



Social Services Improvement Agency

The anatomy of resilience: helps and hindrances as we age

A review of the literature

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Foreword

A principal goal of the Social Services and Well-being Wales Act is to enable people as they age, to overcome the barriers which prevent them from achieving and maintaining well-being and to do so as far as possible without having to turn to formal social care interventions.

But what are those barriers and what do older people think would really make a difference in their lives? Do we assume we know the answers to those vital questions?

In close collaboration with ADSS Cymru and Heads of Adults Social Services in Wales, SSIA will be publishing two new pieces of work which will shed new light in this area. This is the first of them. It is an elegant abstract of the relevant published research evidence from Wales, the UK, and further afield. It is a significant contribution to the literature, designed so that people can find their way readily and quickly to the best evidence that exists.

Important strands emerge. “Social connectedness” and the importance of finding and building on the strengths in individuals, families and communities. How we plan for and cope with (or not) key life events and transitions. What assists us to seek (or stops us from seeking) timely advice? And what can trigger (or arrest) abrupt declines? Each reader will find their own insights and prompts to thought and action.

We are grateful to Imogen Blood and her Associates for producing this literature review for SSIA, and particularly to Parry Davies and Julie Boothroyd for helping to guide this work.

Imogen and her Associates are now working on the second phase. This will see them talk with well over 100 people age 75 and over, individually and in groups across Wales; elderly people, not yet calling on care or support (so that they are less constrained by the experience of how things are now), but beginning to think about the challenges and opportunities ageing will bring. They will particularly talk with carers as well.

We will publish a second report by February 2016. This will give those interviewed a platform to speak powerfully to us about what might make the biggest difference to their sense of well-being and independence as they age, for good or ill. It will be just what those people tell us, not filtered by any organisation, profession or interest group. We will also ask some key leaders in the field to respond to what has been said.

As Councils and their partners think hard about their population needs assessments and how they redesign their response, we are confident that these two reports will be a useful contribution to that thinking. And so, in turn, to the implementation of the Social Services and Well-being Wales Act, to realising the Welsh Government’s well-being outcomes and to enriching the lives of all of us in Wales as we age.

1. Introduction

This research project set out to answer the following questions:

- What are the outcomes that matter most to older people in relation to their personal well-being?
- What are the real and everyday barriers that most prevent older people attaining these outcomes?
- Which roles do and might statutory and voluntary sector ‘services’, community networks and informal carers play in reducing these barriers?
- What are the experiences and ‘pathways’ of those who are just starting to face challenges to their independence and well-being (and their supporters)?
- What is the learning for a whole system approach to early prevention?

This report covers **Stage 1** of the project: an evidence review, which identifies, reviews and critically appraises the Welsh and wider UK literature in relation to the above questions, focusing on carers and older citizens, with a particular focus on those who are not already engaged with services.

Stage 1 is intended to inform **Stage 2** of the project, due to happen between July and September 2015, when we will be going out to different parts of Wales to hear the views of around 100 people aged 75 and around 30 family members who are supporting them, through focus groups and interviews.

Although we initially started out thinking about the significant *barriers* older people might face, we soon agreed that more pertinent questions for service providers (and indeed for all of us as individuals) emerged from a more strengths-based approach:

- What are the secrets of success of those who lead fulfilling and independent lives in their later years?
- Which resources and personal strengths are most relevant to us at this stage of our life course?
- How can we understand the *anatomy of resilience*?

1.2. Structure of this report

We began by considering the findings of recent qualitative research with older people: what are the key messages from this in terms of what matters most to older people themselves?

In **Section 2**, we identify and compare these themes and, from them, develop a working model of the anatomy of resilience, which contains eight different aspects of people’s lives, represented as segments of a circle. We then identify and briefly review the literature on each of these segments.

In **Section 3**, we present our findings from the evidence review in relation to each of the ‘segments’, providing headlines, definitions, key themes and statistics from the evidence, paying particular attention to how each segment relates to the other, and what all this means for the next phase of our research.

In **Section 4**, we propose another working model, to understand the sorts of crises which – often combined with each other – typically bring people to Social Services’ door or to unplanned long-term care. We present headlines from the evidence in relation to some of these factors.

In **Section 5**, we present messages from the evidence review on approaches and models for ‘prevention’.

