Arsyllfa **Wledig** Cymru
Wales **Rural** Observatory

Older People and Place in Wales: demography, policy and community

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1.1) Outline of the research

The following research project was undertaken in response to the interest that the Welsh Government has shown in the experiences of older people as a particular demographic group in Wales. The aim of this project was to examine the experiences of older people living in different kinds of places in Wales. In particular, the focus was on comparing the experiences of older people living in urban, rural, valley and coastal places in Wales, and to explore what effect living in these different kinds of places may have on the experiences of older people.

1.2) Exploring the experiences of older people

For the purposes of this project, we follow the advice of Plane and Jurjevich (2009) and Warnes and William, (2006) that research on older people focus on those over the age of 50, and have taken 55 as our marker. The study was carried out using a combination of statistical survey analysis and case study analysis of the experiences of older people in the four different kinds of places. Therefore we drew together an analysis of changes in the responses of older people to the WRO household survey in 2004, 2007 and 2010/11, and carried out interviews with older people living in seven case study sites in Wales, and interviews with key personnel in the community, voluntary and statutory sector in these different areas. The project could therefore track changes in the experiences of older people over time, and compare the experiences of older people living in different places in a way that was sensitive to the kind of place they were living in, and the activities and resources put in place by local stakeholder groups.

1.2) Selecting case study communities

The case study sites were selected both to represent different kinds of places, and to build on knowledge and contacts that the research team had already developed in particular places. The two rural case study sites (Raglan (Monmouthshire) and Rhayader (Powys)) and one coastal site (Llanarth, Ceredigion) were selected as places the research team had visited and worked in as part of a recent ESRC research project. A second coastal site was selected for its coastal location, the prevalence of Welsh speakers in the area, and to build on knowledge already developed as part of the WRO's Deep Rural Localities research project. The two urban and the valleys case study areas had not been researched before by the research team. One of the urban case study areas (Sketty in Swansea) was selected to represent a combination of relative wealth (although it is also home to a deprived ward) and the number of residential and extra care facilities in the area. The second urban area was selected to represent a greater degree of deprivation and as a place in which a large proportion of the population were over retirement age. Finally, the valleys case study area (Mountain Ash, Rhondda Cynon Taff) was again selected in light of the large proportion of the population over retirement age, but also as an area that combined deprived with less deprived wards.

1.3) Structure of the report

This report is divided into four main sections. First, we describe the places included in the research project, and the methods used to conduct the research. This is followed by an analysis of the older people included in three waves of the WRO household surveys. This statistical analysis provides insight into

changing experiences of older people with respect of their household composition, welfare and wellbeing and quality of life. Chapter 4 provides an analysis of interviews carried out with those involved in developing or implementing policy around older people. As such, it both reveals the variety of change processes that are underway in contemporary policy in Wales, and focuses more specifically on the recent turn to the prevention and wellbeing agenda. Chapter 5 presents an analysis of interviews carried out with older people living in the different case study places. The focus here is on how older people perceive the place in which they live, and their connection with place and community. The final section presents conclusions and offers some suggestions for improving the welfare and wellbeing of older people living in different places in Wales.

2.1) Outline

There were three components to this research project. First, three waves of the household survey carried out for the WRO in 2004, 2007 and 2010/11 were analysed for the effect of age on changing experiences. Second, following from the analysis of the surveys, a series of in-depth semi-structured interviews were carried out with people involved in activities and services for older people in the case study areas. These interviews were then followed by a series of semi-structured interviews with individuals and some groups of older people living in each of the case study sites.

2.2) Utilising three waves of the WRO household survey

The survey of households in rural Wales that was undertaken for the WRO in 2004, 2007 and 2010/11 and which looked in detail at issues of population and migration, community, wellbeing and welfare, local services, employment, and the environment provided a useful basis for a longitudinal analysis of the changing experiences among older people. Whilst these surveys focused on rural places, they did include some interviews with people living in urban areas and, given that over half of the head of households surveyed were themselves over 55, then the data could be analysed both in terms of age range and place of residence. Thus it is possible to explore the changing experiences of older people in Wales as those over the age of 55 compared with the younger 16-54 age group, and in terms of various older age groups in relation to nationality, community, household composition and so on. In addition, given that the data can be further divided in terms of place of residence, we can look in more detail at differences in the experiences of older people living in different counties and place classifications in Wales. A number of changing experiences were identified and are outlined in chapter 3. Thus, unless otherwise stated, all survey data is based on the WRO household surveys of 2004, 2007 and 2010.

2.3) Qualitative interviews

The interview study was designed to gather insights into the places in which older people were living, and the experiences of older people in these places. These data sets were composed of interviews with people involved in some way in delivering services or coordinating activities that impact on the welfare and wellbeing of older people in the case study areas, and interviews with older people living in these places.

As table 2.1 shows, interviews were conducted with representatives from a number of different types of organisations in the various study areas. A large number of interviews were carried out with representatives of the community and voluntary sector in each area, these included representatives of local branches of Communities First, managers of care homes and a meals on wheels service, coordinator's of a lunch club, a 50+ forum and community development workers. Interviews with council officers and council representatives were focused on directors of social services, and the councillor with cabinet responsibility for adult social services, but also included two older people strategy coordinators. Scoping interviews were carried out with leaders of the local community council or key local councillors and functioned both to gather

information and insights about older people in the area, and to introduce the project to key stakeholders. Finally, the Age Concern interviews included interviews with directors of these organisations, and also with local activities coordinators.

Table 2.1 List of service and policy interviews undertaken

Main affiliation	Number of interviews
Age concern	6
Local community or voluntary sector	12
Council officer	6
Council representative	7
Scoping interviews	8

In addition to the service and policy interviews, 60 interviews were carried out with 86 older residents of the seven case study areas. These interviews were carried out at a time and place that was convenient to the older people themselves, and so the vast majority were carried out in interviewees' own homes thereby frequently including a friend, sibling or partner.[1] A number of group interviews were carried out in two care homes (a residential care and an Extracare facility), a church hall, a day centre and a library.

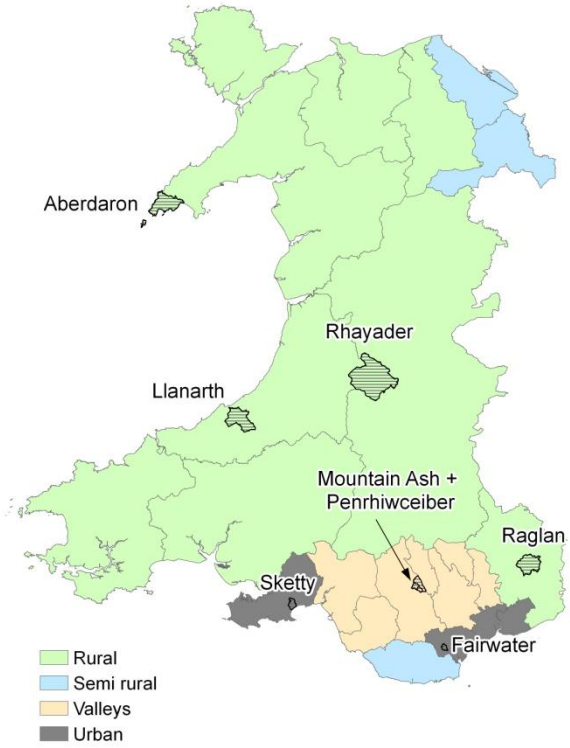
Table 2.2 List of interviews with older people undertaken

Place	Number of interviews	Number of people
Aberdaron	14	16
Llanarth	8	10
Rhayader	9	11
Raglan	7	8
Mountain Ash/ Penrhiwceiber	8	15
Sketty	7	18
Fairwater/Pentrebane	7	8

The interviews were conducted using a semi-structure format which ensured that certain themes were addressed. These interviews ranged from 50 to 75 minutes in length and though interviewees were offered the opportunity to conduct the interview through the Welsh language, none of those took up this offer and all interviews were conducted in English. All of the interviews were imported into Nvivo (a qualitative data analysis software package) where they were fully coded and emergent themes were analysed.

[1] Joint interviewing is an established social research method in which a researcher interviews two respondents. Frequently used when interviewing family members, this method runs the risk of focusing on the more talkative partner. In this study, it was found to be a useful way of gathering information as participants fill in each other's memory gaps, and provided a space in which partners could discuss their different views of the same topic.

Figure 2.1: Map of case study locations



3.1) Introduction

This chapter draws on three rural household surveys conducted by the Wales Rural Observatory (WRO) in 2004, 2007 and 2010-11, respectively, in order to consider changes in the situation and experiences of older rural residents over this period.

Data was collected through telephone surveys conducted with households across rural Wales in which respondents were asked to provide information about themselves, their household and other individuals who lived within the household. The respective survey samples were designed to provide coverage of all rural settlement types and amount to a proportional representation of the nine predominantly rural local authorities in Wales. This chapter focuses on the information provided by survey respondents who were aged 55 and above, and therefore classified as 'older'. This broad age bracket of older people is further disaggregated through analysis of the survey results into the categories of 55-64, 65-74 and 75+ in order to provide a more refined understanding of the different experiences of older residents.

This chapter will focus on the responses to those survey questions of particular relevance to older rural residents and will accordingly be structured around a number of key themes: locality and demographics; household structure; well-being and welfare; and quality of life factors including rural service provision and community. Despite some minor changes in the question design and structure between the three surveys, the cumulative results provide longitudinal data that enables comparison and the identification of changes in older rural households over the seven-year study period.

3.2) Demography and Patterns of Residence

(i) Age profile

Considerable proportions of the respondents to the three WRO rural household surveys were older people: 43% of the 2004 survey, 48% of the 2007 survey and 51% of the 2010 survey were aged 55 and over (see table 3.1).[2]

Table 3.1: Age profile of respondents across the three household surveys

	2004	2007	2010
16-54	57	52	48
55+	43	48	51
55-64	22	25	24
65-74	15	15	19
75+	6	8	9

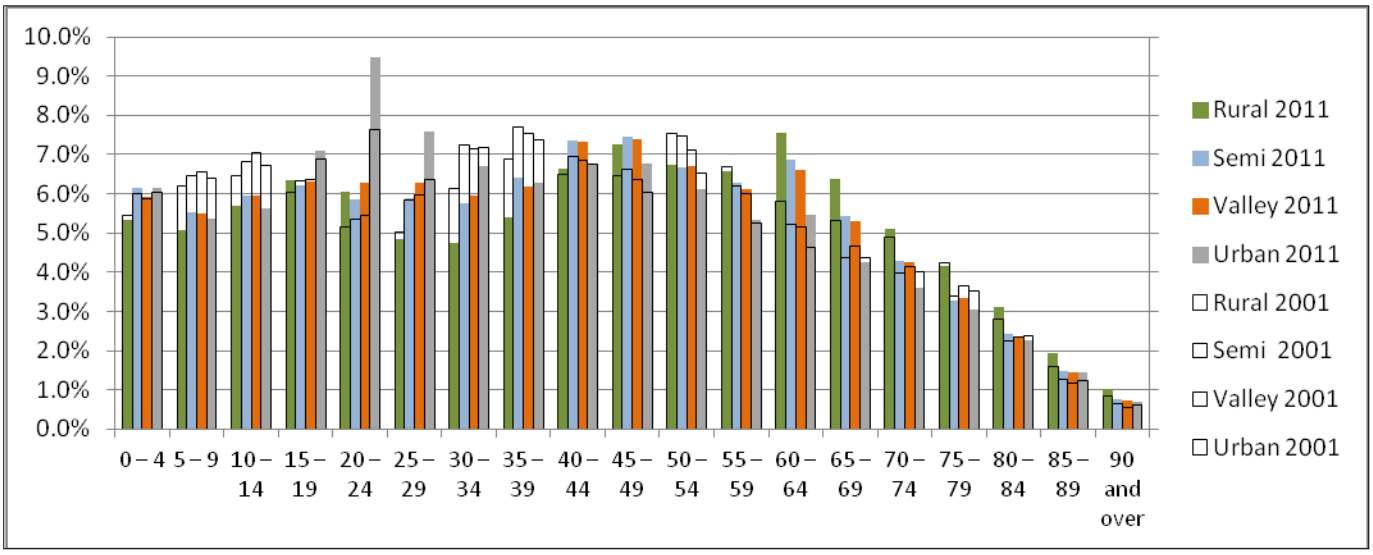
As Table 3.1 illustrates, the overall proportion of the Household Survey respondents who are over 55 has increased over the three successive waves. Within this overall increase, the proportion of respondents aged 55-64 has remained largely stable, whilst there has been an increase in the proportionate size of the 65-74 and 75+ age groups. This shift to a slightly older demographic composition of the household surveys was deliberately designed to reflect the changing demographic composition of rural Wales as revealed in the 2011 census.

The trend towards an ageing population in Wales in general and in rural areas particularly is supported by the release of the 2011 Census data. As illustrated in Figure 3.1,

[2] All figures have been rounded to the nearest decimal place

comparing data from the 2001 and 2011 Censuses has shown an increasing proportion of residents in older age categories and a corresponding decline in younger age categories (although slight increases in the under-fives in some parts of Wales reflects increasing fertility rates). This increase in older cohorts is particularly pronounced amongst the 60-64 and 65-69 age groups, as the post-war baby-boom generation reaches retirement.

Figure 3.1: Age comparison of Wales's population in the 2001 & 2011 Census (Local Authority Analysis)



Source: Census, 2001 and 2011

(ii) Housing tenure

In terms of household tenure, the results reveal a slight decline in rates of outright home ownership among all of the age categories since 2007 with the exception of those over 75, amongst whom the proportion of those who owned their own home outright had increased dramatically in the successive surveys. As has been noted in previous studies, those in the upper age bands were more likely to own their own home without a mortgage. However, what is notable is how there had been an increase in the proportion of those in the 55-64 age group who were buying their home with a mortgage.

A number of different factors could be at play here, including the impacts of recession on savings and pension schemes meaning that those coming into this age category and approaching retirement are comparatively less able to fully pay-off mortgages over a given time-period like previous generations. Furthermore, low interest rates in recent years may also have encouraged some respondents to extend the period over which they pay-off their mortgage, or to take-on new/additional mortgage burdens in order to purchase properties.

