.4918
	New IP 2	In Pensioner	3.07993	3.27045	.616	-4.7939	10.9537
		New IP 1	3.09926	3.56835	.662	-5.4918	11.6903

Domain 2 re-test

ANOVA

Domain_2

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	221.398	2	110.699	.632	.536
Within Groups	9815.961	56	175.285		
Total	10037.359	58			

Domain 2 Post Hoc test using Game-Howell

Multiple Comparisons

Dependent Variable: Domain_2

Games-Howell

(I) Group	(J) Group	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
In Pensioner	New IP 1	4.58431	4.65380	.594	-7.0835	16.2521
	New IP 2	1.00588	3.69717	.960	-8.1507	10.1624
New IP 1	In Pensioner	-4.58431	4.65380	.594	-16.2521	7.0835
	New IP 2	-3.57843	5.28517	.779	-16.6173	9.4605
New IP 2	In Pensioner	-1.00588	3.69717	.960	-10.1624	8.1507
	New IP 1	3.57843	5.28517	.779	-9.4605	16.6173

Appendix Y

Royal Hospital Chelsea Documents Reviewed

The following Royal Hospital Chelsea Documents were reviewed to inform the project discussion as summarised below. Except for Annual Reports, all documents reviewed were internal publications and therefore not publicly available. Requests to review any documents should be made to the author.

Document Name
In-Pensioner Specific Documents
Admissions Policy
In-Pensioner Agreement
In-Pensioner Autonomy Policy
In-Pensioner Choice Policy
In-Pensioner Financial Contributions Policy
In-Pensioner Handbook
Individual Accommodation Policy
Leaving the Royal Hospital Chelsea Policy
Self-Care & Treatment Policy
Sexuality & Intimate Relationships Policy
Other Documents
Annual Report(s)
Health & Wellbeing Oversight Committee Annual Quality Report 2019
In-Pensioner Medical Practice Annual Patient Survey 2018/19
Margaret Thatcher Infirmary (MTI) admissions data 2009-2021
Military Engagement Report 2020
Ministry of Defence Grant in Aid Framework 2021

Admissions Policy

This policy outlined all stages of the In-Pensioner journey from application request to acceptance and subsequent admission to the Royal Hospital Chelsea, including the initial enquiry, assessment, and mandatory four-day stay, which enabled prospective residents to experience life at the Royal Hospital, to the selection and appeals process for those who are considered suitable, or unsuitable.

In-Pensioner Agreement

This document outlined the conditions which In-Pensioners agree to follow throughout their residency at the Royal Hospital. This included the obligation of the Royal Hospital to provide suitable living arrangements for the In-Pensioner, and in turn, the In-Pensioners agreement to follow the rules, regulations and code of conduct whilst living at the Royal Hospital. The In-Pensioner Agreement is signed by both parties on the first day of admission.

In-Pensioner Autonomy Policy

In line with fostering In-Pensioner independence, the In-Pensioner Autonomy Policy outlined the intention to allow In-Pensioners to choose how to live their lives, control their own finances, and freedom of movement within their living environment, subject to this behaviour not placing the In-Pensioner, or those supporting them, at any risk.

In-Pensioner Choice Policy

The In-Pensioner Choice policy detailed the process undertaken by staff and those supporting In-Pensioners to facilitate choice in how they lived at the Royal Hospital and access all services available to them, giving them balanced advice that enabled them to make their own choices. This policy observed the requirements stipulated by various legal Acts including the Human Rights Act 1998, the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS), the Care Act 2014 and the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In-Pensioner Financial Contributions Policy

This policy outlined the financial assessment of, and contribution required by, In-Pensioners to enable them to reside at the Royal Hospital. The policy ensured the financial protection of In-Pensioner income and capital assets and a ceiling limit to the financial contribution, in line with the requirement to surrender of any monies received from Army and/or War Disablement pension and financial assessment.

In-Pensioner Handbook

The In-Pensioner Handbook was a 159-page document that provided a comprehensive overview of what can be expected, and what was required, by all In-Pensioners who live at the Royal Hospital. It highlighted the mission, ethos, and governance, of the Royal Hospital, alongside practical information including rules and regulations relating to the wearing of uniform, mealtimes, Long Ward quiet times, important contact information, and access to the support available including medical and social care support.

Individual Accommodation Policy

The Individual Accommodation Policy set out the Royal Hospital Chelsea's commitment to provide suitable living accommodation for In-Pensioner residents, in the form of furnished individual berths with bathroom facilities, alongside the freedom for In-Pensioners to personalise their rooms, in line with existing policy requirements. Limited shared accommodation exists in the MTI, however this is not applicable to this project.

Leaving the Royal Hospital Chelsea Policy

This policy covered the process for those In-Pensioners who leave the Royal Hospital, either through choice, or as a result of the Royal Hospital considering an In-Pensioner unsuitable, or for those who may require more specialist care than is available at the Royal Hospital. The policy included the procedures for supporting In-Pensioners after they have left and the process for readmission, where applicable.

Self-Care & Treatment Policy

The Self-Care Treatment policy built on the policies that support In-Pensioner choice and maintenance of independence and refers to the creation of a self-care plan to identify areas where support may be required, which may include domiciliary care, to enable In-Pensioner independence whilst protecting those who may also be considered vulnerable and less able to make independent choices.

Sexuality & Intimate Relationships Policy

This policy addressed the relationship status and behaviour of In-Pensioners who, on admission, were required to be of single status and free of dependents. It offered guidance on the procedures for those who develop external or In-Pensioner-to-In-Pensioner relationships, whilst respecting the freedom for In-Pensioners to develop relationships but within the framework of Royal Hospital values, adherence to the law, and the In-Pensioner Agreement.

Annual Report(s)

The Royal Hospital Chelsea prepares an annual report that is presented to the UK Parliament, in line with the conditions of the Chelsea Hospital Act 1876. Each report reviewed gave an overview of the Board of Commissioners responsibilities and governance structure and appointments process, with contributions to the report from the Chief Executive, auditors and legal representatives. Each report outlined the charitable objectives and strategic intentions of the Royal Hospital and offered a summary of the previous years' activities, employee status, and the strategic and financial positioning.

Health and Wellbeing Oversight Committee (HWOC) Annual Quality Report 2019

The HWOC annual quality report offered an annual update on areas including the MTI and medical centre (not included in this project), In-Pensioner admission rates, In-Pensioner engagement, staff development and matters related to service delivery.

In-Pensioner Medical Practice Annual Patient Survey 2018/19

The Medical Practice Annual Patient Survey offered an insight into the patient experience of using the on-site medical centre and covered areas such as offering a welcoming service, listening to patient concerns or needs, explaining things clearly, enabling the patient to be in control of their health and lifestyle, and discussing any treatment plans to support patient health.

Margaret Thatcher Infirmary (MTI) admissions data 2009-2021

This report provided data on In-Pensioners who were transferred from Long Ward independent living to the MTI residential and nursing care facility since its opening in 2009. This data enabled an overview of duration of residency whilst living independently versus the time spent in the MTI prior to death. Separation of the two living environments facilitated the comparison of nursing care residency with similar establishments and national data.

Military Engagement Report 2020

An inaugural report that detailed the engagement between the Royal Hospital and military partners including the Ministry of Defence, Army Regiments and third sector organisations that support the military community.

Ministry of Defence (MoD) Grant in Aid Framework

This document detailed the conditions of the annual financial contribution from the MoD to the Royal Hospital, towards the expenditure necessary to manage the establishment. Reviewed every three years, the Grant in Aid outlined the criteria for applying the grant and key performance indicators to be met by the Royal Hospital Chelsea.

LIST OF REFERENCES

Abbott, S., Fisk, M., & Forward, L. (2000). Social and democratic participation in residential settings for older people: realities and aspirations. *Ageing & Society*, *20*(3), 327-340.