In **Section 6**, we discuss the cross-cutting themes that emerge from the evidence review and consider their implications for service providers and policy makers and for our fieldwork with older people and their supporters.

2. Developing a model to understand resilience

2.1. Overview of the qualitative research with older people

There have been a number of qualitative studies in the UK in recent years asking older people what matters to them, and what helps or gets in the way of this. For example:

- Age Concern England conducted research with older people, exploring their understanding of ‘independence and well-being’ for the Audit Commission (2004) and the Department of Work and Pensions (DWP)
- Bowers, *et al.* (2009), commissioned by JRF, talked to older people who lived in care homes, extra care housing or supported living about their experiences, producing a framework called the *Keys to a Good Life*
- In 2009, a team from Glyndŵr University (Parry *et al*, 2009) conducted qualitative research with 39 people aged 50 and over drawn from 9 counties across Wales¹. They explored themes of health and well-being with participants to inform the Older People’s Wellbeing Monitor for Wales (Welsh Assembly Government 2009)
- The Alzheimer’s Society (Williamson, 2010) asked people who have a dementia diagnosis to prioritise quality of life indicators. 44 people (in England) were involved in the study, through listening events, focus groups and a postal survey
- Katz et al (for Joseph Rowntree Foundation (JRF) 2011) conducted in-depth interviews with 26 older people with high support needs across the UK (including four in Wales) to find out what they valued. They developed a ‘wheel’ which organised ‘what I want and value’ into ‘Social’, ‘Psychological’ and ‘Physical’ aspects and identified a number of barriers and enablers to achieving these: information, finances, technology, equipment, transport, other people’s time, and support
- In our subsequent qualitative research for JRF with 100 older people with high support needs living in housing with care schemes across the UK (Pannell *et al* 2012, Blood *et al* 2012), we used the themes identified by Katz (2011) to analyse our data on older people’s experiences of housing with care and their pathways into it
- The University of Brighton (in partnership with Age UK Brighton & Hove) led a participatory research study, working with older local researchers to explore what well-being means to older people and how it is generated. The project has produced a series of short films, a handbook and a research report (Ward *et al* 2012)
- In a recent study for Age UK Gloucestershire (Blood & Litherland 2015), we interviewed 88 older people living in 12 care and nursing homes across the county (many of whom had dementia) to find out about their experiences of living in care and their views on what makes a good life in care

¹ These were dispersed across Wales, though there appears to have been more coverage in the North than South: Anglesey, Cardiff, Conwy, Denbighshire, Flintshire, Gwynedd, Powys, Swansea, Wrexham.

- Andrews et al (2015) have been working with frontline staff and older people in an action research project to implement some of the findings of the Joseph Rowntree Foundation *A Better Life* project (Blood 2013) in Wales and Scotland.

2.2. Links to outcomes and measures frameworks

The Welsh Government (2015) has established a national outcomes framework for people who need care and support and carers who need support. Core themes include:

- Securing rights and entitlements
- Physical and mental health and emotional well-being
- Protection from abuse and neglect
- Education, training and recreation
- Contribution to society
- Domestic, family and personal relationships
- Social and economic well-being
- Suitability of living accommodation

ONS (2014) has identified the following aspects within its measures of national well-being:

- Personal finance
- Economy
- Education and skills
- Governance
- Natural environment
- Personal well-being
- Our relationships
- Health
- What we do
- Where we live

2.3. The ‘anatomy of resilience’ model

In the table overleaf, we present and compare the key themes that emerged from four of the qualitative studies set out on p.9 (Audit Commission 2004, Bowers 2009, Williamson 2010, Katz 2011).