Table 3.2: Household tenure by age

	16-54			55-64		
	2004	2007	2010	2004	2007	2010
	%	%	%	%	%	%
Owned outright	20	25	24	62	62	61
Being bought with a mortgage	58	54	55	23	24	26
Rented from a local authority	6	5	4	7	5	5
Rented from a housing association	3	4	3	1	3	3
Rented from a private landlord	10	9	11	5	5	4
	65-74			**75+**		
	2004	2007	2010	2004	2007	2010
	%	%	%	%	%	%
Owned outright	80	82	80	76	81	86
Being bought with a mortgage	8	6	7	5	4	3
Rented from a local authority	5	5	5	10	7	4
Rented from a housing association	2	2	4	2	2	3
Rented from a private landlord	3	3	3	5	5	2

(iii) Length of residence

Overall, the surveys show considerable population stability in rural Wales, with decreasing overall proportions living in their residence for up to five years, and increasing proportions living in their residence between six and 20 and more than 20 years. As Table 3.3 below attests to, there was a slight variation in the way the question about length of residence was posed in 2004, which means that the 2004 survey is not directly comparable with the 2007 and 2010 surveys.

Table 3.3: Length of residence by age

Length of Residence	Survey	All	16 - 54	55+	55 – 64	65 - 74	75 +
		%	%	%	%	%	%
Less than 5	2004	36	45	24	29	21	16
1 to 5	2007	28	38	18	21	15	12
1 to 5	2010	21	32	12	14	10	9
More than 5 less than 20	2004	39	43	34	35	33	34
6 to 20	2007	44	49	38	39	39	35
6 to 20	2010	46	53	40	42	40	35
20+	2004	25	12	42	37	47	49
21+	2007	28	13	44	40	46	54
21+	2010	32	15	49	44	50	56

Table 3.3 provides an analysis of the proportion of people across the three older age categories by length of residence. First, we can see that nearly a quarter of those who were cumulatively aged over 55 and interviewed for the 2004 survey had lived in their property for less than five years, while nearly 42% had spent over 20 years in this place of residence. In the 2010 survey, just 12% had spent less than five years in this place of residence, whereas 49% had spent over 20 years. The older population were therefore considerably more likely than the 16-54 age group to have a longer residency in an area. When we look across the age groups we see that all three older age groups were less likely to remain in place for less than five years in the 2007 and again in the 2010 surveys. Thus regardless of their age group, the older people included in these surveys were increasingly likely to live in their residence for longer periods.

(iv) Place of residence

The migration of older people to rural areas is associated with a large distance move to better amenities, to proximity to kin or a return migration to a place the individual had some relationship with earlier in their lives. Looking at fluctuations in where older people are living over the three survey waves in Table 3.4, we can get a sense of the type of place where older people are moving to, or remain living in:

Table 3.4: Place of residence by age

	Survey	All	16-54	55+	55-64	65-74	75+
		%	%	%	%	%	%
Town or city	2004	34	36	31	28	34	34
	2007	38	39	37	36	36	44
	2010	35	39	32	32	29	40
		%	%	%	%	%	%
Large or small village	2004	48	48	48	47	48	51
	2007	49	49	49	49	51	46
	2010	49	45	52	50	54	49
		%	%	%	%	%	%
Hamlet or open countryside	2004	18	16	21	25	18	15
	2007	13	12	14	14	14	10
	2010	16	16	16	18	16	11

Around half of all age groups tended to live in a large or small village across the three survey waves; within older age groups, there were small increases in the proportion of 55-64 and 65-74 year olds within this category of residence over the study period. Whereas, there were more noticeable age-related variations in regards to other places of residence, with members of the 75+ age group more likely to live in a town or city than 'younger' categories of older people due to the increasing service and support requirements associated with older age. A concurrently smaller proportion of this 75+ age group lived in a hamlet or open countryside compared with all other age groups.

At the same time, the proportion of all respondents living in a hamlet or open countryside decreased considerably from 2004 to 2007, before a slight rise again in

2010. This trend was particularly marked among the over 55s, particularly the 55-64 age group, although could in part be related to changes in the classification of rural Wales used in the respective surveys; from being county-based in the 2004 survey, to the ward-based classification adopted in the subsequent surveys in line with the Rural Development Plan for Wales 2007-2013.

(v) National identity

While the distribution of people declaring their national identity as Welsh, English and British remained relatively stable over the three surveys, with Welsh identification remaining strongest with the younger age groups, whilst around 50% of respondents aged 55 and over consistently identified themselves as English or British. This is likely indicative of some of these older individuals having moved into rural areas of Wales for retirement purposes.

The English identity was the most unsettled national identification across the survey waves; dropping from 15% to 14% before rising again to 17% amongst all survey respondents. This trend was more pronounced amongst the over 55s, with a 3% drop in the proportion of older respondents claiming English as their national identity from 2004 to 2007. Disaggregating this data further for the older age categories, there were particularly noticeable changes in the proportion identifying themselves as English within the 65-74 and 75+ age groups. Amongst the 65-74 age group, for example, English self-identification declined by 5% from 2004 to 2007, before increasing by 8% from 2007 to 2010.

Table 3.5: National Identity by Age

		All	16-54	55+	55-64	65-74	75+
		%	%	%	%	%	%
2004	Welsh	53	56	50	50	50	48
	English	15	13	18	17	20	21
	British	31	31	32	33	31	31
		%	%	%	%	%	%
2007	Welsh	54	59	50	51	50	47
	English	14	12	15	15	15	16
	British	32	29	35	34	36	38
		%	%	%	%	%	%
2010	Welsh	53	58	49	52	44	51
	English	17	13	20	17	23	20
	British	30	29	31	31	32	29

3.3) Household composition

(i) Gender

When conducting the Household Survey by phone, the interviewer would have asked to conduct the survey with the head of household. As a result, the gender distribution of the survey respondents reflects only the gender of the person in this designated role. Table 3.6 therefore shows the proportions of respondents in each survey wave who were interviewed as the head of household by their gender. Interestingly, women were more likely to respond as head of household for all of the three older age groups in 2004, but only in one of the age groups (55-64) in 2010. The most pronounced gender imbalance was, however, in 2007, when around 15% more women than men were interviewed as head of household among the 55-64 and 65-74 age groups collectively. The role of head of household may, therefore, shift over time and among age groups.

Table 3.6: Gender of survey respondents

	2004		2007		2010	
	Male	**Female**	**Male**	**Female**	**Male**	**Female**
	%	%	%	%	%	%
55-64	49	51	43	57	46	54
65-74	49	51	42	58	51	49
75+	4	54	49	51	50	50

(ii) Household size

In terms of household size, the three surveys demonstrate how older households are far more likely to be single or two person households in comparison with younger age groups; over 85% of respondents aged 55+ lived in a one or two person household in all survey waves. As is to be expected, those who were aged 75+ were more likely to live by themselves across all years. At the same time, the evidence presented here does suggest that there have been slight variations in housing composition between surveys, with a slight increase in single person households in all age cumulative categories within the 2007 survey.

Table 3.7: Household Size by Age

	`	All	16 - 54	55+	55 - 64	65 - 74	75 +
		%	%	%	%	%	%
1	2004	24	15	37	29	37	62
	2007	25	14	37	27	41	64
	2010	24	12	35	25	36	60
2	2004	37	27	50	51	55	34
	2007	38	27	50	56	52	31
	2010	40	27	52	54	58	38
3+	2004	39	59	13	19	8	4
	2007	37	59	12	18	7	5
	2010	37	62	13	22	7	3

(iii) Cohabitation

The majority of two or more person households across the three survey waves were composed of people who were married or living as a couple. This trend was strongest amongst older age groups, with over 85% of the over 55s in each survey cohabiting in this manner (see table 3.8). Interestingly, the surveys suggest that older households have tended to become more inclined to live within, or perhaps – due to increasing life expectancies – remain living within, a marriage or partnership arrangement over the study period, reaching a peak of 94% amongst the 65-74 age group and 95% amongst the 75+ in the 2010 survey.

Table 3.8: Married/living as a couple by Age

	16 – 54	55 - 64	65 - 74	75 +
	%	%	%	%
2004	76	87	89	87
2007	79	89	93	86
2010	79	88	94	95

(iv) Changing household composition

Older age groups also lived in households characterised by a compositional stability, with larger proportions reporting that no one had moved out in the previous five years (Table 3.9). Interestingly, older people in the 65-74 and 75+ brackets were both less likely and increasingly unlikely to experience change in the composition of their household over the survey period, with the proportion of households where no-one had recently moved out highest for both of these groups in 2010.

This was in contrast with the 55-64 year old age group, who experience the greatest degree of household change; more so than for younger age groups, despite a noticeable drop in household stability amongst the 16-54 age group in 2010. From this it may be inferred that both older children leaving home and retirement transitions, including property downscaling, are contributory factors to household instability amongst 55-64 year olds.

Table 3.9: Households where no one had moved out in the previous 5 years

	16 – 54	55 - 64	65 – 74	75 or over
	%	%	%	%
2004	78	68	86	89
2007	79	67	86	91
2010	75	67	88	94

3.4) Wellbeing and Welfare

(i) Income

The extent of inequality of income between older and younger people has changed over the course of the three surveys as illustrated in Table 3.10, which shows the percentage of households in each income bracket that were occupied by older (55+) or younger (16-54) respondents across the survey waves.

Table 3.10: Household Income by Age

	16-54			55+		
	2004	2007	2010	2004	2007	2010
	%	%	%	%	%	%
Less than £100 per week / less than £5,000 per year	41	39	53	59	61	47
£100-199 / £5,000-£9999 per year	34	27	29	66	73	72
£200-299 / £10,000- £15,500 per year	51	39	37	49	61	63
£300-399 / £15,500-£21,000 per year	63	54	43	37	46	57
£400-£599 / £21,000- £31,000 per year	72	64	56	28	36	44
£600-£999 / £31,000-£52,000 per year	81	74	65	19	26	36
£1,000 a week or more / £52,000 or more per year	76	71	70	24	29	30

In 2004, 59% of households in the lowest household income bracket (<£100 per week) were occupied by older respondents aged 55+, and similarly older households made up 66% of those in the lowest but one income bracket (£100-199 per week). Whereas, at the other end of the income scale, older households accounted for less than 30% of those in each of the top three income brackets.

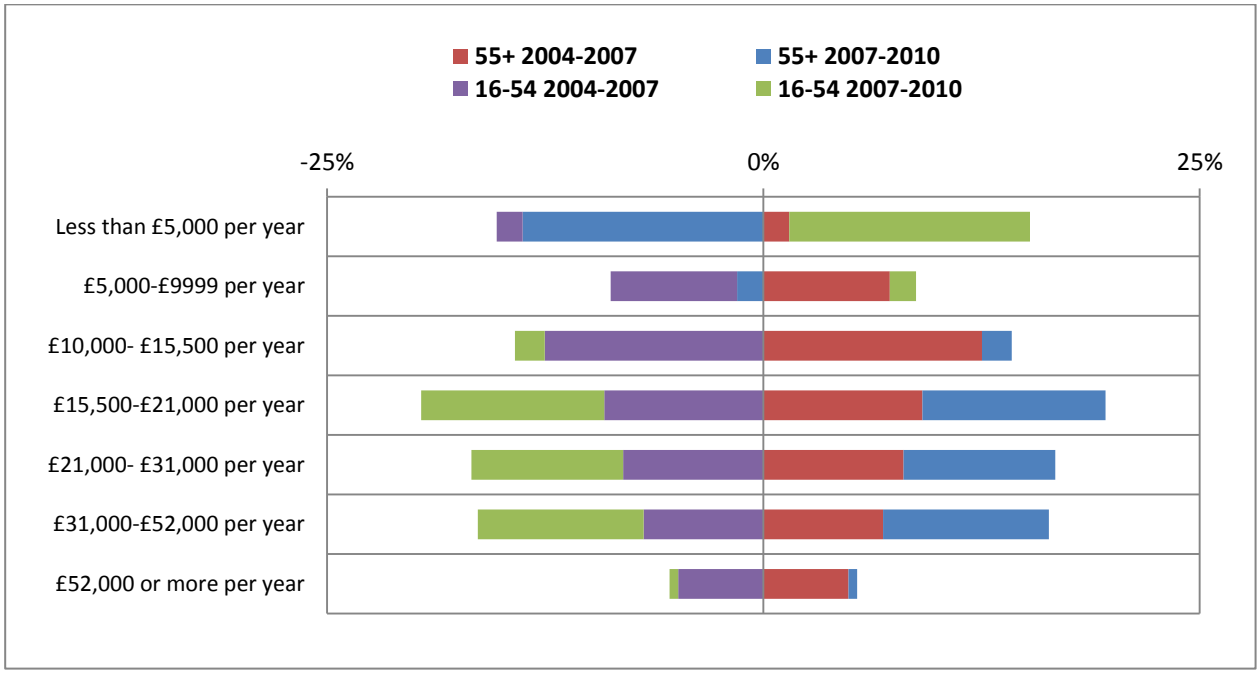
In 2007, the proportion of older households in lower income brackets increased compared to younger households, with 73% of households earning £100-199 per week now occupied by older residents and an increase from 49% to 61% older households in the £200-299 weekly income bracket. At the same time, there were small increases in the proportion of higher income households occupied by older residents, although these brackets remain skewed towards younger households.

By the 2010 survey some of these trends have shifted, with more equalisation of older and younger households in the lowest income brackets potentially as a result of the impacts of recession on working-age households. Older households do, however, continue to dominate in the £100-199 (72%) and £200-299 (63%) weekly income brackets. There have also been shifts towards greater equalisation in the middle income brackets of £300-399 and £400-599 over the course of the survey period, whilst the proportion of older households amongst those earning £600-999 per week also increased from 19% in 2004 to 36% in 2010. A number of different factors may be involved here, but it is reasonable to speculate that with the context of recession and changes to the statutory retirement age, people are continuing to work for longer. Therefore a greater number of older households will contain one or more wage-earners in the 2010 survey.

These changes in inequality of income between older and younger households may be better understood via the graphical representation in Figure 3.2 below. What this

illustrates is how rates of income among different groups changed over the course of the three surveys. First, the red and blue sections highlights how the income of the over 55s had seen positive change over the three surveys. There was a small increase in the proportion receiving an income of £5,000 per year in 2007 compared with 2004, and then a decrease in 2010 compared with 2007. Instead the rate of change was towards older people receiving higher incomes. The converse was true of younger age groups. Essentially, the surveys reveal that older people were reporting rising and younger people were reporting falling incomes during this period.

Figure 3.2: Changes in age-related Income Inequality, 2004-2010



3.5) Quality of life

(i) Attachment to place

When asked what it was that they liked about the area where they lived, respondents pointed to a range of attributes (see Table 3.11 below). Environmental factors, specifically 1) peace and quiet and 2) the scenery, were the most commonly cited factors in place contentment and attachment amongst all age groups; although more of the younger respondents (16-54) cited the former and older respondents (55+) the latter. The proportion of both older and younger residents citing peace and quiet did, however, fall from 2007 to 2010, indicating changing perceptions of the rural environment over time that may be linked to factors such as population and infrastructural change.