Abramsson, M., & Andersson, E. (2016). Changing preferences with ageing–housing choices and housing plans of older people. *Housing, theory and society*, *33*(2), 217-241.

Adams, J., Hillier-Brown, F. C., Moore, H. J., Lake, A. A., Araujo-Soares, V., White, M., & Summerbell, C. (2016). Searching and synthesising 'grey literature' and 'grey information' in public health: critical reflections on three case studies. *Systematic reviews*, *5*(1), 1-11.

Adams, K. B., Leibbrandt, S., & Moon, H. (2011). A critical review of the literature on social and leisure activity and wellbeing in later life. *Ageing & Society*, *31*(4), 683-712.

Age UK. (2022). Housing Options, Different types of housing to suit you. In.

Age UK. (2023). *Paying for Residential Care*. Retrieved 18.03.2023 from https://www.ageuk.org.uk/information-advice/care/paying-for-care/paying-for-a-care-home/

Aitken, D., Cook, G., & Lawson, A. (2016). Villages with enhanced care and support: Final report. In: Northumbria University.

Alabaré Christian Care and Support. (2022a). *Homes for Veterans England*. Retrieved 20.12.2022 from https://www.alabare.co.uk/veterans

Alabaré Christian Care and Support. (2022b). *Homes for Veterans Cymru*. Retrieved 20.12.2022 from https://www.alabare.co.uk/theme/homes-for-veterans-cymru

Allen, K., & Glasby, J. (2013). 'The billion dollar question': embedding prevention in older people's services—ten 'high-impact' changes. *British Journal of Social Work*, *43*(5), 904-924.

Alsaawi, A. (2014). A critical review of qualitative interviews. *European Journal of Business and Social Sciences*, *3*(4).

Anderson, K. A., & Dabelko-Schoeny, H. I. (2010). Civic engagement for nursing home residents: A call for social work action. *Journal of gerontological social work*, *53*(3), 270-282.

Annele, U. U., Satu, K. J. K. J., & Timo, E. S. E. S. (2019). Definitions of successful ageing: A brief review of a multidimensional concept. *Acta bio-medica de l'Ateneo Parmense*, *90*(2), 359-363. https://doi.org/10.23750/abm.v90i2.8376

Armed Forces Act 2011, (2011a). https://www.legislation.gov.uk/ukpga/2011/18/contents

Armed Forces Covenant. (2019). *Armed Forces Covenant Chelsea & Westminster Hospital NHS Foundation Trust Signed Commitment*. Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/792386/Chelsea_and_Westminster_Hospital_NHS_Foundation_Trust_Armed_Forces_Covenant_20190318.pdf

Armed Forces Covenant. (2022). *The Armed Forces Covenant and Veterans Annual Report 2022*. HH Associates Limited on behalf of the Controller of His Majesty's Stationery Office Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1125589/Armed_Forces_Covenant_annual_report_2022.pdf

Armed Forces Covenant. (2023). *Armed Forces Covenant*. Retrieved 30.05.2023

from https://www.armedforcescovenant.gov.uk/
Army. (2022). *Our People. Command Structure*. Retrieved 11.12.2022 from https://www.army.mod.uk/who-we-are/our-people/command-structure/
Ascoli, D. (1974). *A Village in Chelsea: an informal account of the Royal Hospital*. William Luscombe Publisher Limited.
Ashcroft, L. M. (2014). *The Veterans' Transition Review* https://www.veteranstransition.co.uk/vtrreport.pdf
Ashmore, R. D., Deaux, K., & McLaughlin-Volpe, T. (2004). An organizing framework for collective identity: articulation and significance of multidimensionality. *Psychological bulletin*, *130*(1), 80.
AssistedLiving.org. (2021). *What are IADLS or the Instrumental Activities of Daily Living?* Retrieved 10.09.2021 from https://www.assistedliving.org/assisted-living-near-me/what-are-iadls/
Australian Institute of Health & Welfare. (2018). A profile of Australia's veterans 2018. In: Australian Government Canberra, Australia.
Bacon, A., Martin, E., Swarbrick, R., & Treadgold, A. (2022). National Health Service interventions in England to improve care to Armed Forces veterans. *BMJ military health*, *168*(1), 95-98. https://doi.org/10.1136/bmjmilitary-2020-001739
Baldwin, N., Harris, J., & Kelly, D. (1993). Institutionalisation: why blame the institution? *Ageing & Society*, *13*(1), 69-81.
Ballesteros, R. F. (2019). The concept of successful aging and related terms. The Cambridge handbook of successful aging,
Baltes, P. B., & Baltes, M. M. (1990). Psychological perspectives on successful aging: The model of selective optimization with compensation. *Successful aging: Perspectives from the behavioral sciences*, *1*(1), 1-34.
Baji, P., Farkas, M., Dobos, Á., Zrubka, Z., Kovács, L., Gulácsi, L., & Péntek, M. (2021). Comparing the measurement properties of the ICECAP-A and ICECAP-O instruments in ages 50–70: a cross-sectional study on a representative sample of the Hungarian general population. *The European Journal of Health Economics, 22,* 1453-1466.
Bauer, M., Fetherstonhaugh, D., Tarzia, L., Nay, R., Wellman, D., & Beattie, E. (2013). 'I always look under the bed for a man'. Needs and barriers to the expression of sexuality in residential aged care: the views of residents with and without dementia. *Psychology & Sexuality*, *4*(3), 296-309.
Benzies, K. M., Premji, S., Hayden, K. A., & Serrett, K. (2006). State-of-the-evidence reviews: advantages and challenges of including grey literature. *Worldviews on Evidence-Based Nursing*, *3*(2), 55-61.
Biddle, C., & Schafft, K. A. (2015). Axiology and anomaly in the practice of mixed methods work: Pragmatism, valuation, and the transformative paradigm. *Journal of Mixed Methods Research*, *9*(4), 320-334.
Bishop, F. L. (2015). Using mixed methods research designs in health psychology: An illustrated discussion from a pragmatist perspective. *British journal of health psychology*, *20*(1), 5-20.
Blesma, The Limbless Veterans. (2021). *Trustees' Annual and Strategic Report 2021*.
Boswell, J., Thai, J., & Brown, C. (2015). Older adults' sleep. *A. Green & C. Brown*.
Bowers, H., Clark, A., Crosby, G., Easterbrook, L., Macadam, A., MacDonald, R., Macfarlane, A., Maclean, M., Patel, M., & Runnicles, D. (2009). Older people's vision for long-term care. Joseph Rowntree Foundation. In.
Bowes, M. A., Ferreira, N., & Henderson, M. (2018). The influence of psychosocial