Regarding the location of their place of residence, the proximity to different types of features or services appeared more/less noteworthy for different groups of older people. For instance, in terms of proximity to specific natural features including mountains or the beach, the importance of this appeared to decline in older age with it being cited by 16% of 55-64 year olds and 11% of those aged 75+ in the 2010 survey. On the other hand, local facilities and amenities were recognised as important by more of those in the oldest (75+) age group throughout the three survey waves in comparison to all other age groups.

Table 3.11: Place Attachment Factors by Age

	16 – 54			55 - 64			65 –74			75+		
	2004	**2007**	**2010**	**2004**	**2007**	**2010**	**2004**	**2007**	**2010**	**2004**	**2007**	**2010**
	%	%	%	%	%	%	%	%	%	%	%	%
Environment: Peace and Quiet	40	55	49	38	52	50	37	52	48	26	45	34
Environment: The scenery	20	24	33	25	31	37	26	33	40	28	26	37
Environment: Good location	6	20	23	1	19	22	1	24	21	1	20	20
Environment: Pleasant environment	13	18	19	16	24	21	17	24	26	18	26	26
The location: Proximity to specific location (i.e. beach, countryside, mountains	6	10	16	6	11	16	5	11	15	7	12	11
The location: Local facilities/ amenities	9	10	15	8	11	16	13	9	16	16	11	19
The people/personal reasons: Community Spirit/ village life	11	9	17	8	8	16	11	9	15	13	12	14
The people/personal reasons: Friendly people and/ or neighbours	18	9	13	22	15	18	23	17	22	33	18	26
The people/personal reasons: It's where I am from	16	8	9	17	7	11	18	8	11	20	12	15

Neighbourliness was more frequently recognised as a factor in place attachment by those in the 75+ age group, and more generally amongst more older (55+) than younger (16-54) people across the three surveys. The consequence of this factor did vary over time, however, declining for all older age groups from a peak in 2004 to 2007 before increasing again in 2010 (although this may be related to variations in survey design). Whilst neighbourliness therefore appeared more important for older people in the 2010 survey, younger respondents (17% compared to 15% of the over 55s) cited community spirit/village life as a factor. This factor also appeared to decline with older age, from 16% amongst the 55-64 year olds to 14% amongst the over 75s in 2010, whilst place attachment based on actually coming from that place was strongest amongst the older age group (75+) for all three survey waves.

Overall, it appears that whilst most residents value the rural environment, different factors take on more or less importance during different stages of older age. Here, for example, those nearer to retirement appeared to value the proximity of outdoor attractions to a greater extent, whilst services and amenities take on increasing meaning as people grow older. Similarly, the importance of good neighbours, as opposed to necessarily a sense of wider community life, also increased with older age; this will be examined further in the next section.

(ii) Sense of community

The vast majority of respondents in all three surveys (77% in 2004, 78% in 2007 and in 2010) agreed that there was a sense of community in their local area. While the sense of community was felt across the age ranges, it was particularly keenly felt by older age groups who were more likely to agree strongly that "there is a sense of community in the place that I live" (Table 3.12).

Table 3.12: Proportion agreeing strongly that there is a sense of community in their place of residence

	16-54	55-64	65-74	75+	all	55+
	%	%	%	%	%	%
2010	41	47	50	54	45	50
2007	45	49	52	52	47	50
2004	40	49	55	57	45	52

This was a pattern that was repeated in other areas of community feeling, such as the sense of membership of the local community or the sense that people in the community look out for one another. That is, older people were more positive and more inclined to agree strongly with positive statements about living in their community. For instance, in each of the three surveys, appreciably more people who were over 55 at the time of the survey agreed strongly with the statement that "I definitely enjoy living in my community" than those in the 16-54 age group (2004 – 72% of 16-54 compared with 82% of 55+; 2007 – 67% of 16-54 compared with 75% of 55+; 2010 – 68% of 16-54 compared with 88% of 55+).

Interestingly, there had been an overall drop in the proportion of all respondents

who felt that the ability to speak Welsh was important for participating in the community (from 39% in 2004, to 34% in 2007 and 30% in 2010). Older age groups were only slightly more inclined to feel that Welsh was needed to participate in their community, but there had been a noteworthy drop in the proportion of people who were 75 and over who felt that Welsh was important in this way (agreed or strongly agreed) from around 38% in both 2004 and 2007 to 27% in 2010.

(iii) Ability to influence decision making

In terms of the survey respondents' perception that they could influence decisions that affect their local area, both the under and over 55 age groups followed the overall trend (for all age groups cumulatively) in their tendency to disagree that they could influence decisions. Overall, these negative responses remain relatively consistent, only dipping slightly in 2007 (51% in 2004; 46% in 2007 and 52% in 2010).

On the other hand, the surveys record considerable change in people's positive perception that they can influence decisions. 34% of all those asked in 2004 agreed or agreed strongly that they could influence decisions, compared with 39% in 2007 and 32% in 2010, and with those aged over 55 around 5% more inclined to feel they could influence decisions in all three surveys than those under 55. Within these changes in responses, age therefore only appeared to be a factor in relation to the interviewees' positive sense that they could influence decisions.

Focusing on respondents who *strongly agreed* with the statement only, for all age groups there was a 3% drop between the 2007 and 2010 surveys (Table 3.13). Upon breaking this data down by age, this drop that was mirrored in both the younger (16-54) and older (55+) age groups, but was most keenly felt within the older age range by respondents within the 55-64 bracket. Here strong agreement was appreciably lower in 2010 (8%) than in 2007 (14%), suggesting that those nearing retirement age have become increasingly less positive about being able to shape their community.

Table 3.13: Proportion strongly agreeing that I can influence decisions that affect this area

	16 - 54	55+	all	55 - 64	65 - 74	75+
	%	%	%	%	%	%
2010	6	10	8	8	10	14
2007	9	13	11	14	10	15
2004	9	13	11	14	13	12

(iv) Views on the quality of rural services

In all three household surveys, respondents were questioned about their perception of the quality of services, being asked to rate the provision of a range of local services as good, fair or poor. Table 3.14 shows the proportion of good or poor responses in each survey wave across all age ranges collectively. Of immediate note is the overall decline in the percentage of respondents who rated services in their place of residence as 'good' from 2004 to 2007. At the same time, only the post office and food shops

were rated poorer in 2007 compared with 2004, indicating a greater shift towards service provision being regarded as 'fair'.

By the 2010 survey there are signs of improvement in the perception of some rural services following the noted decline in 2007. Thus, the NHS, policing, public transport and food shops were rated 'good' by similar proportions of the 2010 respondents as in the 2004 survey, with a corresponding decline in the proportion of respondents also rating these services as 'poor'. This gives an overall impression that many rural services had declined in the period up to the 2007 survey, and while some had recovered somewhat in 2010, others like schools, post offices, banks and building societies and community centres have not returned to the satisfaction levels witnessed in the 2004 survey. At the same time, despite improvements in perception of policing and public transport, these remain the services receiving the lowest levels of public satisfaction with less than 45% of respondents rating them as 'good' in each of the three surveys.

Table 3.14: Perceptions of Rural Service Provision

	Good			Poor		
	2004	2007	2010	2004	2007	2010
	%	%	%	%	%	%
NHS	72	67	71	8	7	5
Policing	43	39	44	20	16	12
Public transport	40	36	40	29	25	23
Schools	81	67	73	3	2	3
Food shops	69	65	70	7	9	7
Post Office	82	76	77	4	5	5
Banks and building societies	73	64	67	9	9	9
Community centre	63	50	57	10	7	5
Leisure facilities	56	53	56	17	12	11

Leaving aside the less positive outlook captured in the 2007 survey and comparing the perceptions of respondents aged under and over 55, respectively, we see that as a group, older people were consistently more positive and less negative about local services. That is, a greater proportion of the over 55s rated all services as good (except for schools and leisure facilities in the 2007 and 2010 surveys), and were less inclined to rate services as poor (excepting policing in the 2004 survey and post offices in the 2010 survey). Moreover, 10% more of the over 55s rated the NHS as good than under 55s.

Comparing views across the age ranges in Table 3.15, we can see that the 55-64 age group are more closely aligned to the views of younger people in regards to rural services, whilst the 65-74 and over 75s groups more closely share views on service provision. A standout point of difference across the age groups is attitudes to public transport, with 36% of 16-54 year olds rating these services as 'good' in 2010 compared to 55% of those aged 75+, with positive attitudes dramatically increasing with age and greater potential usage of and reliance on public transport.

Table 3.15: Proportion of age groups rating rural services as 'good'

	16-54			55 - 64		
	2004	2007	2010	2004	2007	2010
	%	%	%	%	%	%
NHS services	66	62	66	77	69	72
Policing	41	39	43	42	36	45
Public transport	35	31	36	39	35	38
Schools	79	70	75	83	65	71
Food shops	65	61	68	71	66	68
Post Office	79	74	75	85	77	78
Banks and building societies	69	62	64	76	66	67
Community centre	57	48	56	70	52	57
Leisure facilities	53	54	58	57	57	54
	65-74			75+		
	%	%	%	%	%	%
NHS services	81	77	79	81	76	82
Policing	48	41	43	52	43	50
Public transport	54	45	46	56	54	55
Schools	87	64	70	89	58	71
Food shops	78	70	70	78	72	79
Post Office	88	78	78	92	83	84
Banks and building societies	80	66	70	84	69	72
Community centre	73	54	58	76	47	58
Leisure facilities	62	51	54	64	47	52

(v) Quality of life

The 2007 and 2010 household survey respondents were asked to rate their own quality of life; a question that was not asked in such a direct way to the 2004 respondents, and so data from the 2004 survey is not drawn on here. The question around this rating was posed in slightly different ways in the 2007 and 2010 surveys (Tables 3.16 and 3.17), but the responses were nonetheless interesting.

Table 3.16: 2007 survey - How would you rate your quality of life?

	16-54	55-59	60-64	65-74	75+	60+	Total
	%	%	%	%	%	%	%
Very good	57	62	63	66	65	65	60
Fairly good	36	31	29	28	28	28	33
Neither good nor bad	5	4	4	4	3	4	4
Fairly bad	2	2	2	1	3	2	2
Very bad	1	1	2	2	1	2	1
Don't know	0	0	0	0	0	0	0

Table 3.17: 2010 survey - If we were to define 'equality of life' as how you feel overall about your life, including your standard of living, your surroundings, friendships and how you feel day-to-day, how would you rate your quality of life? Would you say...?

	16-54	55-59	60-64	65-74	75+	60+	Total
	%	%	%	%	%	%	%
Very good	49	55	60	64	64	63	55
Fairly good	41	36	31	29	29	30	36%
Neither good nor bad	7	7	6	3	5	5	6
Fairly bad	2	2	2	2	1	2	2
Very bad	1	0	1	1	0	1	1
Don't know	0	0	0	0	0		0

Whereas in the 2007 survey, respondents were merely asked to rate their own quality of life, in the 2010 survey respondents were directed to think about their quality of life in specific contexts. What emerges is a general picture in which the 2007 respondents were more positive about their quality of life than the 2010 respondents (60% reported a very good quality of life in 2007, in contrast with 55% in the 2010 survey), whilst in 2010 there is a corresponding increase in respondents rating their quality of life as 'fairly good' as opposed to 'very'. Overall then, the 2010 respondents had a marginally poorer quality of life, with 1% fewer of the 2010 sample rating this as either fairly good or very good than in 2007.

Breaking down this data by age, however, reveals that it is younger age groups who are experiencing a more considerable drop in their perceived quality of life. Here the 16-54 age group were noticeably less inclined to state they had a very good quality of life in the 2010 survey than in the 2007 survey, whilst the cumulative proportion claiming either a very or fairly good quality of life fell by 2% between the surveys.

Directly comparing age groups in the 2010 survey, we can see more equalisation in the younger age group (16-54) between those rating their quality of life as very or fairly good; 49% for the former and 41% the latter. These figures move further apart in favour of 'very good' as age increases, to the point that 64% of those aged 75+ rated quality of life as very good compared to only 29% as fairly good. That said, the older age groups were still marginally less enthusiastic ('very good') about their quality of life in 2010 compared to 2007. In particular, the younger older (55-59 and 60-64 year olds) were reporting a slight drop in their quality of life in comparison with the older old.

3.6) Conclusions

This chapter has drawn on data from three rural household surveys (2004, 2007 and 2010) to consider changes in the situation and experiences of older rural residents over this period, and in comparison with younger age groups

Overall, the surveys are reflective of the general trend towards an ageing population in rural Wales as a result of both the in-migration of retirees (with higher levels of British and English national identity recorded amongst older age groups) and older people continue to age in place. This contributes towards a general sense of stability in terms of

population and residence patterns amongst older people across the survey waves. At the same time, there are variations across older age groups, with the heightened service and support requirements of 'older' old age likely encouraging a greater proportion of the 75+ age group to live closer to larger rural service centres. Another interesting trend to emerge across the surveys was an increasing propensity for people to remain living within marriage or partnership arrangements later into their older age, with increasing life expectancies but also policy shifts towards better supporting older people to live in their own homes as potential contributory factors here. The health and wellbeing benefits for older people to remain living in their own homes is supported in different ways by the survey data, with various facets of rural life including the natural environment, sense of community and rural services highly valued by older age groups.

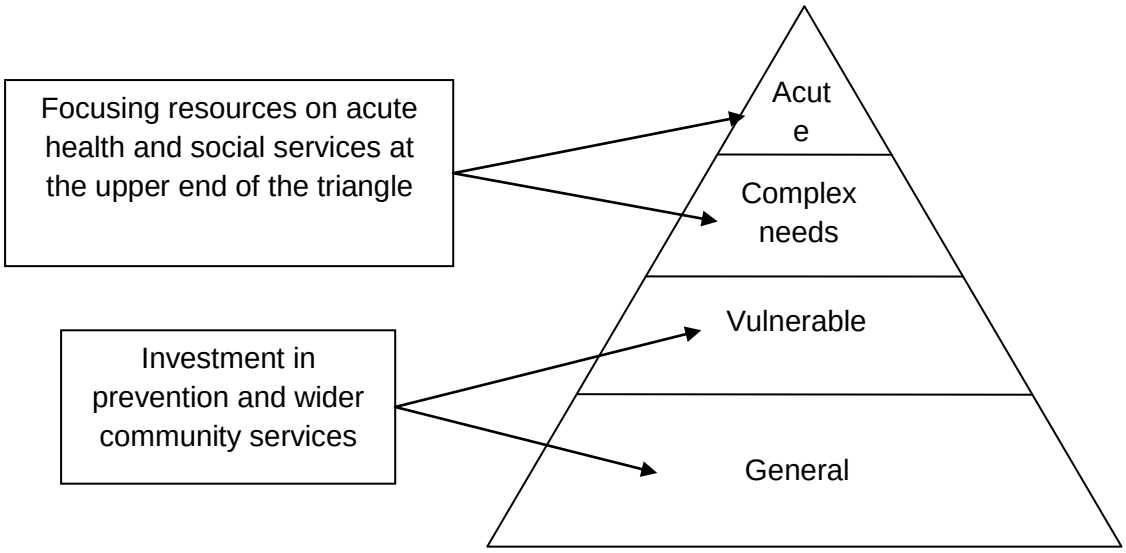
Against this backdrop of general population stability, the context of recession and public spending cuts during the latter half of the survey period has impacted across multiple domains of rural life for all age groups in different ways. Decreases in household income and perceived quality of life were more noticeable amongst younger age groups, although older people continue to disproportionately make up the majority of low income households in rural areas. At the same time, as some older people continuing to work for longer whether out of choice or financial necessity, a greater number of older households in the 2010 survey were likely to contain a wage-earner and therefore fall within middle to higher income brackets. Similarly, whilst older people continue to be more likely to own their own home outright, a noted increase in the proportion of respondents at or nearing retirement age (55-64) who had a mortgage over the survey period would also appear reflective of the changing economic climate. These emerging differences in experience amongst older age groups appear indicative of the broad and varied life span which older age (55+) now encompasses, and the highly varied capabilities and needs of different older people in rural areas.

4.1) Introduction: Older People, Policy and Wales

Since devolution, policy making in Wales has focused on voice, trust, citizenship, and the co-production of services. These policy orientations have been brought together through the focus on localism. The localist focus places an emphasis on the use of collaboration and partnerships in which local communities play a key role in negotiating and planning policy along with local government and the NHS (see Birrell, 2009: 153). Thus, through the combination of such concepts, policy in Wales "stresses citizenship, equality of outcome, universality and collaboration rather than competition and consumerism" (Williams, 2011: 15).

In relation to health and social services in Wales specifically, this policy emphasis has manifest in the development of a preventative agenda by the Welsh Government in recent years. Thus, in *Fullfilled Lives, Supportive Communities,* the Welsh Government set out prevention as part of the core function of social services. Here social services were to "provide services which help people to prevent or delay the need for more intensive services" (2007: 15). Recently, the new Social Services and Wellbeing (Wales) Bill transforms prevention into a duty shouldered by Local Authorities. The specific duty is "to seek to promote the well-being of (a) people who need care and support and (b) carers who need support" (para 4), and this duty directs local authorities to ensure the "range and level of service" that it "considers" as "contributing towards preventing or delaying the development of people's needs for care and support" (para 6, section 2). Although this duty has been placed with Local Authorities in Wales, in practice the duty is shared by Health Boards through their participation in developing the Single Integrated Plan for each Local Authority area. This move towards prevention also represents a shift to focus on the lower tiers of the triangle of care, and to a focus on low level services. The shift of focus from the person centred care of older people with complex and acute care needs, to ensuring that there is provision for prevention and wider community services for older people, represents an interest in inverting of the so called triangle of care. The inversion is merely a reprioritisation of elements that are normally at the bottom such as in figure 4.1.

Figure 4.1 Refocusing on lower elements of the triangle of care



By inverting the above (figure 4.1) triangle "it is hoped that services could begin to invest in preventative services for a larger number of older people, thus reducing future crises" (Glasby, 2012: 52). The problem with this approach has been its aspirational nature and the absence of political commitment (see Allen and Glasby, 2010). The difference in Wales is about how the current discussion has been incorporated into the overall Welsh Government strategy and installed in legislation covering social services in Wales. This provides clear political backing to this policy. Moreover, this move to a wellbeing and prevention agenda in Wales is set within a policy context which emphasises activating older people using a system of policy entrepreneurs with strong links to the state and civil society. These entrepreneurs include the Older People's Commissioner for Wales, older people's champions and older people strategy coordinators. The role of these entrepreneurs has been to develop and integrate policy to better meet the needs of older people within an overarching Strategy for Older People.

In the following chapter, we discuss the changing policy context in Wales. In the policy interviews carried out for this project, the interviewees tended to focus on prevention and person centred care, with less attention paid to participation; with the latter having arguably become a relatively settled area of public policy. As such, we will begin with a discussion of policy developments before entering into a lengthy discussion of prevention. The focus on prevention has ramifications for the way community and society is organised and is therefore of importance to the wider population of older people.

4.2) Changing policy context

The move towards prioritising wellbeing and prevention takes place in the context of a variety of other policy processes. Some of these form part of the wider policy move towards prevention, some do not. In the following we examine the policy developments locating the preventative agenda as one among several developments.

(i) Person centred care

The general thrust of service development in Wales has been based on the commitment to caring for older people in their own home by developing a more person centred approach to the care of older people:

> We're in the process of significant change at the moment… we have a comprehensive what's called a transformation agenda which is about trying to make services more person centred and also about making them sustainable because… apart from the demographic situation the financial situation is also heavily stacked against us. (Council officer 1)

The basis of this person centred approach was a set of ideas that could be used to open up conversations with older people about their aspirations and the potential role of care in supporting them to achieve these. The start point for person centred care was the critique of local authorities as responding in an institutionally organised way to everyday need:

> we often over engineer responses, so people who are lonely, not coping too well end up getting a whole suite of services rather in the same way that you go to the GP and come out with a script when maybe what you needed to do was to talk or be coached and supported to find a good solution, so that's really quite a fundamental thought shift for us, (Council officer 2)

The objective here is to reduce the risk that needs would be misrecognised and identified in ways which would automatically trigger a social service intervention. But this also meant changing the culture associated with care provision so that local authorities engaged in conversations with service users about their needs and resources.

The move to a conversation that is more cautious about the use of local authority resources reshapes the organisation of services provided by local authorities. Essentially this was a form of rationing of care resources by seeking to develop smarter targeting of the available resources. For instance, re-enablement[3] was refocused so that "anyone new to us we will expect to at least be looked at in terms of are there opportunities for re-ablement before we get into a further, more detailed assessment" (Council officer 3). Thus, this interviewee spoke of exploring new forms of assessments which were:

> better able to capture the individual…and their needs and their wants and desires…which is likely to move to a more descriptive assessment documentation…more of an idea of a conversation…a letter or something saying we've had this conversation…this is what we see your needs are and we suggest you contact Age Concern or the library service is available or Meals on Wheels or whatever (Council officer 3)

The conversation between the service provider and the older person would, therefore, shift so that the social and community based resources would be made more apparent before entering into a conversation on local authority services.

[3] Re-enablement refers to the provision of care services in an intensive manner over a short period of time after some event or care episode, with the aim of helping people regain their independence. The interviewees participating in this study used different variants of this term including re-enablement, re-ablement, re-enabling and reabling.

The move to person centred care was not just a move from a default provision of local authority resources, to a more holistic view of the individual as situated in a community that may also provide resources, but could continue as a sensitisation to the particular care needs of the individual within the care system.

(ii) Systemic problems in supported self-care

Re-enablement constitutes the main mechanism that has been developed to help vulnerable older people to live in the community after a crisis. However, a number of interviewees, primarily people working for Age Concern, pointed to failures in the system designed to re-enable vulnerable older people. The problems arose with people who were discharged home at inappropriate times of day and night, but also as a result of difficulties arising from coordinating health and social care on the continuation of care in the community:

> "We get a lot of hospital discharge issues where people are discharged and there's no care package in place or they can't be discharged home because it can't be agreed upon what services they can have and then our advocates get involved a lot with attending the […] multi-disciplinary meetings" (Age Cymru 1).

One interviewee was clear that this "model is not working" and that delays in the hand over from health to social services was causing deterioration in the condition of many older patients:

> [...]they can be waiting six to twelve weeks for an assessment. Now they can be fit to go home but they will go downhill then because they are waiting for their discharge okay, now by the time they're then passed onto us they're no longer going to be capable of managing alone, so we might go in for up to six weeks but they are going to go onto a larger care package from social services whereas if we'd actually got them out at the time they were fit to be discharged we probably would've sustained them with very little on-going support. (Age Cymru 2)

Such problems did not just arise as older people were exiting secondary health care and (re)entering the care of social services, but also as they moved from the care of social services to secondary care: "one of the things I've picked up on for example just by talking to the consultants in [local District General Hospital] was their frustration that too many people end up staying overnight or a number of days in acute beds because the care package was cancelled before they arrived" (Council Representative 3). Of course, these are problems with the coordination and integration of health, social care services and the third sector. With many district general hospitals running at near full capacity, such problems could develop into crises for health care providers in particular.

(iii) Developing market based governance arrangements

The move to rearranging organisations so that they are better able to help older people to help themselves is set within a range of institutional changes directed towards increasing competition, reducing running costs and enhancing sustainability. In order to deliver this change, policy leaders had focused on reconstituting the connection between the service provider and the user:

> [...] there's a sense that we often serially assess people erm and yet don't always get down to the heart of

> what their express needs are, linked to that is the particular issue about the extent to which things like unified assessment have become very deficit based, essentially let's make a list of all the things you can't do Shane, and all the problems you've got in life. Whereas we think erm we should have a much more asset based conversation which of course recognises the problems that you're bringing to the table, but equally talks about your strengths your interests and the community connections that you've got or that perhaps you've lost and could be rebuilt, and so really try to find that quite a lot. (Council officer 2)

> [...] our revised operating policy is already saying we are moving from a targeted model of re-ablement to an intake rather than a re-ablement so…anyone new to us we will expect to go at least be looked at in terms of are there opportunities for re-ablement before we get into a further, more detailed assessment [...] um we are then looking at going back to the person centred stuff that we started with-how do we make those assessments more better able to capture the individual…and their needs and their wants and desires…which is likely to move to a more descriptive assessment documentation…more of an idea of a conversation…a letter or something saying we've had this conversation..this is what we see your needs are and we suggest you contact Age Concern or the library service is available or Meals on Wheels or whatever….[right] (Council officer 3)

This effort to view the user of public services as an "individual" with "needs" "wants and desires" as well as "strengths", "interests" and "community connections", has ramifications for the wider policy culture. For instance, alongside the transformation of the assessment process and the construction of the individual as an active co-producer rather than a passive recipient of services, there was the need to reorganise services "so that [they] would fit in with when people are coming to us seeking information or we've done an assessment and we've had a conversation with people. We are better able to signpost them to some of those [community or voluntary sector] services" (Council officer 3).

(iv) Reorganisation as service integration

The move to focus more on the individual was bringing about a reorganisation of service provision for older people. As is evident from the following quotes, this is recognised to involve both the continued integration of services provided by health care and social services, and closer working arrangements with residential and social care:

> one of the things we've learned […] is that actually we're not working with new referrals, 90% of the people that come to us [as] referrals are known to us or our health colleagues in one way or another and of course if you talk about GPs and you say well what proportion of people in hospital or being referred to social services are known to GPs the answer is 100%, […] one of the issues about episodic approach to interacting with people is you don't maximise that learning and so you know you get them into hospital, and they start from scratch (Council officer 2)

> So our ambition is to shift away from the traditional model of in-house residential care to a more specialised model which is based around reabling people. We've tended not to see re-ablement as a part of residential care, when people go in then they're there for the rest of their lives, and we are shifting our model towards one which says well if someone does come into one of our residential homes our first aim will be to try to return them back to their own home by investing in a lot of service and support to help them to return home. (Council officer 1)

The key here was how the goal of re-enablement drove service providers to think of new ways in which services could work together to help older people live in the community. Interestingly, the drive to help older people continue to live in the community impacted not just public sector service providers, but cascaded through the service delivery system: "…it's not just services that we provide …it is the Derby and Joan Club…it is the OPA [Old Age Pensioner] Group…it is the local church…so it's about us having that intelligence as well and we can act as a form of community connector…" (Council officer 3). We will focus on the impact of policy on the community below, but here it is worth noting the cultural emphasis of this change. The focus is not specifically on one organisation, but on the way that social services and the local authority interact with community groups and third sector organisations to foster a culture of care in the community.

(v) Increasing the care market

Restructuring services so that they were in a better position to deliver care to people in their own homes not only meant finding ways of connecting with community based organisations to deliver services, but also expanding the market for care provision. Interviewees in one of the urban case study sites situated the development of care markets within a process of regionalising (broadly, the proposed reorganisation of local authorities to cover larger geographic areas) service delivery mechanisms and provision:

> Obviously in the next few years we're preparing for regionalisation and we recognise the whole world is about to change because everything's going to become even more hyper competitive. What we're doing at the moment is creating formal collaborations with other agencies to enable us to actually put ourselves in the best position to make sure that older people get the best services that they can get, [...] so you know in our respect we just say halleluiah to the regionalisation because you want to stop this postcode lottery. (Age Cymru 2)

This interest in developing care markets such that increasing demand for care services will be met by a greater variety of providers including Registered Social Landlords and charities was, at the same time, tempered by an acknowledgement that private sector providers have an interest in securing a profit and delivering care. In the second urban case study area, a different approach to market development was being taken by the local authority through the formation of a social enterprise:

> "we don't particularly want to tender our old people services but at the moment we are looking at developing a special purpose vehicle to deliver domiciliary care… so social enterprise kind of model… a wholly owned company of the council…um which will not

> necessarily disrupt the market" (Council Officer, 5).

Thus, politicians and senior managers in the urban case study areas were interested in expanding care markets in order to safeguard care services for older people.

(vi) Developing contracting processes

In regards to care commissioning, contracting processes continued to remain a difficult point for some social service providers in terms of being locked into paying low tariffs to some long-standing contractors. Nevertheless, two developments in care commissioning were identified in the process of carrying out this research.

First, there has been a move to outcome based commissioning in one of the urban case study areas. This outcomes based contracting involves making a shift from spot to relational contracting, or from purchasing services in a discrete way from relatively independent providers with no grounds to expect that another contract relationship will be used in the future, towards a situation where purchasers and providers work together to build trust so that they may cooperate on service delivery into the future. As can be seen in the following interviewee comments, this shift challenges the purchaser and providers with developing a range of new commissioning and contracting processes:

> we'll get into a relationship based approach between the providers and the services users or their representatives which is more around, well, to maintain this person they're going to need support to do certain things but how those things get delivered and how we do them will be up to negotiation between the individual service user and their families and the carers so there can be more flexibility around that because what we find is very often people are unhappy about the fact they may have four twenty minute calls during the course of a day when they feel that they require a bit more time sometimes than others, but because of the nature of the way we commission and pay for the commission for the care, it's in blocks of twenty minutes and thirty minutes or whatever it happens to be. (Council officer 1).

Here there is a greater reliance on trust but also an appreciation of the fluidity of care provision so that purchasers and providers would need to develop contractual based processes to monitor and report activity in wholly new ways.