factors in veteran adjustment to civilian life. *Clinical psychology & psychotherapy*, *25*(4), 583-600.
Bowling, A. (1993). The Concepts of Successful and Positive Ageing. *Family practice*, *10*(4), 449-453. https://doi.org/10.1093/fampra/10.4.449
Bowling, A., & Dieppe, P. (2005). What is successful ageing and who should define it? *BMJ*, *331*(7531), 1548-1551. https://doi.org/10.1136/bmj.331.7531.1548
Bradshaw, S. A., Playford, E. D., & Riazi, A. (2012). Living well in care homes: A systematic review of qualitative studies. *Age and ageing*, *41*(4), 429-440. https://doi.org/10.1093/ageing/afs069
Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, *3*(2), 77-101.
Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative research in sport, exercise and health*, *11*(4), 589-597.
Braun, V., & Clarke, V. (2021). One size fits all? What counts as quality practice in (reflexive) thematic analysis? *Qualitative research in psychology*, *18*(3), 328-352.
Braun, V., & Clarke, V. (2022b). Conceptual and design thinking for thematic analysis. *Qualitative Psychology*, *9*(1), 3.
Braun, V. C., Victoria. (2022a). *Thematic analysis : a practical guide*. Los Angeles : SAGE.
Brown, R. (2020). The social identity approach: Appraising the Tajfellian legacy. *British Journal of Social Psychology*, *59*(1), 5-25.
Brownie, S., & Horstmanshof, L. (2012). Creating the conditions for self-fulfilment for aged care residents. *Nursing ethics*, *19*(6), 777-786. https://doi.org/10.1177/0969733011423292
Burnell, K., Crossland, J., & Greenberg, N. (2017). The health and social care of older veterans in the UK. *Military veteran psychological health and social care: Contemporary issues*, 81-95.
Campbell, S., Greenwood, M., Prior, S., Shearer, T., Walkem, K., Young, S., Bywaters, D., & Walker, K. (2020). Purposive sampling: complex or simple? Research case examples. *Journal of research in Nursing*, *25*(8), 652-661.
Care Quality Commission. (2022). *Royal Hospital Chelsea Margaret Thatcher Infirmary Inspection Report* https://api.cqc.org.uk/public/v1/reports/a60baf59-5f2a-49e5-9c44-69ce6d9f8b3c?20220322130000
Care Quality Commission. (2023). *About Us*. Care Quality Commission Retrieved 05.04.2023 from https://www.cqc.org.uk/about-us
Carr, S., & Fang, C. (2022). “We Are Good Neighbors, But We Are Not Carers!”: Lived Experiences of Conflicting (In) dependence Needs in Retirement Villages Across the United Kingdom and Australia. *The gerontologist*, *62*(7), 974-983.
Carter, N., Bryant-Lukosius, D., DiCenso, A., Blythe, J., Neville, A. (2014). The use of triangulation in qualitative research. *Oncology Nursing Forum, 41(5), 545-547*
Centre for Ageing Better. (2019). *Home truths. Housing options and advise for people in later life: Learning from communities in Leeds*. https://ageing-better.org.uk/sites/default/files/2019-07/Home-truths-report.pdf
Chapko, M. K., Manheim, L. M., Guihan, M., Sullivan, J. H., Zhou, X.-H. A., Li, W., Mambourg, F. J., & Hedrick, S. C. (2009). Assisted Living Pilot Program: Utilization and Cost Findings. *Journal of aging and health*, *21*(1), 208-225. https://doi.org/10.1177/0898264308328930

Chen, L.-K., Peng, L.-N., Lin, M.-H., Lai, H.-Y., Hwang, S.-J., & Lan, C.-F. (2010). Predicting mortality of older residents in long-term care facilities: comorbidity or care problems? *Journal of the American Medical Directors Association*, *11*(8), 567-571.
Collins Dictionary. (2022). *Hospital: variable noun*. Retrieved 15.12.2022 from https://www.collinsdictionary.com/us/dictionary/english/hospital
Communities & Local Government Committee. (2018). *Housing for Older People, Second Report of Session 2017-19*. House of Commons
Connelly, L. M. (2010). What is phenomenology? *Medsurg Nursing*, *19*(2), 127.
Cook, G., & Bailey, C. (2011). Promoting intergenerational connectivity in care. *Nursing & Residential Care*, *13*(12), 591-593. https://doi.org/10.12968/nrec.2011.13.12.591
Cook, G., Thompson, J., & Reed, J. A. N. (2015). Re-conceptualising the status of residents in a care home: older people wanting to 'live with care'. *Ageing and society*, *35*(8), 1587-1613. https://doi.org/10.1017/S0144686X14000397
Cooney, A., Murphy, K., & O'Shea, E. (2009). Resident perspectives of the determinants of quality of life in residential care in Ireland. *Journal of advanced nursing*, *65*(5), 1029-1038.
Cooper, L., Andrew, S., & Fossey, M. (2016). Educating nurses to care for military veterans in civilian hospitals: An integrated literature review. *Nurse Education Today*, *47*, 68-73.
Cooper, L., Caddick, N., Godier, L., Cooper, A., Fossey, M., & Engward, H. (2017). A model of military to civilian transition: Bourdieu in action. *Journal of Military, Veteran and Family Health*, *3*(2), 53-60.
Corr, J., & Tarou, L. (2006). Behavior and Personality in the Study of Successful Aging. In (pp. 741-748). https://doi.org/10.1016/B978-012369391-4/50063-1
Coughlan, M., Cronin, P., & Ryan, F. (2009). Survey research: Process and limitations. *International journal of therapy and rehabilitation*, *16*(1), 9-15. https://doi.org/10.12968/ijtr.2009.16.1.37935
Creswell, J. W., & Clark, V. L. P. (2017). *Designing and conducting mixed methods research*. Sage publications.
Crotty, M. J. (1998). The foundations of social research: Meaning and perspective in the research process. *The foundations of social research*, 1-256.
Davies, S. (2003). Creating community: the basis for caring partnerships in nursing homes. *Partnership in Family Care*, *218*, 237.
Dawadi, S., Shrestha, S., & Giri, R. A. (2021). Mixed-methods research: A discussion on its types, challenges, and criticisms. *Journal of Practical Studies in Education*, *2*(2), 25-36.
Department for Levelling Up, Housing and Communities (2019).*Guidance Housing for older and disabled people* London: Department for Levelling Up, Housing and Communities Retrieved from https://www.gov.uk/guidance/housing-for-older-and-disabled-people
Department of Health. (2001). *National Service Framework for Older People* London: Department of Health Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/198033/National_Service_Framework_for_Older_People.pdf
Department of Health. (2002). *Intermediate Care: Moving Forward. National Service Framework for Older People Supporting Implementation*. London
Dharm-Datta, S., Etherington, J., Mistlin, A., Rees, J., & Clasper, J. (2011). The

outcome of British combat amputees in relation to military service. *Injury*, *42*(11), 1362-1367.
Drebing, C. E., Reilly, E., Henze, K. T., Kelly, M., Russo, A., Smolinsky, J., Gorman, J., & Penk, W. E. (2018). Using peer support groups to enhance community integration of veterans in transition. *Psychological Services*, *15*(2), 135-145. https://doi.org/https://doi.org/10.1037/ser0000178
EAC Housing Care. (2018). *Housing Options for Older People in Scotland*. Elderly Accommodation Counsel. Retrieved from https://housingcare.org/resources/housing-options-for-older-people-in-scotland/
EAC Housing Care. (2021). *Extra Care Housing.* Elderly Accommodation Counsel. Retrieved from https://housingcare.org/downloads/kbase/3259.pdf
EAC Housing Care. (2022a). *Housing Care: Retirement & Sheltered Housing*. Elderly Accommodation Counsel. Retrieved from https://housingcare.org/guides/sheltered-housing-retirement/
EAC Housing Care. (2022b). *Residential care homes*. Retrieved 19.12.2022 from https://housingcare.org/guides/residential-care-homes/
EAC Housing Care. (2022c). *Housing Care: Retirement Villages*. Retrieved from https://housingcare.org/guides/retirement-villages/
EAC Housing Care. (2022d). *Housing Care: Care homes with nursing*. Retrieved from https://housingcare.org/guides/retirement-villages/
Eckhardt, A. L., & DeVon, H. A. (2017). The MIXED framework: A novel approach to evaluating mixed-methods rigor. *Nursing Inquiry*, *24*(4), e12189.
Edmunds, T., Dawes, A., Higate, P., Jenkings, K. N., & Woodward, R. (2016). Reserve forces and the transformation of British military organisation: soldiers, citizens and society. *Defence Studies*, *16*(2), 118-136.
Egilsdottir, H. O., Heyn, L. G., Brembo, E. A., Byermoen, K. R., Moen, A., & Eide, H. (2022). The value of a redesigned clinical course during COVID-19 pandemic: an explorative convergent mixed-methods study. *BMC nursing*, *21*(1), 94-94. https://doi.org/10.1186/s12912-022-00872-8
Engel, L., Mortimer, D., Bryan, S., Lear, S. A., & Whitehurst, D. G. (2017). An investigation of the overlap between the ICECAP-A and five preference-based health-related quality of life instruments. *PharmacoEconomics*, *35*, 741-753.
Erskine. (2022). *Our Care Homes*. Retrieved 20.12.2022 from https://www.erskine.org.uk/get-support/our-care-homes
Ettelt, S., Williams, L., Damant, J., Perkins, M., & Wittenberg, R. (2022). What kind of home is your care home? A typology of personalised care provided in residential and nursing homes. *Ageing & Society*, *42*(5), 993-1013.
Evans, S., & Means, R. (2007). BALANCED RETIREMENT COMMUNITIES? *A Case Study of Westbury Fields. St Monica Trust, Bristol*.
Falk, H., Wijk, H., Persson, L. O., & Falk, K. (2013). A sense of home in residential care. *Scandinavian Journal of Caring Sciences*, *27*(4), 999-1009.
Fan, L., Hou, X.-Y., Zhao, J., Sun, J., Dingle, K., Purtill, R., Tapp, S., & Lukin, B. (2015). Hospital in the Nursing Home program reduces emergency department presentations and hospital admissions from residential aged care facilities in Queensland, Australia: a quasi-experimental study. *BMC Health Services Research*, *16*, 1-9.
Fetters, M. D., Curry, L. A., & Creswell, J. W. (2013). Achieving integration in mixed methods designs—principles and practices. *Health services research*, *48*(6pt2), 2134-2156.