The second development in commissioning processes had been developed in a second case study area where work had been invested into commissioning services based on geographic areas:

> because of the way in which we've arranged our contractual arrangements with the private sector by giving them a geographical area that will assist, or should assist, in some level of consistency and efficiency to overcome some of those barriers (Council officer 3)

Here the purchaser had moved to a costs and volumes arrangement governing contracts linked with activity in specific areas. These modes of commissioning provide ways of managing the care market by stabilising contractual processes using some additional consideration, i.e., trust and geographic area. The first interviewee above drew trust into relationships through the use of commissioning process that

encourage providers to co-produce outcomes with users by enabling flexibility in the way that care is delivered. Older users could therefore exert greater control over the care aspects of their lives while the local authority developed contract monitoring systems that supported their relations of trust with providers. The second interviewee drew geography into contract negotiations as a way of encouraging efficient delivering of care, and potentially managing the time carers need to attend different service users:

> I would like to see us more try and develop sort of an area model as well because we've, we're currently, everybody provides everywhere and I think it would be better if we could try and start sort of contracting on a sort of area on a geographical basis or a community basis and not, whoever it's with whether it's a commercial company or [unclear-0.18.53.5] or whatever but I think that would try and employ people from within that community. I think that would go some way to addressing the travel time between things and people would know the people or know the families of the people who're providing the care and they would know you know other people (Council representative 4)

(vii) The preventative agenda

Overall, the social care and health care services dealt with three sets of older people: those who are older and may one day enter into the care system; those who are currently at risk of needing care services; and those who currently need care services. These three groups are captured in the triangle of care as those who are in need of acute or complex care, those vulnerable to needing care, and the general population (Figure 1). But what is interesting here is how care providers were extending preventative work to ensure that older people who were both at risk of needing care, and those not currently at risk, would be encouraged to look after themselves.

Mindful of financial pressures, the discussion on prevention was directing local authorities to pay attention to the wellbeing of clients:

> the sort of discussion I have with my politicians and my chief exec is how I manage the, the demographic time bomb on it and so on that people talk about. So ... there are some authorities who are just saying we're going to raise eligibility, [...] Now the monies are going to get worse and worse[…] and in a sense this is now underpinned by the Welsh policy you know what's coming out of other ministers who are saying we've got to get back to that wellbeing agenda... (Council officer 2)

The main objective of preventative work was thus to stem the demand on health care services, as this council officer was duly aware:

> I'm very conscious myself of the importance of early intervention prevention, to prevent people developing more chronic conditions; [if not] there could be, then substantial expense to social services and the health services (Council officer 3)

This was to be accomplished by averting the build up of pressure on services so that services would not find themselves overburdened with unsustainable demand. Here there was a general recognition amongst interviewees that, whilst health and care services have been highly successful at increasing the longevity of the population, it may be difficult to

continue to achieve this level of success in the way with reduced resources. Therefore, as one Council Representative stated: “We’ve got to build an alternative way of doing this” (Council Representative 2). Finding alternative means of helping older people has been about developing structures that would enable the older population to age actively, or achieve a kind of successful ageing:

> People in their fifties might not consider themselves as older but it’s all about that preparation for later life and older life. It’s (older people’s strategy) full of things like digital inclusion, fall prevention all sorts of health and wellbeing thing. That in itself is something that is geared towards prevention and preparation for older age. (Council representative 1)

The vision was to help people in the third age to live longer as active older people by preparing for this period of their life, building the sense of community and by harnessing the desires of older people to live in their own homes and to pass on an inheritance to following generations:

> it seems to me that this way addresses what people actually want as well, people don’t hold their hands up and say please put me in a residential home, people want to stay in their own house for as long as they can… they don’t want to spend on residential care and those sort of things as well, they want to pass it on to their children which is a legitimate desire and if we can meet those desires then I think people will have a more fulfilling older years (Council representative 3)

The difficulty with this model was that preventing the flow of demand may simply mean increasing the length of time that people need certain kinds of personal or home care so that “it seems awful but if people are going to live longer they are going to cost us more…” (Council Officer 5). On the other hand, to the extent that prevention is successful, it may mean moving the age at which people need complex care interventions, prevention could mean lengthening the time people spend in the community before spending a short period in the care system prior to their death. Indeed, the term prevention suggests that successful interventions will halt the demand on health and care services, whereas this agenda is actually more about delay:

> I think one of targets is to… delay statutory intervention. So the longer they feel comfortable or happy in their own homes, you know, it is a lot about mental health as well. But we do have a system where we measure how happy they feel, how social they are or whatever. That is part of their membership forms and you know, the longer that they feel they have seen people and can get about using community transport or local taxi service, then hopefully they can remain in their own homes longer and be more independent longer. (Age Cymru 2)

Thus prevention was driven by constrained financial resources, and understood as a means of stemming potentially unsustainable demand on health and social care resources. Prevention involved working to enable better planning for the future, to help older people to age successfully by building capacity in the community, and encouraging them to take more responsibility for their own health and welfare themselves. But prevention was also associated with the potential increased cost of looking after the older

old who would eventually become a burden on the care system.

(viii) Summary of policy reorganisation

The policies surrounding the delivery of services to older people were therefore changing in a number of ways. These changes included work to focus more on the individual, problems with the operation of the re-enablement scheme, changes in the governance of markets, working with service providers, and developments in commissioning and contracting processes. Thus the development of the preventative agenda was just one of a number of developments. Nevertheless, to the extent that prevention involves inverting the triangle of care and working with the general population of older people, then these policy developments may have greater immediate implications for many more older people.

4.3) The prevention model

Achieving a successful model of ageing involves developing mechanisms that allow older people to live a good life in the community. The term 'prevention' draws attention to a form of anticipatory counteraction – stemming, delaying, impeding, precluding, obviating, postponing – rather than setting out a goal to be achieved. The goal is precisely to not allow a situation to take place. So anticipating the possibility of over stretched budgets and overburdened health and social care systems, the question then is what preventative measures and strategies are being used to avert such crises.

(i) Prevention and risk

The first measure was to use various modes of service delivery to monitor the wellbeing of older people, such as the drivers delivering meals on wheels:

> People are being seen every single day, that social interaction which is so valued […] it allows them when something has changed even if it might be a sense of something is not quite right, they're not as talkative as they used to be, there's something not right. That linkage to other aspects of our care staff to oversee, to ensure, to prevent it is really valuable and therefore I see, I sometimes wonder why community meals should be anywhere else other than in social care arena (Council Representative 3)

This of course begs the question about those people who are not in contact with the care services and therefore at greater risk, due to the difficulties of identifying and responding to their needs "before they go into crisis" (Age Cymru, 2). Obviating care needs could, therefore, be achieved for some older people by using current delivery mechanisms as a mode of surveillance that could communicate observations to care providers. Interestingly, however, none of the interviewees talked about this kind of system in a concrete way, and such a system may be beset with problems. For instance, in the course of delivering meals, meals on wheels drivers have contact with older people and may be asked, and provide, practical help. However, these drivers are not insured to do so, and may in fact be in breach of their work contract in providing such help. These drivers could, conceivably, report observations of the wellbeing of clients but this may require the use of a standardised tool rather than rely on general observations. Therefore there remains a great deal of challenge in developing mechanisms that would help alleviate pressures by responding to changes in older peoples situations before a crisis develops.

What was also notable was how the problem that may bring about the crisis that prevention seeks to avert was constantly changing:

> I suppose it's quite seasonal. In the winter it's all about heating and keeping warm, I've run out of oil. I can't afford oil. What's the cheapest place for oil or gas? So it's quite seasonal and now because all the changes in the welfare benefits we get a lot of calls about that now so it really depends on what's going on in the bigger picture as to what calls we're getting in here. (Age Cymru 1)

Changes in the weather or in institutional arrangements may raise different needs, each of which contributes to countering pressures on care service providers. But the problem then arose as to which service actually contributes to the preclusion of service crises. For instance, toenail cutting is a service that can be offered to all older people and presented in tandem with other prevention services:

> In fact I quite like the toenail cutting model in terms of you've got the toenail cuttings, you've got the health prevention, if it was prevention or that side of things, then you've got information and advice on hand if somebody wants a form filling in and all that, you've got the social side of things, there's tea and coffee, volunteers going about and how are you Mrs Jones, having a chat and it just works really well. It ticks so many boxes. If we could pick that up and roll that out in the different communities I'd like to do that and it's all of our services coming in as one really. (Age Cymru 1)

Or toenail cutting could be focused on preventing the accumulation of demand on podiatry services:

> The surveys I've done of those clients is essentially how did you cut your toenails before? Half of them – I don't, so their toenails just keep growing and growing and growing until they're cutting the flesh and that's when they go to the doctor and might actually receive something… We're now seeing their feet once every eight weeks, because it's a low enough cost that they can actually afford to do it, we can then monitor their feet and then notice that their shoes are the wrong type of shoes and those types of things […] and then we refer them to podiatry if they need a proper podiatry treatment. (Age Cymru 3)

Equally, to properly preclude demand on the care services, some interviewees would argue in favour of home visits:

> We can, I mean, I would love to be able to do home visits because if I do a home visit to do an Attendance Allowance I see whether people are coping. I mean, I've done home visits and I've seen people at risk staggering to do things that...falling over with irons and things that, practical things that you can immediately say, well, have you ever thought about this, this and this? You know, you can stop it happening, but… it's half a day, two hours to do an Attendance Allowance and probably an hour and a half travelling each way. I mean, I can only do one of those in a week. (Age Cymru 4)

The problem with home visits, especially in rural places, is that such visits can consume a great deal of time. So even

though home visits are particularly effective modes of helping to prevent the onset of crises, they are difficult to deliver in an efficient and economic manner.

Nevertheless, this work of anticipating and countering problems through specific services raised the interests of the council officers interviewed and, whilst currently an aspiration for some, a degree of low level service provision had been achieved elsewhere: “we needed to modernise and move it in different direction and like you say the preventative model that’s where we are, you know low end support, we wouldn’t want to go high end” (Age Cymru, 2). Thus at least one interviewee correlated anticipatory counter action with the purpose and work of her organisation.

(ii) The prevention orientation

The main mechanism used to counter an anticipated problem was to increase the resilience of the individual so that they could find resources within themselves and their community to deal with problems before turning to the public services:

> if you’ve got a neighbour that cares, if you’ve got someone down the road that cares, if you’ve got a church club that the lady goes to once or twice a week and then she goes to church on Sundays that’s an important thing in her life. It’s important that the community is expecting her to turn up and knows if she hasn’t turned up or helps her get there and helps her get home, and she has the sort of link with other people in the community through doing that. I think those are hugely valuable and the more we can sustain and nurture those kinds of relationships the better somebody’s wellbeing is, which is something slightly beyond the social services care level… (Council officer 1)

What the investment in prevention does is shore up this capacity of the individual and their community to care for the self. To the extent that increasing the resilience of older people involved helping them to continue to live in their own home, then prevention can be achieved by a housing, communal or tele care solution; as this council officer (Officer 3) describes in regards to the latter “we’ve invested in tele care, again seeing that as part of that preventative agenda, and tele care at its basic, the basic lifeline service is about reassurance isn’t it, reassurance for the older person themselves and more likely reassurance for family”.

The point here is that prevention, or more precisely anticipatory counter measures, work by altering the willingness of the older person to manage their own care needs. This is achieved by reassuring them that help is nearby, or providing the basis for an active mode of life.

(iii) Community intervention

Thus far we have established the extent to which prevention refers to a cultural orientation. Anticipatory counter measures involve working to prevent the emergence of a problem by increasing the resilience of the older person and better supporting their positive outlook and ability to live an active life. But prevention was also being institutionalised through the development of specific roles that would foster this positive outlook.

Across the case study sites, a number of community intervention schemes were being experimented with. The primary model used was a functionalist and communitarian form of community development. This is a variant of

community development that "highlights the positive features of communities rather than their failings, but draws attention to what might happen if shared responsibilities are neglected" and which "is based on the belief that the role of community development is to assist communities to become self-reliant and cohesive, participating in civil society as a unified body of active citizens" (Gilchrist and Taylor, 2011: 22). In order to generate this cohesive self-reliant community, the communitarian form of community development focuses on identifying and mobilizing the assets (skills, capacities, talents etc.) found in the community. However, by focusing on assets rather than needs, this approach tends to ignore the political dimension and focuses on outcomes rather than causes (2011: 23).

This functionalist and communitarian model of community development operates by identifying resources that may be situated in the community and connecting individuals with these resources:

> [...]I get referrals from all different teams…intake team, mental health… Age Cymru, self-referrals…and then I'll have a chat with them on the phone, if needs be I'll do a house visit, and try and put them into a group that's going on in the community… could be a luncheon club or somebody that wants to join a Bridge Club… and even the first time if they're nervous I'll take them and introduce them, work with them to find you how much the taxi will be there and back or if we can get community transport… (Community Connector)

Thus, this model merely involved connecting the individual with a community through a common interest. Local area coordination can also involve mapping the assets that older people have within a community and what they can offer, in addition to what they need. For example, "finding out about the retired accountant who is happy to give his Saturday morning once in a while to individuals who want to start up a business" (Council Representative 3). This of course means working on common interests and enhancing the sense of wellbeing in the wake of articulating these interests. The ambition is for members of the community to find that they can provide help to others, and in doing so, both increase their sense of self worth and enhance their sense of community.

The other point here is how this version of community development enhances the individual sense of self-worth by beginning with those who may be vulnerable, lonely and isolated:

> So there are five GP networks across [urban area] and we've linked each of the community connectors into those networks to help to support people who might otherwise go to their GPs and perhaps not necessarily have any particular health issues or any particular social care issues, but are beginning to show some signs of struggling with some of the things they're doing or maybe being that little more isolated than they used to be; maybe because they've lost friends or whatever it happens to be, and sort of linking them into what local activities may be in the area. (Council officer 1)

It is also worth noting that there is a move to using the assessment process as a means of conversing with older people and introducing some elements of community development through a more fluid assessment discussion: " […] you know quite immediately if the conversation

picks up the concept of older people having assets as well as deficits you begin to open up possibilities" (Council officer 2).