Finnegan, A., & Randles, R. (2022). Prevalence of common mental health disorders in military veterans: using primary healthcare data. *BMJ Mil Health*.
Flack, M., & Kite, L. (2021). Transition from military to civilian: Identity, social connectedness, and veteran wellbeing. *Plos one*, *16*(12), e0261634.
Flynn, T. N., Huynh, E., Peters, T. J., Al-Janabi, H., Clemens, S., Moody, A., & Coast, J. (2015). Scoring the ICECAP-A capability instrument. Estimation of a UK general population tariff. *Health economics*, *24*(3), 258-269.
Fugard, A. J., & Potts, H. W. (2015). Supporting thinking on sample sizes for thematic analyses: a quantitative tool. *International Journal of Social Research Methodology*, *18*(6), 669-684.
Fullwood, D. (2015). Understanding and managing the health needs of veterans. *Nursing Standard (2014+)*, *30*(10), 37.
Gage, H., Dickinson, A., Victor, C., Williams, P., Cheynel, J., Davies, S. L., Iliffe, S., Froggatt, K., Martin, W., & Goodman, C. (2012). Integrated working between residential care homes and primary care: a survey of care homes in England. *BMC geriatrics*, *12*(1), 1-10.
Galletta, A. (2013). *Mastering the semi-structured interview and beyond: From research design to analysis and publication* (Vol. 18). NYU press.
Galvani-Townsend, S., Martinez, I., & Abhishek, P. (2022). Is life expectancy higher in countries and territories with publicly funded health care? Global analysis of health care access and the social determinants of health. *Journal of Global Health*, *12*.
Gauntlett-Gilbert, J., & Wilson, S. (2013). Veterans and chronic pain. *British Journal of Pain*, *7*(2), 79-84.
Gilman, C., Haverhals, L., Manheim, C., & Levy, C. (2018). A qualitative exploration of veteran and family perspectives on medical foster homes. *Home health care services quarterly*, *37*(1), 1-24. https://doi.org/10.1080/01621424.2017.1419156
Giraldi, M., Mitchell, F., Porter, R. B., Reed, D., Jans, V., McIver, L., Manole, M., & McTier, A. (2022). Residential care as an alternative care option: A review of literature within a global context. *Child & Family Social Work*, *27*(4), 825-837.
Glicken, M. D. (2009). *Evidence-Based Counseling and Psychotherapy for an Aging Population*. https://doi.org/10.1016/C2009-0-01906-0
Goffman, E. (1961). *Asylums: Essays on the social situation of mental patients and other inmates*. AldineTransaction.
Goodwin, L., Norton, S., Fear, N., Jones, M., Hull, L., Wessely, S., & Rona, R. J. (2017). Trajectories of alcohol use in the UK military and associations with mental health. *Addictive Behaviors*, *75*, 130-137.
Gottlieb, B. H., & Gillespie, A. A. (2008). Volunteerism, health, and civic engagement among older adults. *Canadian Journal on Aging/La Revue canadienne du vieillissement*, *27*(4), 399-406.
Grant, V. B., & Simpson, R. G. (2022). Improving NHS primary care for military veterans. *The British journal of general practice: the journal of the Royal College of General Practitioners*, *72*(716), 134-135. https://doi.org/https://doi.org/10.3399/bjgp22X718781
Gribble, R., Wessely, S., Klein, S., Alexander, D. A., Dandeker, C., & Fear, N. T. (2019). Who is a 'veteran'? Understanding definitions of the term among the British public: a research note. *The RUSI Journal,* 164(7), 10-17.
Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. *Handbook of qualitative research*, *2*(163-194), 105.

Guihan, M., Thomas, M. D., Mambourg, F. J., Li, W., Chapko, M. K., & Hedrick, S. C. (2009). Assisted Living Pilot Program: Background, Methods, and Facility Characteristics. *Journal of aging and health*, *21*(1), 172-189. https://doi.org/10.1177/0898264308328926

Gulia, K. K., & Kumar, V. M. (2018). Sleep disorders in the elderly: a growing challenge. *Psychogeriatrics*, *18*(3), 155-165.

Gustavsen, E. (2013). Equal treatment or equal opportunity? Male attitudes towards women in the Norwegian and US armed forces. *Acta Sociologica*, *56*(4), 361-374.

Hafford-Letchfield, T., Simpson, P., Willis, P. B., & Almack, K. (2018). Developing inclusive residential care for older lesbian, gay, bisexual and trans (LGBT) people: An evaluation of the Care Home Challenge action research project. *Health & social care in the community*, *26*(2), e312-e320.

Haig Housing. (2022). *What we do*. Retrieved 20.12.2022 from https://www.haighousing.org.uk/about-us/what-we-do/

Hall, J. N. (2013). Pragmatism, evidence, and mixed methods evaluation. *New directions for evaluation*, *2013*(138), 15-26.

Harrison, R. L., Reilly, T. M., & Creswell, J. W. (2020). Methodological rigor in mixed methods: An application in management studies. *Journal of Mixed Methods Research*, *14*(4), 473-495.

Hashemnezhad, H., Heidari, A. A., & Mohammad Hoseini, P. (2013). Sense of place" and "place attachment. *International Journal of Architecture and Urban Development*, *3*(1), 5-12.

Hauge, Å. L. (2007). Identity and place: a critical comparison of three identity theories. *Architectural science review*, *50*(1), 44-51.

Haverhals, L. M., Manheim, C. E., Gilman, C. V., Jones, J., & Levy, C. (2016). Caregivers Create a Veteran-Centric Community in VHA Medical Foster Homes. *Journal of gerontological social work*, *59*(6), 441-457. https://doi.org/10.1080/01634372.2016.1231730

Hayes, C., Bell, K., & Graham, Y. (2020). Alcohol use of UK military personnel during active service and on return to civilian life: veterans' experiences. *Mental Health Practice*, *23*(2).