(iv) Prevention and impact

Among the themes in relation to prevention was the difficulty in measuring the impact of preventative work. The difficulty with assessing impact was precisely that evaluations may be seen as accumulating stories that illustrate how preventative work may support people in the community and trying to use these stories in connection with decision making process:

> So one thing for example with some of this stuff is we'll be able to get some nice stories about people with disability to regain a more meaningful role in their community and begin to contribute as well as take from, and so on, but issues like what does this mean for dementia are key hard issues. This sort of thing has to include helping communities manage people with dementia for longer, or in different ways or so on, because otherwise, we're just going to build nursing home after nursing home, so there's some really hard edged challenges to what is a very exciting policy direction I think. (Council officer 2)

The main difficulty here was how evaluation was routed through customer satisfaction surveys or was being considered after the introduction of the service:

> I do think one of our measures […] will be how many connections do you have to your community […] and maybe another measure might be how many people coming in and out of your house all the time. You know in a good way and in a bad way in terms of paying people. I think those are the sort of measures we'll be playing with to understand are people living lives of independence with appropriate support from the state or are they basically living institutionalised life. (Council officer 2)

The problem with this approach was that unless some data had been collected before the service was introduced, it becomes difficult to gauge the impact of the service. A simple form of impact assessment would compare the experiences of quality of life of older people living in an area before and after the introduction of a service, or comparing experiences of people in two or more comparable areas where those in one place are offered a service, and those in another are not. Research can therefore do more than simply document "nice stories" but provide assessments of the impact of preventative measures. This would require the use of multi-method research projects which, crucially, assess service provision and user experiences both before *and* after the introduction of the preventative service.

4.4) Conclusions

As the above has shown, there are quite a number of policy discussions affecting older people in Wales. The development of person-centred-care, re-enablement and service integration were rooted in the long-standing commitment to the co-production of care outcomes through collaboration between public services and their clients. In addition, there are a number of ways in which care markets are developing and are being organised in the different places. However, at the time of this research project, the central policy discussion was focused on prevention and wellbeing. The introduction of a duty to statutory legislation requiring local

authorities to ensure that older people have access to preventative services renews attention on the need to promote health and wellbeing. But as discussed above, the difficulty remains that a focus on prevention is vulnerable to a changing political climate, and is difficult to measure. This latter point also implies that local authorities have the opportunity to rebadge existing services as preventative in order simply to be seen to comply with this legislation. But what the above shows is that there is a genuine interest in, and commitment to, the promotion of prevention for older people in Wales among all those involved in developing and implementing policy.

Nevertheless, there remains work in establishing the cost effectiveness of preventative services in order to justify sustaining the streaming of funding to third sector providers of low level and preventative services. So long as these services are seen as additional or supplementary to the core care services provided by local authorities, they remain vulnerable to cuts and peripheral to the governance of care provision. At this juncture there is an opportunity to establish whether and to what extent prevention, or anticipatory counter measures, effects the welfare and wellbeing of older people by gathering baseline data prior to developing new services, or by comparing the effects on the health and wellbeing of comparable populations living in comparable places but who are in receipt of different services.

5.1) Introduction

This section presents data gathered on the experiences of older people living in different places in Wales. The discussion centres on older people's experiences of place and community focusing on the efforts older people undertake in order to live an active life in their place of residence. If older people are not merely to cope with their situation in different kinds of places, they need to manage their life so that they may maximise their own welfare and wellbeing. This involves engaging with one's objective physical location as a range of services and facilities that enable older people to live in a place, and engaging with the local community in order to access socially located resources in the area. Therefore this chapter proceeds by first examining how older people engage with their objective and subsequently their social location in the different places studied.

The data highlights both the similarities and differences between the experiences of older people living in urban, rural, valley and coastal parts of Wales. In doing so, it provides an account of the experience of older people living in these different areas.

5.2) Comparing places

Before entering a discussion of the experiences of the older residents, it is worth noting some of the points of contrast and comparison between the places. As noted in table 5.1, there was a significant variation between the places in terms of their access to services and facilities. The first point here is that two of the case study areas involve combinations of places. Mountain Ash and Penrhiwceiber form neighbouring villages as do Fairwater and Pentrebane. Interviews were carried out in Penrhiwceiber as well as Mountain Ash in view of the large number of people from this area who volunteered to be interviewed while the local insistence that Pentrebane be included with Fairwater led to the decision to carry out interviews in this area. However, the local narratives varied slightly in these areas and so they are separated for the purposes of Table 5.1.

As table 5.1 shows, there was a clear contrast between places that had a range of facilities and places with rather few. Llanarth, Pentrebane and Aberdaron had less then half the facilities found in Rhayader, Mountain Ash, Sketty and Fairwater. Thus, a broad range of types of facilities was found in rural, valley as well as urban places, while narrow ranges were found in urban as well as rural and coastal places.

Also of note is that the Valleys areas included in this study had the highest WIMD (Wales Index of Multiple Deprivation) scores. However, parts of the urban areas – the Sketty Park area in Sketty, and part of the Pentrebane area of Fairwater, also achieved high deprivation scores. Finally, over 40% of the populations of Raglan, Rhayader and Aberdaron were, according to the 2011 Census data, over 55. This was over 12% more than the 28% who were over 55 in Penrhiwceiber and Fairwater. But what is also noteworthy was the varying proportions of the populations that were over 75. 16% of the population of Rhayader, 14% in Sketty and 13% of those in Raglan were over 75 while 7% of those living in Penrhiwceiber, and 9% in Llanarth, Mountain Ash and in Fairwater were over 75.

Table 5.1 Comparison of local facilities and services

	Rural			Coastal	Valley		Urban		
	Rhayader	Llanarth	Raglan	Aberdaron	Mountain Ash	Penrhiwceiber	Sketty	Fairwater	Pentrebane
Food shop	1	1	1	1	1	1	1	1	1
Public house	1		1	1	1	1	1	1	1
Post office	1		1	1		1	1	1	
Garage/service	1	1	1		1	1	1	1	
Butcher	1		1	1	1			1	
Baker					1		1	1	
Newsagent	1				1	1	1	1	
Bank	1				1		1		
Free Cash Machine	1		1		1		1	1	
Dentist	1		1		1	1	1	1	
Pharmacy	1				1	1	1	1	
School	1	1	1	1	1	1	1	1	1
Library (permanent/mobile)	1		1		1	1	1	1	
Community Centre/Village hall	1	1	1			1		1	1
Recycling facilities	1								
Church/Chapel	1		1	1	1	1	1	1	1
Bus stop	1	1	1	1	1	1	1	1	1
Train halt					1				
Total	**16**	**5**	**12**	**7**	**15**	**12**	**14**	**15**	**6**

Table 5.2 Comparison of key local policies and statistics

	Rural			Coastal	Valley		Urban		
	Rhayader	**Llanarth**	**Raglan**	**Aberdaron**	**Mountain Ash (East and West)**	**Penrhiwceiber**	**Sketty**	**Fairwater**	**Pentrebane**
Notable local policy	Community warden scheme	Communities First area	Community development officer		Communities First area	Communities First area	Community connector Communities First area	Communities First area Healthy, wealthy and wise	Communities First area
WIMD score β	16.7	17.2	8.9	20.5	33.9	48	11.2	28	
WIMD outlier β					Mountain Ash West 2 – 51.4	Penrhiwceiber 1 – 77	Sketty Park – 39.5		Fairwater 5 (Pentrebane) – 51.3
Population γ	2,088	1,616	1,928	965	7,347	5,789	14,301	12,981	
Proportion 55+ γ	44%	37%	42%	40%	32%	28%	37%	28%	
Proportion 75+ γ	16%	9%	13%	11%	9%	7%	14%	9%	

β Source, StatsWales, Wales Index Multiple Deprivation 2011
γ Source, Census 2011

5.3) Older people's experience of place

Across the study areas we see that older people living in Powys and Ceredigion were the most positive about their satisfaction with place (table 5.3), while those living in urban areas were least positive. Nevertheless those most dissatisfied with place were living in Ceredigion and Gwynedd. Interestingly, those in Ceredigion were also the most polarised group, combining the largest proportion of very satisfied and fairly or very dissatisfied.

Table 5.3 Satisfaction with place among older age groups by Local Authority area

		Very or fairly satisfied	Neither satisfied nor dissatisfied	Very of fairly dissatisfied
		%	%	%
55-59	Ceredigion	90	0	10
	Gwynedd	93	2	5
	Monmouthshire	95	6	0
	Powys	91	6	4
	Valley/Urban Local Authorities	95	3	2
60-64	Ceredigion	95	3	3
	Gwynedd	93	2	6
	Monmouthshire	91	0	9
	Powys	93	3	3
	Valley/Urban Local Authorities	91	2	8
65-74	Ceredigion	89	3	8
	Gwynedd	93	0	7
	Monmouthshire	94	3	0
	Powys	98	1	1
	Valley/Urban Local Authorities	93	4	4
75+	Ceredigion	100	0	0
	Gwynedd	91	3	6
	Monmouthshire	93	0	7
	Powys	91	0	7
	Valley/Urban Local Authorities	96	2	2

Source, WRO Household Survey 2010

Table 5.4 Satisfaction with place among 55+ by Local Authority area

	Very satisfied	Fairly satisfied	Neither satisfied nor dissatisfied	Fairly dissatisfied	Very dissatisfied	Don't know
	%	%	%	%	%	%
Ceredigion	74	18	2	4	2	0
Gwynedd	71	22	1	2	4	0
Monmouthshire	72	21	2	1	2	1
Powys	76	18	3	1	2	0
Valley/Urban Local Authorities	69	25	3	3	1	0
All	74	20	2	2	2	0

Source, WRO Household Survey 2010

Breaking satisfaction with place down further (table 5.4), we find that satisfaction is fairly evenly distributed across older age groups. This balanced view of the places in which people lived was repeated in the interviews. But these interviews also allowed us to explore older people's views of place.

(i) Older people's perception of place

First, many of those interviewed were satisfied that they could access all of the services and facilities they needed. This satisfaction was shared by the residents of the Extracare facility[4] included in this study, as well as those living in rural villages:

> ...best thing I ever did was to come back…marvellous…[...], especially at our age like isn't it, we can't get out so much as we used to…so it's nice that's it all….at our fingertips like.. (Sketty, Extra care group)

Being able to access a hairdresser, shop and restaurant on site had a considerable effect on these interviewees' sense of satisfaction with place. This ability to access local facilities was also underlined by the interviewees living in the various areas:

> We've got everything. You've got bowling greens, you've got leisure centres, you've got nice parks, we've got good facilities for older people. You can get from A to B pretty quick. We use our bus passes. Numerous, numerous things. Good library. It's got everything you could possibly want (Fairwater older person 3)

> **Interviewer:** That's right yeah, and how would you describe Raglan as a place for older people to live in then?
> **Respondent:** Oh I think it's excellent, it's got everything you need. It's got a pharmacy, the mini market and the Post Office. A couple of butchers shops, a couple of pubs.
> **Interviewer:** Right, how are the pubs doing?
> **Respondent:** Well there's the Beaufort and there's two pubs. [...] No, it's an excellent place to live really, good bus service and mostly flat. Although they're not very good

[4] Extracare housing refers to a form of housing for older people that combines independent living with high levels of care. Extracare differs from residential and domiciliary care insofar as in Extracare residents live as tenants in their own private spaces within a housing complex where they have access to care provided on site (see Burholt et al., 2010).

at gritting the pavements if it's icy. (Raglan 131)

Satisfaction with place was therefore linked with the facilities found in the place, the transport options, and the accessible topography. Interestingly, accessibility was frequently mentioned in relation to satisfaction with place:

> **Interviewer:** and all the doors are automatic aren't they as well?
> **Respondent 1:** yes, except in the lounges and that's a bone of contention..they are very heavy to push open.. if Diane gets in there she can't get out…but there's always someone to let her in and out isn't there? When we play cards like isn't it… (Sketty Extracare group)

Thus what makes a place a good place to live in for older people involved a combination of facilities and access to these facilities. Those who felt they lived in a good place frequently pointed to their proximity to facilities that they could get to safely and without undue effort.

But the interviewees were also very aware that the facilities they valued were vulnerable to various pressures. For instance, one Public House/Bed and Breakfast was reported to have closed due to mismanagement:

> A joke, you're telling me, and then another incident there was a rep staying there, he got up in the morning, no breakfast or anything. And he [the owner] gave him [the client] £10 to go to New Quay for breakfast! And you don't run the place like that do you? Oh no he was the joke of the year and he's gone now. He drinks a lot himself. (Llanarth 851)

While this is an isolated story, it draws attention to the vulnerability of a valued local facility to closure following poor management practices. Local facilities more generally were seen as vulnerable to the economics of running small businesses:

> The shops are … they always close because there isn't … there's not enough trade. We've now got two grocery shops, which is a bit of an improvement. Um, we had two grocery shops, but the one 'Honest John' we called him, John [Morris] died and his son couldn't afford to keep the business going [...] (Rhayader 705)

Change and competition here produced a better service primarily because of where the new shop facility was located. But the general theme of services under pressure was underlined by two older business owners who linked negative effects on their businesses with a new Tesco's, poor weather, and public sector cut backs:

> **Respondent 2:** We've been affected down there by, Tesco has been the big hit.
> **Respondent 1:** Number one.
> **Respondent 2:** The recession another one, the weather is another one, and also tied up with the recession is the fact that there's been a lot of cut backs in public sector servants who use this road a tremendous amount. So they've, you know, as councils have laid people off and the Welsh Assembly have laid people off, they obviously aren't there on the road now to call in. And also I've learned that a lot of them that are on the road, they've had their expenses have been done away with [...] (Rhayader 586)

Of these, the perception that small businesses were suffering as a result of the competition with large shopping facilities was strongly felt by older people.

The use of a large retailer like Tesco or Asda was seen as undermining valued local shop facilities:

> **Interviewer:** Because I'd like to talk a little bit about how the shops around here have changed
> **Respondent (female)**: There are a lot fewer but it's probably because a lot of people; there's a free bus mostly for the elderly that goes to Asda's...
> **Respondent (male):** There's a load of pound shops around
> **Respondent (female)**: It's not that. They catch the bus and they go to Asda's so the local shops are taking a pounding then. They go to a weekly shop sort of thing (Mountain Ash Older resident 5 couple)

Interesting here is how the female interviewee corrected her husband's observation that "There's lots of pound shops around" with the argument that the use of free buses to go to Asda's meant that "the local shops are taking a pounding". The result of competition with large retailers was the proliferation of low end charity and pound shops in this area with few additional facilities, and then the absence of choice or of local facilities was again driving people to shop in the large retailers. In any event, transport facilities in this area were leading to the loss of local shops. We get a clearer view of the uneasy combination of accessibility of facilities and the economically driven use of these facilities if we look more closely as older people's critiques of place.

(ii) Older people's critiques of place

In contrast to the degree of satisfaction with place found in the survey, a large number of the interviewees were more circumspect about their place of residence. The critiques of place articulated by older people were driven by the absence of local services and facilities, and were quite strongly felt in Cardiff and the Valleys case study areas:

> ... what's happened – I don't know why it is – but they finished building this place and then it was sort of forgotten because nothing has come in you know. There's not a doctor's surgery…there's not a chemist…nothing like that…you know…we had a little Post Office up the top but that's closed, they've got one down the bottom now…[...]..it seems strange doesn't it…[...] a forgotten place! (Cardiff Older person 8)

> **Interviewer:** So not much has changed really in 50 years or so?
> **Respondent:** No like I say we've got no shop or anything up here, the little school closed, we had a school down here…[...]
> **Interviewer:** But there's no local shop or Post Office nearby?
> **Respondent:** No they all closed
> **Interviewer:** And the pub is only open a few hours a day
> **Respondent:** Yes it's open a few hours a day, I don't think it's open all day, and we've got the golf club, did you see it on your way up? (Mountain Ash Older Person 1)

Here we find both a critique of an urban place that has not had the investment in services and facilities, and a critique of a valley's place that has lost many of its services and facilities following the closure of the coal mines. Interviewees in both places described their place as 'forgotten' indicating that Local Authorities have been investing elsewhere while neglecting their locality. Thus one Local Authority had "spent twenty two million building a shopping mall in Pontypridd which, you know, they have had three or four there and they just keep improving them, so it is

like wasting money and we can't even get a playing field here" (Mountain Ash, nearby Working Men's Club). Thus there was a sense of disappointment with decision makers and a sense of disenfranchisement as local facilities and services were not being invested in.

The critique, however, was not just of the availability of services, but also of the accessibility of the local area. The importance of accessibility was underlined by those interviewed in care facilities who talked of their move into these facilities as driven by the experience of living in places that were difficult to navigate:

> [...] and I was living in a block of flats and I became a bit handicapped and I couldn't do the stairs...and I came here...[...] I was on the 9th floor [...] I wanted to come back to Sketty, Sketty was where I wanted to be...and I came back...and it's the best thing I ever did…because it's flat...you don't have stairs to do…you've got the lifts..[yeah] (Sketty Extra care group)

Indeed, fears about not being able to access local places caused some interviewees alarm:

> [...] they told me they didn't know if I would walk again and I thought 'wheelchair', and my friends up the road said "don't worry about it [Rita],[5] I'll zoom it up for you, you'll be able to get from here to there in your wheelchair" and just had a vision of myself popping round the lanes in this wheelchair going like a bomb, you know, trying to take photographs, but anyway, yes I got the knee done but I didn't go out in the ice or anything because if I slipped I'd have had it, so it would be a wheelchair then. (Raglan 106)

In summary, whereas satisfaction with place was based on the availability of facilities that older people were able to access, dissatisfaction was driven by the absence of facilities, the sense that the place had been neglected, and the inability to access facilities. But older people's use of facilities was also organised by their economic interests in maximising the value of their money, which meant using free transport to shop in large retailers rather than use their local facilities. Thus the problem arises as to how to reconcile the economic interest in maximising the use of fixed incomes and the local business person's interest in making a profit with the community interest in retaining accessible and convenient local facilities.

5.4) Older people's experiences of community

Managing life in different kinds of places therefore requires older people to find ways of dealing with their need to access services and facilities in their place while managing their needs using personal and public transport options. But the older people interviewed did not relate with place only as a source of goods and services, but also as a social resource. In many ways, connecting with community involves overcoming any individual hesitancy, and accepting the need and inclination to connect with others in order to overcome personal isolation. What was interesting about these interviews was just how strongly interviewees felt that the experience of social isolation was caused by individual, and not social, characteristics:

> **Interviewer:** Sure. I mean are you involved in, don't know, different

[5] Personal names have been changed throughout the document to protect the anonymity of sources.

organisations and things in the town?
Respondent: Yes we got lots. I will go as far to say that if anybody is lonely in Rhayader it's their fault. We've got a wonderful community centre in The Arches...have you heard about it? (Rhayader, interview 6)

When my sister went that was the last link [family member] you know then…you've got to make it that you've got to…there's nothing you can do about it…well make yourself into that position you're in, you know… (Mountain Ash Older person 1)

And you see if you don't want to go out all you've got to do is pick up your intercom and talk to one of your neighbours on the phone you know which is a good thing…yeah….there's no need for anybody to be lonely. They are lonely because they don't want to bother…lonely from choice you know…yes…too many things going on…yes..and then we've got all these facilities…lovely.. (Sketty extra care group)

For these interviewees, it was up to the individual to overcome their own isolation by making connections with others. Living in a rural village and in a care facility, the first and third interviewees above clearly felt that many people chose their isolation, and therefore any sense of loneliness they might have was of their own making. The second interviewee connects the loss of family members with the interest in becoming involved in the community. Her own isolation drives her to engage with the community.

Interestingly, a number of interviewees spoke of their lack of interest in becoming involved with such groups. Many would connect with family rather than community:

Interviewer: do you ever feel isolated living here…?
Respondent: Not really no because I've got my son and..I can be with them in you know two or three minutes...so no, it doesn't bother me at all... (Cardiff Older person 8)

The Fairwater/Pentrebane case study site stood out as a place in which there was an issue with isolation. One older couple living in this area felt able to identify people who were lonely, but they did not feel lonely themselves:

Respondent: Yeah. No I don't think uh we feel isolated. Mind you I mean I suppose in years to come perhaps when we can't drive or something like that it might make a difference. Because I mean we spend so much of the time outside … [...] I mean the lady across the road lost her husband a couple of years ago and she's on her own in that house and I know it's quite a big house. She's got family in Fairwater which go up there … (Fairwater/Pentrebane, interview 1)

In this area there were ongoing efforts to draw older people out of their homes and into contact with the community while key members of this community found themselves connecting with people in different areas. The isolation was fermented by the absence of social resources and facilities, a situation that was being tackled at the time of the study.

To the extent that many older interviewees were interested in engaging with others in their community, the problem shifts to that of identifying a social and physical space

in which a sense of commonality may arise. In many places this commonality was found in various sites and fora:

> But Carol's [a local cafe] on the corner amuses me. I think it is on a Tuesday, people go there and they go to the lower part downstairs and it is almost like a club. They have a cup of tea...they stay there for flipping hours you know, talking. Asking about things or talking about things. It is absolutely amazing...they are never kicked out. Mind you they...some of them will stay to dinner and things like that you know. But you can't imagine it really, sort of going into a cafe and having a cup of tea and probably staying there for three flipping hours (Rhayader, interview 6)

There were many stories of trips to local shops taking hours as people stopped for a chat, but fewer of people congregating in pubs and cafes on a weekly basis just to talk, even though this provides the functional equivalent of a luncheon club. The point here is how the interest in community drew many older people together into such groups. But also, in contrast, members of some communities encountered difficulty initiating this kind of connection:

> Yeah, you tell me how we get them, how we get them together. Because we've tried and we can't. Now there's a point in question, the community centre down here. How do people get up to the community centre when they're elderly? They've got so many steps or you've got to walk round that you know. [...] You cannot get to it. It's ridiculous. (Cardiff, Older residents 5 and 6)

Here we find a concern that the physical location of the community centre inhibits the development of a community spirit as older people find it difficult to access the centre. But this is underscored by a long term concern that people in the area were disinterested in engaging with their community.

5.5) Community activity

(i) Perception of community activity

The interviewees took a variety of perspectives on the availability of groups and activities. Many interviewees mentioned a variety of activities in their local area that they could engage in:

> **Interviewer:** Are there any other clubs and groups?
> **Respondent:** Bowls, sailing, indoor bowls, darts, snooker, golf, there's a lot of golf played here. A friend of mind over the road, his wife died, he's now totally taken up with golf, and he's out four days a week with it. There he's made his circle of friends. (Llanarth, interview 8)

> Oh no there is plenty to do and of course we got the museum as you know, which is Peter Cox's baby isn't it in a way. There are all sorts of things going on there, there is a Shakespeare club, and there is a book discussion club. We've got all sorts of various clubs. In fact you can be out morning, afternoon and evening here. (Rhayader, interview 6)

While some of the places appeared to have a greater offering of clubs and groups than others, while some interviewees pursued specialist interests in clubs that were more county wide, those living in each area did speak of engaging with local clubs and activities. As we can see from the above, the issues arising here were about the accessibility of clubs

and groups, that there were clubs that served the interest to the individual, that these clubs were affordable and inclusive.

(ii) Interest

While many interviewees could identify clubs or groups that served their own interests, others had little inclination or interest in the local activities:

> **Respondent (male):** There is a lot of or rather they do cater in the valleys for the elderly I'm not saying they don't but it is something of your own making. Myself I wouldn't want to go to an old age centre and sit supping tea, it's not my thing and it's not [Jane]'s either.
> [...]
> **Respondent (female)**: What you find is it's mostly people; the elderly that go there that haven't got a husband. They're widows like you know and they go there. (Mountain Ash Older Resident 5 couple)

Here this couple identify two reasons for not participating in a particular activity. One has to do with the actual activity ("sit supping tea"), and the second with the absence of identification with members ("They're widows like, you know, and they go there"). The distaste for the activity and the lack of identity with the group form material groups for a disassociation with this group. Other interviewees mentioned different reasons for their unwillingness to participate, including "well I don't want to go out in the nights[...] Come seven o'clock I don't want to be out I want to be in you know" (Sketty Extracare resident). One interviewee did not join a local walking group "because I walk a lot anyway" (Mountain Ash Older Person 4) thus there was no incentive to join this group. Another issue was about accessibility:

> **Respondent 1:** No I don't. I don't think there is anybody from here going now.
> **Respondent 2:** Mum doesn't drive anyway.
> **Respondent 1:** The woman that used to go there, she passed away didn't she? So there is nobody from the top going now. (Aberdaron, interview 9)

Finally, there was the need to provide a range of activities so that people could select an activity they wished to participate in. For one interviewee:

> [...] plenty is going on. Different types of dancing and...I don't belong to any of that. I belong to the 50+ club. Why it's called 50+ I don't know, none of us are 50 there. We have discussions and things like that. We've got WI, we've got Mothers Union and things. There are plenty of social things. (Rhayader, interview 6)

In summary, the interest in participating in community was not something that was equally shared among older people. Those interviewed selected the groups or activities that they wished to become involved with based on their own interests and their identity. Thus, although there may be a range of activities in any particular place, the older residents may still select from among the available activities.

(iii) Clubs becoming inactive

A theme that emerged strongly in four of the places was about the loss of clubs as a result of ageing and death:

> **Respondent:** yes it [the Conservative Club] used to be very busy years ago…it's gone very quiet now..like all the clubs so…um it's not…you don't look forward to going

down there..it's not exciting anymore…you're not going to see many people for a start and most of them down there, they just sit and they don't do anything……
Interviewer: But you've not been getting new people into the Conservative Club either..you've just been sort of like…
Respondent: No and sadly because it's a nice place but no…down..
(Cardiff Older Person 8)

The issues here were to do with the loss of existing participants, and the unwillingness of younger older people to become involved. Thus the Women's Institute in "Llanarth was very buoyant until last year, a lot of lads died in the [inaudible 0:16:28.7] but we are about 25 in numbers. It's not bad" (Llanarth, interview 7). This loss of community was not only instigated by death and exit from community, but also the difficulty in recruiting younger people to become members. On recruiting new members, one interviewee indicated that efforts were made but were unsuccessful: "No, I wish I could, I wish I could, but they're just not interested you see, soon it will be only old fogeys like us" (Llanarth 851):

Respondent: Nobody younger, we were all getting on, in our 70s and erm. Well a couple in their 80s, used to, you know, we were waiting on people younger than ourselves. Can't get any young people to...
(Raglan older resident 7)

Thus there was this sense of a loss of community that was combined with a loss of volunteers willing to work to create the community. The problem here arose with how, on the one hand, existing volunteers age and become unable to carry out their volunteering duties, while younger older people are less interested in participating in these forms of community and so the constituents of community age there are no available human resources to take up the role of volunteer.

(iv) Activities for fourth agers

Many of those interviewed associated community based activities with people of older age groups. Thus there was a resistance to joining groups associated with older people:

Respondent: [...] It is good and I know it sounds daft to say it, but I don't think I am old enough for [inaudible 0:06:27]. I am not being unkind. I don't mean that unkindly, but a lot of my age group they retire and then it's just sort of family and sitting at home. I am...don't think I am denying it I am not. They will sit and watch television, but I have...
Interviewer: They can be inward looking can't they?
Respondent: Yes, I haven't got that type of life. [...] Then again I think you probably keep more healthy if you keep active, that's my opinion
(Rhayader, interview 6)

The problem for this interviewee was that while she sought to connect with community, the available communities were composed of older old people that this interviewee did not identify with. Thus she was critical of her own age group for not seeking to connect with others, but also reticent about connecting with a group she did not share a great deal with. At the same time it is worth noting that those in care homes find they have little access to such activities:

Interviewer: Right was there none [community activities] in West Cross or did you not hear about anything going on, I mean sometimes they are organised through the local church or …

> **Respondent:** Yes that's right but no I don't [unclear 0:10:31], we have somebody come from the church to sing for us but otherwise no. (Sketty High Dependency Interview 2)

Interestingly, a care manager in one of the care homes noted how news of the researchers visit prompted a number of residents who would not normally participate in group activities to spend the morning in the communal area. Indeed, many of those in care homes were not interested in activities such as singing or bingo, but were interested in research.

5.6) Sense of community

As table 5.5 shows, with the notable exception of those living in Ceredigion, older people in the case study areas have a stronger sense of community than younger people.

Table 5.5: Sense of community among older age groups by Local Authority area

	Ceredigion	Gwynedd	Monmouthshire	Powys	Valley/Urban Local Authorities
	%	%	%	%	%
All	79	82	78	80	73
16-54	80	80	79	81	71
55-59	76	82	61	75	79
60-64	78	84	82	85	76
65-74	73	81	81	80	69
75+	90	88	86	77	86

Source, WRO Household Survey 2010

Moreover, the sense of community was particularly strong among those who are over 75 suggesting that the older old have the strongest sense of community. But this sense was weak among the 55-59 year old group in Monmouthshire (where many in this age group commute to work in nearby cities) and among the 65-74 year old group in the Valleys/ Urban local authority area. Thus the sense of community is linked in complex ways with both place and age.

In the interviews, there was a strong sense of (i) a loss of community, (ii) value for the support provided by the community (iii) the absence of community and (iv) the presence of a strong sense of community. The interviewees drew their sense of community from the cultural practices taking place in the area. To the extent that the interviewees had a sense of community, this sense was structured by how these practices were changing and developing.