Hedrick, S., Guihan, M., Chapko, M., Manheim, L., Sullivan, J., Thomas, M., Barry, S., & Zhou, A. (2007). Characteristics of Residents and Providers in the Assisted Living Pilot Program. *The gerontologist*, *47*(3), 365-377. https://doi.org/10.1093/geront/47.3.365

Hedrick, S. C., Guihan, M., Chapko, M. K., Sullivan, J., Zhou, X.-H., Manheim, L. M., Forsberg, C. W., & Mambourg, F. J. (2009). Assisted Living Pilot Program: Health Outcomes. *Journal of aging and health*, *21*(1), 190-207. https://doi.org/10.1177/0898264308328929

Hill, R. D. (2010). A Positive Aging Framework for Guiding Geropsychology Interventions. *Behavior therapy*, *42*(1), 66-77. https://doi.org/10.1016/j.beth.2010.04.006

Hornsey, M. J. (2008). Social identity theory and self-categorization theory: A historical review. *Social and personality psychology compass*, *2*(1), 204-222.

House of Commons Library. (2022). *UK defence personnel statistics*. https://researchbriefings.files.parliament.uk/documents/CBP-7930/CBP-7930.pdf

House of Commons Library. (2023). *A brief guide to previous British defence reviews*. https://researchbriefings.files.parliament.uk/documents/CBP-

7313/CBP-7313.pdf
House of Commons Library. (2023a). *Tackling the under-supply of housing in England London*: UK Parliament Retrieved from https://researchbriefings.files.parliament.uk/documents/CBP-7671/CBP-7671.pdf
Housing LIN. (2011). *Strategic Housing for Older People*. Housing Learning and Improvement Network.
ICO. (2023). *UK GDPR Guidance and Resources*. Information Commissioners Office. Retrieved 28.09.2021 from https://ico.org.uk/for-organisations/uk-gdpr-guidance-and-resources/
Iecovich, E. (2014). Aging in place: from theory to practice. *Anthropological notebooks*, *20*(1), 21-33.
Ikin, J. F., Sim, M. R., McKenzie, D. P., Horsley, K. W., Wilson, E. J., Harrex, W. K., Moore, M. R., Jelfs, P. L., & Henderson, S. (2009). Life satisfaction and quality in Korean War veterans five decades after the war. *Journal of Epidemiology & Community Health*, *63*(5), 359-365.
Iversen, A., Dyson, C., Smith, N., Greenberg, N., Walwyn, R., Unwin, C., Hull, L., Hotopf, M., Dandeker, C., & Ross, J. (2005). 'Goodbye and good luck': the mental health needs and treatment experiences of British ex-service personnel. *The British Journal of Psychiatry*, *186*(6), 480-486.
Johnson, B. (2001). Toward a new classification of nonexperimental quantitative research. *Educational researcher*, *30*(2), 3-13.
Kagan, S. H. (2023). Dismantling the structural ageism of 'ageing in place' to ensure 'ageing in the right place'. *International journal of older people nursing*, *18*(1), e12525-n/a. https://doi.org/10.1111/opn.12525
Kahana, E., Lovegreen, L., Kahana, B., & Kahana, M. (2003). Person, environment, and person-environment fit as influences on residential satisfaction of elders. *Environment and behavior*, *35*(3), 434-453.
Käihkö, I. (2018). Broadening the perspective on military cohesion. *Armed forces & society*, *44*(4), 571-586.
Kalfoss, M. H., Low, G., & Molzahn, A. E. (2008). The suitability of the WHOQOL–BREF for Canadian and Norwegian older adults. *European journal of ageing*, *5*, 77-89.
Kallio, H., Pietilä, A. M., Johnson, M., & Kangasniemi, M. (2016). Systematic methodological review: developing a framework for a qualitative semi-structured interview guide. *Journal of advanced nursing*, *72*(12), 2954-2965.
Kaul, K., Goodman, L. S., & McCargo, A. (2020). Instead of Aging in Place, How About Trying to Age in the Right Place? *Generations (San Francisco, Calif.)*, *44*(2), 1-8.
Kenter, A. (1980). Residential care and the Veterans Administration. *Journal-American Health Care Association*, *6*(6), 30-30.
Kheirbek, R. A. F., A; Wilson-Bell, L; DeGrote, S. (2018). Life at the Extreme: Characteristics of Veteran Centenarians in Long-Term Care. *Annals of Longterm Care*, *26*(5), e25-e32.
Kiernan, M. D., & Hill, M. (2018). Framework analysis: a whole paradigm approach. *Qualitative Research Journal*.
Kiernan, M. D., Osbourne, A., McGill, G., Jane Greaves, P., Wilson, G., & Hill, M. (2018). Are veterans different? Understanding veterans' help-seeking behaviour for alcohol problems. *Health & social care in the community*, *26*(5), 725-733.

Kirke, C. (2009). Group cohesion, culture, and practice. *Armed forces & society*, *35*(4), 745-753.
Klemenčič, V. S., & Leskovar, V. Ž. (2023). The role of open space and green areas in the design of an inclusive nursing home environment during Covid-19 period. *Energy Reports*, *9*, 85-91.
Knapp, M. R. J. (1977). The Activity Theory of Aging An Examination in the English Context. *The gerontologist*, *17*(6), 553-559. https://doi.org/10.1093/geront/17.6.553
Król-Zielińska, M., Kusy, K., Zieliński, J., & Osiński, W. (2011). Physical activity and functional fitness in institutionalized vs. independently living elderly: A comparison of 70–80-year-old city-dwellers. *Archives of Gerontology and Geriatrics*, *53*(1), e10-e16.
Kruse, A., & Schmitt, E. (2015). Shared responsibility and civic engagement in very old age. *Research in Human Development*, *12*(1-2), 133-148.
Ladyman, J. (2002). *Understanding philosophy of science*. Psychology Press.
Lautamatti, E., Mattila, K., Suominen, S., Sillanmäki, L., & Sumanen, M. (2022). A named GP increases self-reported access to health care services. *BMC Health Services Research*, *22*(1), 1262. https://doi.org/10.1186/s12913-022-08660-5
Leech, N. L., Dellinger, A. B., Brannagan, K. B., & Tanaka, H. (2010). Evaluating mixed research studies: A mixed methods approach. *Journal of Mixed Methods Research*, *4*(1), 17-31.
Lemke, S., & Moos, R. H. (1989). Ownership and Quality of Care in Residential Facilities for the Elderly. *The gerontologist*, *29*(2), 209-215. https://doi.org/10.1093/geront/29.2.209
Leung, J. C. (2010). Residential care services for older people in China: From state to market provisions? *Social Development Issues (Follmer Group)*, *32*(1).
LeVasseur, J. J. (2003). The problem of bracketing in phenomenology. *Qualitative Health Research*, *13*(3), 408-420.
Levy, C. R., Jones, J., Haverhals, L. M., & Nowels, C. T. (2013). A qualitative evaluation of a new community living model: Medical foster home placement. *Journal of nursing education and practice*, *4*(1), 162.
Local Government Association. (2022). *Housing our Ageing Population*. https://www.local.gov.uk/publications/housing-ageing-population#demographic-and-policy-context
Lum, T. Y., & Lightfoot, E. (2005). The effects of volunteering on the physical and mental health of older people. *Research on Aging*, *27*(1), 31-55.
Mankowski, M. (2017). Aging LGBT military service members and veterans. *Annual Review of Gerontology and Geriatrics*, *37*(1), 111-125.
Maringira, G. (2016). On Entering the Military Organization. *Journal of Political & Military Sociology*, *44*, 103-124.
Marques, S., Swift, H. J., Vauclair, C.-M., Lima, M. L., Bratt, C., & Abrams, D. (2015). 'Being old and ill'across different countries: Social status, age identification and older people's subjective health. *Psychology & health*, *30*(6), 699-714.
Mayhew, L., RIchayzen, B., & Smith, D. (2017). *Does living in a retirement village extend life expectancy? The case of Whiteley Village*. ILC-UK.
McCann, M., Grundy, E., & O'Reilly, D. (2012). Why is housing tenure associated with a lower risk of admission to a nursing or residential home? Wealth, health and the incentive to keep 'my home'. *J Epidemiol Community Health*, *66*(2), 166-169.

McKee, K., Harrison, G., & Lee, K. (1999). Activity, friendships and wellbeing in residential settings for older people. *Aging & mental health*, *3*(2), 143-152.
Meyer, E. G. (2015). The importance of understanding military culture. *Academic Psychiatry*, *39*, 416-418.
Ministry of Defence. (2019a). *Annual population survey: UK armed forces veterans residing in Great Britain 2017* https://www.gov.uk/government/statistics/annual-population-survey-uk-armed-forces-veterans-residing-in-great-britain-2017
Ministry of Defence. (2019b). *Annex A: Population Projections: UK Armed Forces Veterans residing in Great Britain 2016 to 2028*. https://www.gov.uk/government/publications/population-projections-uk-armed-forces-veterans-residing-in-great-britain-2016-to-2028
Ministry of Defence. (2020). *JSP 536 Governance of Research Involving Human Participants Part 2: Guidance. V.3.1 16 March 2020*. https://www.gov.uk/government/publications/defence-research-involving-human-participants-jsp-536
Moghimi, D., Scheibe, S., & Freund, A. M. (2019). The model of selection, optimization, compensation. In (pp. 81-110). https://doi.org/10.1016/B978-0-12-812756-8.00004-9
Moher, D., Liberati, A., Tetzlaff, J., Altman, D. G., & PRISMA Group*, t. (2009). Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. *Annals of internal medicine*, *151*(4), 264-269.
Montross, L. P., Depp, C., Daly, J., Reichstadt, J., Golshan, S., Moore, D., Sitzer, D., & Jeste, D. V. (2006). Correlates of Self-Rated Successful Aging Among Community-Dwelling Older Adults. *The American journal of geriatric psychiatry*, *14*(1), 43-51. https://doi.org/10.1097/01.JGP.0000192489.43179.31
Morse, J. M., & Cheek, J. (2014). Making room for qualitatively-driven mixed-method research. In (Vol. 24, pp. 3-5): Sage Publications Sage CA: Los Angeles, CA.
Mulliner, E., Riley, M., & Maliene, V. (2020). Older people's preferences for housing and environment characteristics. *Sustainability*, *12*(14), 5723.
Murphy, D., & Turgoose, D. (2019). Exploring patterns of alcohol misuse in treatment-seeking UK veterans: A cross-sectional study. *Addictive Behaviors*, *92*, 14-19.
Museum, I. W. (2023). *History timeline of 20th and 21st Century wars*. Retrieved 05.01.2023 from https://www.iwm.org.uk/history/timeline-of-20th-and-21st-century-wars
Myers, M. D. (1999). Investigating information systems with ethnographic research. *Communications of the Association for Information Systems*, *2*(1), 23.
Netherland, J., Finkelstein, R., & Gardner, P. (2011). The age-friendly New York City project: An environmental intervention to increase aging resilience. *Resilience in aging: Concepts, research, and outcomes*, 273-287.
NHS England. (2019). *Appointments in General Practice 2019*. Retrieved 07.05.2023 from https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice/september-2019#
NHS England. (2023). *Physical activity guidelines for older adults*. National Health Service Retrieved 23.04.2023 from https://www.nhs.uk/live-well/exercise/exercise-guidelines/physical-activity-guidelines-older-adults/
NHS Research Health Authority. (2020). *Mental Capacity Act*. NHS RHA. Retrieved

03.08.2020 from https://www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/mental-capacity-act/
Nuttall, R. P. J. (2003). Home of the Chelsea Pensioners, Official Guide. In T. R. H. Chelsea (Ed.). Derby: Heritage House Group Ltd.
NVIVO. (2022). *About NVivo*. Retrieved 22.04.2022 from https://help-nv.qsrinternational.com/12/win/v12.1.112-d3ea61/Content/about-nvivo/about-nvivo.htm
O'Cathain, A., Murphy, E., & Nicholl, J. (2008). The quality of mixed methods studies in health services research. *Journal of health services research & policy*, *13*(2), 92-98.
OECD. (2015). *Frascati Manual 2015*. Retrieved 23.12.2022 from https://www.oecd.org/innovation/frascati-manual-2015-9789264239012-en.htm
Office for National Statistics. (2022). *Trends in patient-to-staff numbers in GP practices in England: 2022*. Retrieved from https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/articles/trendsinpatienttostaffnumbersatgppracticesinenglan d/2022
O'Neill, M., Ryan, A., Tracey, A., & Laird, L. (2022). 'Waiting and Wanting': older peoples' initial experiences of adapting to life in a care home: a grounded theory study. *Ageing & Society*, *42*(2), 351-375.
Ormerod, R. (2006). The history and ideas of pragmatism. *Journal of the Operational Research Society*, *57*, 892-909.
OSCR. (2022). *Who we are*. Retrieved 15.11.2022 from https://www.oscr.org.uk/about-oscr/who-we-are/
Östlund, U., Kidd, L., Wengström, Y., & Rowa-Dewar, N. (2011). Combining qualitative and quantitative research within mixed method research designs: a methodological review. *International journal of nursing studies*, *48*(3), 369-383.
Paige, C., Dodds, C., & Jones, C. (2021). Mental health and well-being of LGBT+ Veterans dismissed from the British Armed Forces before January 2000. *Journal of Military, Veteran and Family Health*, *7*(S1), 122-126.
Pannell, J. A., Hannah; Kenway, Peter (2012). *Market Assessment of Housing Options for Older People*. https://npi.org.uk/files/5213/7485/1289/Market_Assessment_of_Housing_Options_for_Older_People.pdf
Pelto, P. J. (2015). What is so new about mixed methods? *Qualitative Health Research*, *25*(6), 734-745.
Pietrzak, R. H., Tsai, J., Kirwin, P. D., & Southwick, S. M. (2014). Successful aging among older veterans in the United States. *The American journal of geriatric psychiatry*, *22*(6), 551-563.
Popay, J., Roberts, H., Sowden, A., Petticrew, M., Arai, L., Rodgers, M., Britten, N., Roen, K., & Duffy, S. (2006). Guidance on the conduct of narrative synthesis in systematic reviews. *A product from the ESRC methods programme Version*, *1*(1), b92.
Pracht, E. E., Levy, C. R., Williams, A., Alemi, F., & Williams, A. E. (2016). The VA medical foster home program, ambulatory care sensitive conditions, and avoidable hospitalizations. *American Journal of Medical Quality*, *31*(6), 536-540.
Presbyterian Support Central. (2020). *Annual Report 2019/20*.