(i) The loss of community

The sense that community had been lost was articulated in a number of ways. The change and loss of community was felt in one Church in which the participants had once been Welsh speakers and the service would be provided through the medium of Welsh whereas "you take Aberdaron now, very few people, welsh people, go to the Church. They go to Chapels. But a Church, err, has sort of things, well we've got to, everybody has to understand and it just shows, you know how things have changed" (Aberdaron 122). The composition of the community has changed so that its roots in a common

language and culture have been eroded. But this was not the only sense of loss. A number of interviewees pointed out that how "When we were young there was more of a community than there is now. People haven't got the time these days that they used to then" (Aberdaron, interview 9). In addition, there are fewer people physically inhabiting the space of community:

> Saturday we went; [Sian] my daughter; we went out Saturday and she was saying mum its quiet everywhere. On Monday night she came over and we went out together dancing and she was like look at it; she drives see; she was driving from here to Aberdare and back and she said there's nobody about and you're talking 9.30 – 10pm then coming home. No one about and years ago you would have seen them standing round the pub door, they've got their pint in their hand and they'd all be crowded there but no. (Mountain Ash, Older person 4)

This contrast highlights how society has changed and thus also the place and role of community. People simply have less time available to invest into their community than they once might have had. The sense of community lost was particularly strong in the valleys area:

> **Respondent (female):** When the pits used to close for the annual holidays wasn't it and everybody, all different streets used to walk up the Cwm and there used to be hundreds of you walking up there but nobody goes now it's not the same. The community isn't the same.
> **Interviewer:** I see
> **Respondent (male)**: We used to hang our front door key from the letter box. Can you imagine doing that today? (Mountain Ash older resident 5 – couple)

These older interviewees combined a sense of loss of community with a clear sense of community. Thus these interviewees juxtaposed a social engagement that exemplified community with descriptions of current relations that lack this sense of community. In many ways, the loss of community equates the social and economic ties that made a unique sense of community possible with a sense of community. But this fails to recognise how community is continuously reformed through the efforts that people make to overcome their potential isolation.

(ii) Community support

A second theme here revolved around the support that older people gave and received from other members of their community. In this regard interviewees mentioned how they were involved in providing help to others, and, or how, they were themselves the recipients of social support:

> The lady over the road, she is a bit younger than me but she's not coping very well with age so I go there every morning to make sure she is okay. What we do twice a week is she cooks one course and she cooks one. We eat across there. There is another couple up the road, we play scrabble and [inaudible 0:20:05.6]. There's a lot of that sort of thing going on. My phone will ring once a day or so with somebody checking up. (Llanarth, interview 8)

A number of interviewees spoke of similar forms of mutual support through a kind of benign mutual surveillance. Here, the sense of community arose out of the efforts people made to look out for one another, and their appreciation that there

were people who would look out for individuals:

> Yes indeed. Everybody's very caring, oh yes they look out for you that's one of the nicest things here. Though one morning I normally wake up fairly early, get up early, I was a bit later it was about 9:30 and my neighbour across the road saw that my blinds were still drawn and she phoned up to see if I was alright. Well some people would say oh isn't she nosey but I didn't, I thought that was rather nice. If I had been poorly she would have done something about it because they do, these neighbours do. (Rhayader, interview 8)

Thus the familiarity with and knowledge of others enabled many older people in rural places to monitor the welfare of neighbours and to act on perceptions that neighbours were in need of some help.

(iii) The absence of community

Finally, a perception that was quite strong in urban areas was about the absence of community. In these areas the question of community was interpreted in relation to the neighbourhood. For instance, one interviewee reinterpreted the question by asking "what was the last royal occasion we had….?" (Fairwater older person 2) and discussed the ensuing community gathering. The point, though, was that community comes about during exceptional moments – like the Royal wedding – and is otherwise absent. This absence of community at the neighbourhood level was repeated by a number of interviewees in urban areas:

> Not here at all….it's better up where [Marge] is but down here, no…I can tell you now..I know next door and next door but one…I don't know anybody else up the hill…just go down two doors down and I don't know anybody in those flats…as I said they've been there 50 years, I don't know anybody in those flats at all because they come and go…it's, whether it's DSS people I don't know what it is…but there's a constant influx and then next thing you'll see a removal van and they've gone and then there's another…but no, there's not much community here I can tell you round this part…no… (Cardiff, older person 8)

A number of problems were associated with community in these areas. The presence of transient populations, the lack of contact with neighbours and the accessibility of groups so that: "you've got to get to anywhere if you, if they were going to the cinema or the theatre or anything like that you've got to get there, it's not here" (Fairwater older person 2)

(iv) The strong sense of community

This experience contrasted with the strong sense of community in rural neighbourhoods:

> **Interviewer:** But is there a strong sense of community here now anyway? Or is it kind of ...
> **Respondent:** Well here, we're lucky. Yeah, we are, we're very close and very, the [unclear 25.17] is over there you know what I mean and I go over and I chat to them and see how they are, and because at [unclear 25.23] over there, one is in a wheel chair and I go over and see him and we have a chat there, and her across the road, and oh no, we've quite good here, I'm glad I moved here really. (Llanarth 851)
>
> Yeah, people walk in all the time, if they pass and I'm home they'll come

> in and have a cup of coffee and we talk and it's nice, yeah. (Aberdaron 144)

Interestingly, whereas Cardiff older person 8 above (himself in his 80s) acted as a kind of handyman for his neighbours, this willingness to help out did not ferment a stronger sense of social attachment. This contrasted with the two rural interviewees above who emphasise how they "go over and see" and "have a cup of coffee" and talk with neighbours. The main difference seems to be the willingness to invest time to talk with neighbours.

In the rural villages and towns the sense of community was linked with facilities and local events. Thus, in Raglan:

> Sense of community? They had a good erm music festival, the beginning of June, I think that went well. I didn't go to any of it though, not very interested in rock, they had some good things at the church that Friday evening. A concert or something. It was good they said. (Raglan older resident 7)

> Why I like. The main reason is it's got a very, very good community spirit. You go to certain areas and you don't get to know people and things like that...doesn't happen in Rhayader. I mean going to the shops now, I go down most days to the shops locally, it's not a question of sort of buying milk and this and that. They will talk to you and they got time to talk to you. So there is a community spirit all together, they are really marvellous. (Rhayader, interview 6)

The events triggering a gathering helped to generate a sense of community, while the occasion of visiting the local shops instilled a sense of community in Rhayader. Equally, this generator of community spirit was also found in the Extracare scheme included in the study:

> **Interviewer:** Would you say there is a sense of community here?
> **Respondent 1:** Oh yes….I mean you can go downstairs anytime of the day..there's always somebody sitting around…spend a few hours down there, the restaurant closes at four, sometimes especially in the summer we wish it was a bit later…sometimes we are there till half past four…sometimes aren't we…they don't throw us out do they…but the actual restaurant itself is closed..the bar as I call it…and they do lunches 12 till two isn't it... (Sketty, extracare group)

Nevertheless, some interviewees felt that the sense of community was unevenly shared in their locality. For instance

> There's a stronger sense of community among the older people than the young, um, that could be all over, that may not necessarily be here, um, and probably because the young seem to be more materialistic than the old. I suppose the old have given up being materialistic, perhaps they were, but now they're not because you get on in years and see the futility of it all anyway (Rhayader, 705).

The sense of community therefore varied between places so that older people had a variety of different experiences of community.

5.7) Conclusions

Regardless of where they live, older people's assessments of place are closely tied with access to services and facilities.

The presence or absence of key services and facilities can impact the ability of older people successfully to manage their lives in different places. However, generally speaking the older people included in this study were successfully able to manage their lives in the different case study areas. The interviews revealed that the dissatisfaction with place arose from a lack of investment in services and facilities, rather than an inability to cope with life in the place. Nevertheless, there are many old older people who find they can no longer function in place, and move to some form of supported living accommodation. The fact remains that there is continuing pressure on services and facilities and conflicting needs and interests so that older people both have an interest in securing the continuity of locally based services and facilities but are also interested in shopping in the large retail facilities whose presence undermines these facilities. The main divide appeared between the experiences of place of those living in coastal and rural and those in valley and urban areas. While older people in the urban and valley areas included here were concerned with the loss of services and facilities, they appeared more resigned to the inevitability of this loss than those in rural and coastal areas. Moreover, their critiques were directed as much at the lack of political will to expand goods and services, as to the absence of facilities themselves.

Although older people do appreciate the activity and vibrancy of their communities, their willingness to connect with community and to sustain community activities was based on their own interests. Community appeared as rather brittle in the case study areas. While there is a perception that there is a lot going on in the community, and these are lauded as contributing to the common good, they are also criticised insofar as they are not interesting to many, particularly younger older people, were inaccessible to those who did not belong to certain communities with the area, or did not reflect a true version of community. Equally, many older people, particularly in urban areas, have little real experience of community in their place and are critical of the lack of infrastructure that may support community. Overall, there was the sense that many older people valued community, others were content to rely on friends and family for support. But there was also a sense that the forms of togetherness needed to be rethought to better reflect the interests of a more diverse population of older people, with increasingly varied interests. In this regard there is a need to reconsider the willingness of older people to belong to groups or clubs that may be more knowledge then class or interest based.

Section 6 Conclusions

This report has considered the effect of place on demographic ageing in Wales. The report begins with an analysis of the changing experiences of the older people who participated in three waves of the WRO household survey. Analysis of this data revealed certain trends in the experiences of older people living in rural places in Wales. This survey analysis provides the background for research conducted in six places that were purposively selected to provide insight into a range of experiences in different types of localities/ communities in order to capture the diversity (and commonalities) in experiences of ageing in Wales. Based on the research material produced, we provide an analysis of developments in policy thinking across Wales and an analysis of the experiences of older people living in different types of places.

Summarising the report, the statistical analysis presented in Chapter 3, focuses on the ageing of the population in rural Wales. Within this ageing, we see stabilities – in relation to housing tenure and length of residence. We also see changes in the residence of older age groups, with the heightened service and support requirements of 'older' old age encouraging many of the 75+ age group to live closer to larger rural service centres. This trend towards older people managing their own needs is also reflected in the tendency of older people to remain in partnerships later into their older age. The effects of recession and economic change were also evident to the extent that increasing proportions of older households contained a wage-earner, and increasing proportions of older people who had a mortgage at or near retirement age. The analysis of interviews with those involved in policy presented in Chapter 4 drew attention to the development of more person centred policy on the one hand, but also the development of policy suited to place, on the other. Whilst there is an increasing emphasis on prevention and wellbeing, it is evident from this report that prevention is understood in a number of different ways. Finally, Chapter 5 presents an analysis of interviews carried out with older people living in the case study areas. This analysis drew attention to the importance of key services in older people's satisfaction with place, and to the abilities of older people to cope with life in their place of residence. The analysis of the interviewee's experiences of community highlighted the brittle nature of community for a population with diverse needs and interests. At the same time, however, interviewees valued the presence of community activities.

The joining together of the downward pressure on public finances, the successes of the health and social care providers in extending life expectancy, and the expansion of the older population, contributes to the sense of urgency in this debate. Interestingly, the core issues have been addressed by the House of Lords Select Committee on Public Service and Demographic Change (2013). Overall, this Select Committee:

> heard that a new model of care is needed, more focused on prevention, early diagnosis, intervention, and managing long-term conditions to prevent degeneration. Older people need care that is joined-up around the

> needs of the individual. It must be person-centred, with patients engaged in decisions about their care and supported to manage their own conditions. (2013: 63)

What is interesting is that what the Select Committee is discussing is how to reformulate the connections between primary and secondary health care providers, and social care providers, to deliver services at the level of the community. What is needed, therefore, are ideas about how services can work together to deliver care and support for older people living in the community. This means working to identify new ways of thinking about health care and social care delivery, but also, about the roles and resources of the community and voluntary sector, and the user of services. This report documents some of the developments, pressures, ideas and responses to the problems that ageing presents to society in Wales. These include the integration of health and social care, changes to commissioning and contracting arrangements, the development of the care market and the expansion of a prevention agenda which increases focus on the community. But in respect of these developments, the points raised by the House of Lords Select Committee here, are highly perceptive. In its report, this Committee discusses the problem of coordinating care in a system of conflicting interests; the need for integrated care, available 24 hours a day, and in a person centred manner; for a rebalancing of care spend away from acute hospitals to the community; and the need to build a care infrastructure within the community.

While the Select Committee (2013) was critical of the lack of government response to an impending crisis, it is worth noting that the situation has not developed into a systemic crisis. The census data suggests that the population of Wales is ageing, but we are only beginning to witness the effect of increased care needs with, thus far, only a minor expansion in the numbers of people over 75 years of age. However, there has been a sizeable increase in the proportion of younger older people who will require some level of care as they age. But the survey data does suggest that older people may be taking future care needs into account in making house moves, and are more ready to move to rural towns and cities than the open countryside. In addition, the changing demographic profile suggests that people are increasingly ageing as couples, and so can find help and support from a partner. Nevertheless, the population is ageing and therefore changes are needed in how services are developed and provided.

It turns out that the challenge of an ageing society is about how to reshape society at the level of community. But how is it possible to construct society suited to an ageing population at the level of the community? As the Select Committee points out, with population ageing and the need to develop a more preventative approach to ageing, there is a need to rebalance the provision of health care from acute based to community based provision. This rebalancing requires the development of an efficient and effective community based infrastructure along with a leadership willing to argue for the transfer of resource from secondary to primary care providers. While there have been developments of a community based infrastructure, this needs to be expanded. Within the statutory sector there is a need

to develop and to consider rolling out, community level preventative schemes. Schemes that service the needs of local older residents (such as community warden schemes), and schemes that encourage older people to find resources among themselves (Swansea's community connectors) are being developed. These initiatives support older people to live alone for longer by providing local access to services, and encouraging the development of social capital among older people. However, these community level interventions are vulnerable to financial cut backs to the extent that policy makers feel that the effects of such services cannot be evidenced through systematic research, while the development of such an infrastructure is dependent on the unique social and organisational history of any given community.

Two points follow from these observations. On the one hand, the argument that preventative services cannot be evidenced using research appears to be based on a misapprehension of research. The main thrust of this argument has been that preventative services, particularly those that use community resources to avert foreseeable outcomes, can only document individual stories without amounting to 'hard' proof. By proceeding to simply compare and contrast the experiences of people before and after, or in places where services have and have not been introduced, research can transform personal insight into how prevention effects individual lives into a more general argument about the effectiveness of different kinds of initiatives. Such insights can be fleshed out by inquiring into the effects of services on social networks, or social capital, but the validity of a research based argument derives from the comparison of experience. The second point is that people talk about prevention in both a medical or social manner. There is an orientation to prevent certain medical problems from arising by directly addressing medical cause, such as falls. And there is an orientation towards preventing need by encouraging people to find resources in their community. The fact that prevention can mean such different things allows it sufficient flexibility to be used in a variety of ways (see Windle, Francis and Coomber, 2011). But people working in local authorities and the community and voluntary sector do need some additional guidance to help direct and justify their work on prevention.

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