https://www.psc.org.nz/wp-content/uploads/200910_PSC_-Annual-Report-web-version.pdf
Public Health England. (2014). *Everybody Active, Every Day - An evidence-based approach to physical activity*. London Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/374914/Framework_13.pdf
Randles, R., & Finnegan, A. (2022). Veteran help-seeking behaviour for mental health issues: a systematic review. *BMJ Mil Health*, *168*(1), 99-104.
Reed, J., Cook, G., Sullivan, A., & Burridge, C. (2003). Making a move: Care-home residents' experiences of relocation. *Ageing & Society*, *23*(2), 225-241.
Reed, J., Payton, V. R., & Bond, S. (1998). The importance of place for older people moving into care homes. *Social Science & Medicine*, *46*(7), 859-867.
Reeves, S., Kuper, A., & Hodges, B. D. (2008). Qualitative research methodologies: ethnography. *BMJ*, *337*.
Repper, J., Aldridge, B., Gilfoyle, S., Gillard, S., Perkins, R., & Rennison, J. (2013). *Peer support workers: Theory and practice*. Centre for Mental Health London.
Rhead, R., MacManus, D., Jones, M., Greenberg, N., Fear, N. T., & Goodwin, L. (2022). Mental health disorders and alcohol misuse among UK military veterans and the general population: a comparison study. *Psychological medicine*, *52*(2), 292-302.
Richardson, G., Cleary, R., & Usher, R. (2022). The impact of the COVID-19 restrictions on nursing home residents: An occupational perspective. *Journal of Occupational Science*, *29*(3), 386-401.
Ritchie, J., Lewis, J., Nicholls, C. M., & Ormston, R. (2013). *Qualitative research practice: A guide for social science students and researchers*. sage.
Robbins, I., Gordon, A., Dyas, J., Logan, P., & Gladman, J. (2013). Explaining the barriers to and tensions in delivering effective healthcare in UK care homes: a qualitative study. *BMJ Open*, *3*(7), e003178.
Robinson, D., Green, S., & Wilson, I. (2020). Housing options for older people in a reimagined housing system: A case study from England. *International Journal of Housing Policy*, *20*(3), 344-366.
Roccas, S., & Brewer, M. B. (2002). Social identity complexity. *Personality and social psychology review*, *6*(2), 88-106.
Rogers, W. A., Ramadhani, W. A., & Harris, M. T. (2020). Defining Aging in Place: The Intersectionality of Space, Person, and Time. *Innovation in aging*, *4*(4), igaa036-igaa036. https://doi.org/10.1093/geroni/igaa036
Rorty, R. (1999). *Philosophy and social hope*. Penguin UK.
Rowe, J. W., & Kahn, R. L. (1987). Human aging: usual and successful. *Science*, *237*(4811), 143-149.
Rowe, J. W., & Kahn, R. L. (1997). Successful aging. *The gerontologist*, *37*(4), 433-440.
Rowe, J. W., & Kahn, R. L. (2015). Successful Aging 2.0: Conceptual Expansions for the 21st Century. *The journals of gerontology. Series B, Psychological sciences and social sciences*, *70*(4), 593-596. https://doi.org/10.1093/geronb/gbv025
Royal British Legion. (2022). *Our care homes*. Retrieved 20.12.2022 from https://www.britishlegion.org.uk/get-support/care-and-independent-living/our-care-homes
Royal British Legion. (2014). *A UK Household Survey of the Ex-Service Community*. https://www.britishlegion.org.uk/get-involved/things-to-do/campaigns-policy-

and-research/policy-and-research/the-uk-ex-service-community-a-household-survey
Royal College of General Practitioners. (2023b). *Veteran Friendly Accredited GP Practices*. https://elearning.rcgp.org.uk/mod/book/view.php?id=12533&chapterid=285
Royal Horticultural Society. (2023). *RHS Chelsea Flower Show 2023*. Retrieved 09.06.2023 from https://www.rhs.org.uk/shows-events/rhs-chelsea-flower-show
Severinsen, C., Breheny, M., & Stephens, C. (2016). Ageing in unsuitable places. *Housing Studies*, *31*(6), 714-728.
Shamai, S. (1991). Sense of place: An empirical measurement. *Geoforum*, *22*(3), 347-358.
Shan, Y. (2022). Philosophical foundations of mixed methods research. *Philosophy Compass*, *17*(1), e12804.
Sharma, G. (2017). Pros and cons of different sampling techniques. *International journal of applied research*, *3*(7), 749-752.
Siebold, G. L. (2007). The essence of military group cohesion. *Armed forces & society*, *33*(2), 286-295.
Sixsmith, A., & Sixsmith, J. (2008). Ageing in Place in the United Kingdom. *Ageing international*, *32*(3), 219-235. https://doi.org/10.1007/s12126-008-9019-y
Sixsmith, J., Fang, M. L., Woolrych, R., Canham, S. L., Battersby, L., & Sixsmith, A. (2017). Ageing well in the right place: partnership working with older people. *Working with older people (Brighton, England)*, *21*(1), 40-48. https://doi.org/10.1108/WWOP-01-2017-0001
Skevington, S. M., Lotfy, M., & O'Connell, K. A. (2004). The World Health Organization's WHOQOL-BREF quality of life assessment: psychometric properties and results of the international field trial. A report from the WHOQOL group. *Quality of life Research*, *13*, 299-310.
Slettebø, Å. (2008). Safe, but lonely: Living in a nursing home. *Vård i Norden*, *28*(1), 22-25.
Smeitink, M. M., Smaling, H. J., van Tol, L. S., Haaksma, M. L., Caljouw, M. A., & Achterberg, W. P. (2022). Activities for Residents of Dutch Nursing Homes during the COVID-19 Pandemic: A Qualitative Study. *International Journal of Environmental Research and Public Health*, *19*(9), 5465.
Smith, N., Towers, A.-M., Palmer, S., Beecham, J., & Welch, E. (2018). Being occupied: supporting 'meaningful activity' in care homes for older people in England. *Ageing & Society*, *38*(11), 2218-2240.
Snilstveit, B., Oliver, S., & Vojtkova, M. (2012). Narrative approaches to systematic review and synthesis of evidence for international development policy and practice. *Journal of development effectiveness*, *4*(3), 409-429.
Spiro, A., Settersten, R. A., & Aldwin, C. M. (2016). Long-term outcomes of military service in aging and the life course: A positive re-envisioning. *The gerontologist*, *56*(1), 5-13. https://doi.org/10.1093/geront/gnv093
Stathi, A., Greaves, C. J., Thompson, J. L., Withall, J., Ladlow, P., Taylor, G., Medina-Lara, A., Snowsill, T., Gray, S., & Green, C. (2022). Effect of a physical activity and behaviour maintenance programme on functional mobility decline in older adults: the REACT (Retirement in Action) randomised controlled trial. *The Lancet Public Health*, *7*(4), e316-e326.
Steven, A., Wilson, G., Turunen, H., Vizcaya-Moreno, M. F., Azimirad, M., Kakurel, J., Porras, J., Tella, S., Pérez-Cañaveras, R., Sasso, L., Aleo, G., Myhre, K.,

Ringstad, Ø., Sara-Aho, A., Scott, M., & Pearson, P. (2020). Critical Incident Techniques and Reflection in Nursing and Health Professions Education: Systematic Narrative Review. *Nurse educator*, *45*(6), E57-E61. https://doi.org/10.1097/NNE.0000000000000796
Sundin, J., Forbes, H., Fear, N. T., Dandeker, C., & Wessely, S. (2011). The impact of the conflicts of Iraq and Afghanistan: a UK perspective. *International Review of Psychiatry*, *23*(2), 153-159.
Tajfel, H. (1978). Social categorization, social identity and social comparison. *Differentiation between social group*, 61-76.
Tammes, P., Payne, R. A., Salisbury, C., Chalder, M., Purdy, S., & Morris, R. W. (2019). The impact of a named GP scheme on continuity of care and emergency hospital admission: a cohort study among older patients in England, 2012-2016. *BMJ Open*, *9*(9), e029103. https://doi.org/10.1136/bmjopen-2019-029103
Tavel, P. (2008). Successful Ageing A Survey of the Most Important Theories. *Human Affairs*, *18*(2), 183-196.
The Almshouse Association. (2022). *What is an Almshouse?* Retrieved 20.12.2022 from https://www.almshouses.org/what-is-an-almshouse/
The Almshouse Association. (2022a). *Almshouses Today*. Retrieved 20.12.2022 from https://www.almshouses.org/almshouses-today/
The Care Inspectorate. (2022). *About Us*. The Care Inspectorate. Retrieved 15.11.2022 from https://www.careinspectorate.com/index.php/about-us
The NHS Constitution for England, (2011b). https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england
The Royal Cambridge Home. (2021). *About Us. What makes us different?* Retrieved 15.09.2021 from https://www.royalcambridgehome.org/about
The Royal Hospital Chelsea. (2021). *Royal Hospital Chelsea Account 2020-21*. https://www.chelsea-pensioners.co.uk/sites/default/files/rhcaccounts21.pdf
The Royal Hospital Chelsea. (2022a). *Annual Report and Consolidated Financial Statements for The Year Ended 31 March 2022*.
The Royal Hospital Chelsea. (2022b). *Eligibility & How to Apply*. Retrieved 11.12.2022 from https://www.chelsea-pensioners.co.uk/eligibility-how-apply
The Royal Hospital Chelsea. (2022c). *Our Welfare Team*. Retrieved 11.12.2022 from https://www.chelsea-pensioners.co.uk/our-welfare-team
The Royal Hospital Chelsea. (2022d). *Governance*. Retrieved 11.12.2022 from https://www.chelsea-pensioners.co.uk/governance
The Royal Hospital Chelsea. (2022e). *Our Medical Centre*. Retrieved 11.12.2022 from https://www.chelsea-pensioners.co.uk/our-medical-centre
The Royal Hospital Chelsea. (2022f). *Our Care Home*. Retrieved 11.12.2022 from https://www.chelsea-pensioners.co.uk/our-care-home
The Royal Hospital Chelsea. (2022g). *Annual Report and Consolidated Financial Statements for The Year Ended 31 March 2022*. 11.01.2023
The Royal Hospital Chelsea. (2023). *Tours at the Royal Hospital* Retrieved 09.06.2023 from https://www.chelsea-pensioners.co.uk/tours
The Royal Hospital Chelsea. (2022h). *About Us*. Retrieved 08.03.2022 from https://www.chelsea-pensioners.co.uk/about-the-rhc
The Royal Variety Charity. (2015). Brinsworth House - residential and nursing care for the entertainment industry. In T. R. V. Charity (Ed.).
Tivers, J. (1999). 'The home of the British Army': the iconic construction of military

defence landscapes. *Landscape Research*, *24*(3), 303-319.
Tracy, S. J. (2010). Qualitative quality: Eight “big-tent” criteria for excellent qualitative research. *Qualitative inquiry*, *16*(10), 837-851.
UK Government. (2019). *UK Medical Officers' Physical Activity Guidelines* Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/832868/uk-chief-medical-officers-physical-activity-guidelines.pdf
UK Government. (2022a). *Levelling up the United Kingdom* London: Her Majesty's Stationery Office Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1052706/Levelling_Up_WP_HRES.pdf
UK Government. (2022b). *LGBT Veterans Independent Review* Crown Copyright. Retrieved 07.03.2023 from https://www.gov.uk/government/organisations/lgbt-veterans-independent-review/about
UK Government. (2023, 16.05.2023). *Taskforce to transform older people's housing underway* https://www.gov.uk/government/news/taskforce-to-transform-older-peoples-housing-underway
United Nations. (2022). *Peace, dignity and equality on a healthy planet*. Retrieved 20.12.2022 from https://www.un.org/en/global-issues/population
United Nations Department of Economics and Social Affairs. (2020). *World Population Ageing 2020 Highlights: Living arrangements of older persons* https://www.un.org/development/desa/pd/content/WFP-2020-highlights-accelerating-action-ensure-universal-access-family-planning
US Department of Veteran Affairs. (2021). *Geriatrics and Extended Care: Residential Settings and Nursing Homes*. US Department of Veterans Affairs Retrieved 14.12.2021 from https://www.va.gov/GERIATRICS/pages/Nursing_Home_and_Residential_Services.asp
Vespa, J. E. (2020). Those who served: America’s veterans from World War II to the War on Terror. *World War II (December 1941 to December 1946)*, *485*(463), 22.
Veterans Affairs Canada. (2020). *Facts and Figures Summary December 2020 Edition*. Retrieved 08.12.2021 from https://www.veterans.gc.ca/eng/about-vac/news-media/facts-figures/summary
Vickers, E. (2015). Queen and country: Same-sex desire in the British Armed Forces, 1939-45. *Queen and country*, 1-208.
Wales, C. C. f. E. a. (2022). *About Us*. UK Government Retrieved 15.11.2022 from https://www.gov.uk/government/organisations/charity-commission/about
Walker, H., & Paliadelis, P. (2016). Older peoples’ experiences of living in a residential aged care facility in Australia. *Australasian Journal on Ageing*, *35*(3), E6-E10.
Wang, Z., Zheng, Y., Ruan, H., Li, L., Duan, L., & He, S. (2023). Association between social activity frequency and overall survival in older people: results from the Chinese Longitudinal Healthy Longevity Survey (CLHLS). *Journal of Epidemiology and Community Health*, jech-2022-219791. https://doi.org/10.1136/jech-2022-219791
Watts, G., & Wilkinson, E. (2020). What the NHS is learning from the British army in the covid-19 crisis. *BMJ*, *369*.
Webster, M. (2022). *Hospital: noun*. Retrieved 15.12.2022 from

https://www.merriam-webster.com/dictionary/hospital
Weir, B., Cunningham, M., Abraham, L., & Allanson-Oddy, C. (2019). Military veteran engagement with mental health and well-being services: A qualitative study of the role of the peer support worker. *Journal of Mental Health*, *28*(6), 647-653.
Williamson, V., Greenberg, N., & Stevelink, S. A. (2019a). Perceived stigma and barriers to care in UK Armed Forces personnel and veterans with and without probable mental disorders. *BMC psychology*, *7*, 1-7.
Williamson, V., Harwood, H., Greenberg, K., Stevelink, S. A., & Greenberg, N. (2019b). Impact of military service on physical health later in life: a qualitative study of geriatric UK veterans and non-veterans. *BMJ Open*, *9*(7), e028189.
Wong, P.-H., Kourtit, K., & Nijkamp, P. (2021). The ideal neighbourhoods of successful ageing: A machine learning approach. *Health & Place*, *72*, 102704.
Wood, N. (2016). *The Military Human: Understanding Military Culture & Transition Continuing Professional Development Impact Report October 2015 to June 2016*. https://www.yorksj.ac.uk/media/content-assets/professional/documents/Military-Human-CPD-Impact-Report-Final.pdf
Woodhead, C., Rona, R. J., Iversen, A. C., MacManus, D., Hotopf, M., Dean, K., McManus, S., Meltzer, H., Brugha, T., & Jenkins, R. (2011). Health of national service veterans: an analysis of a community-based sample using data from the 2007 Adult Psychiatric Morbidity Survey of England. *Social Psychiatry and Psychiatric Epidemiology*, *46*, 559-566.
World Health Organization. (1996). *WHOQOL-BREF: introduction, administration, scoring and generic version of the assessment: field trial version, December 1996*.
World Health Organization. (2004). *A glossary of terms for community health care and services for older persons*. WHO.
World Health Organization. (2021). *World Health Statistics 2021: Monitoring Health for the SDGs, Sustainable Development Goals*. https://apps.who.int/iris/bitstream/handle/10665/342703/9789240027053-eng.pdf?sequence=1&isAllowed=y
World Health Organization. (2022a). *Ageing and Health*. Retrieved 14.12.2022 from https://www.who.int/news-room/fact-sheets/detail/ageing-and-health
World Health Organization. (2022b). *Hospitals*. Retrieved 15.12.2022 from https://www.who.int/health-topics/hospitals#tab=tab_1
World Veterans Federation. (2021). *Members*. Retrieved 15.01.2021 from https://theworldveterans.org/
Wu, L.-F. (2002). Predictive factors of self-care capacity in veterans' care institution residents. *Journal of Nursing Research*, *10*(3), 195-204.
Wynn, T., & Wynn, S. (2019). A History of the Royal Hospital Chelsea 1682-2017: The Warriors' Repose. *A History of the Royal Hospital Chelsea 1682-2017*, 1-208.
Yamada, A.-M., Atuel, H. R., & Weiss, E. L. (2013). Military culture and multicultural diversity among military service members: Implications for mental health providers. In *Handbook of multicultural mental health* (pp. 389-410). Elsevier.