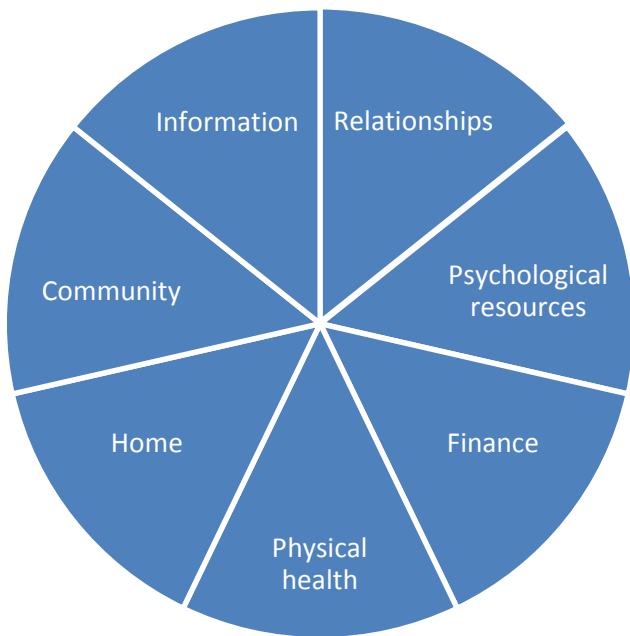
From this exercise, we identified seven core themes around which to organise this evidence review. Unsurprisingly, these resonated pretty strongly with both the National Outcomes Framework and the National Well-being Measures listed on the previous page. Our thematic headings are presented in the wheel below. We believe this model offers a starting point to describe and understand the ‘anatomy of resilience’ – or the things that help older people to retain their well-being and independence and reduce the risk and impact of crises.

Table comparing key themes from existing research with older people on quality of life

Bowers (2010)	Williamson (2010)	Katz (2011)	Audit Commission (2004)
Personal identity & self esteem	Relationships or someone to talk to	Personal relationships	Housing and Home
Meaningful relationships	Environment	Good relationships with carers	Neighbourhood
Personal control and autonomy	Physical health	Social interaction	Social activities/networks
Home and personal surroundings	Sense of humour	Making a contribution	Getting out and about
Meaningful daily & community life	Independence	Cultural & social activities	Income
Personalised support & care	Ability to communicate	Self-determination	Information
	Sense of personal identity	Continuity & adjusting to change	Health/ healthy living
	Ability or opportunity to engage in activities	Humour & pleasure	
	Ability to practise faith or religion	Sense of self	
	Experience of stigma	Mental health	
		Safety & security	
		Good environment	
		Physical health	
		Physical activities	
		Getting out and about	

We have used colours to group related themes across the studies, and in order to develop the working framework for our evidence review.

The Anatomy of Resilience



After our initial scoping of the literature, we added a further theme of '**Work and Learning**'. Perhaps unsurprisingly, this theme did not emerge from the studies conducted with older people living in care homes (Bowers 2009) those with a diagnosis of dementia (Williamson 2010) or high support needs (Katz 2011). However, for our proposed cohort of those aged 75 and over, who are independent, but starting to encounter barriers, questions of retirement, work and involvement in both formal and informal learning may well still be relevant.

The International Longevity Centre (2015) recently announced that over 16,000 people aged 80 and over in England are still in paid employment. Nevertheless, we expect that the vast majority of those we speak to will not be working, however for this group, we believe it will be important to understand their pathways over the preceding 15 years.

3. Findings from the review by theme

3.1. Relationships

Headlines

Older people consistently say that their relationships are one of the most important contributors to their well-being (see for example Blood 2013, Bowers 2009, Williamson 2010, Katz 2011). Relationships can be varied and complex, and may include those with:

- Spouse or partner (though many older people will be single, separated or divorced and, as age increases, many will be bereaved)
- Family members (i.e. relatives by blood and by marriage/partnership) although some (especially the very old, and single people) may have no relatives, others may not be in touch with their birth families (we know, for example, this is more likely to be the case for lesbian, gay or bisexual (LGB) people of this generation (Stonewall 2011))
- Close friends can be more important and involved than relatives (again, many LGB people – and others - build ‘families of choice’)
- Colleagues (if still working, or volunteering); other students (if engaged in lifelong learning)
- Acquaintances and members of the local community (e.g. neighbours, local shops, librarian, pub, faith groups, etc.)
- Paid staff and volunteers from statutory agencies (e.g. GP, social worker); voluntary sector (e.g. memory cafes, carers forums); or formal care services (e.g. homecare, day services)
- Pets are, in some cases, the main source of companionship, although this can complicate people’s choices (e.g. barriers to moving house if there is a “no pets” rule in flats, sheltered or retirement housing).

Relationships are key to health and well-being. There is good evidence to show that:

- Loneliness and isolation impact significantly on both physical and emotional health
- Carer stress and breakdown is likely to lead to crisis (for cared-for person) and ill-health (for the carer).

There have been some evaluations of initiatives to tackle both of these issues.

We present an overview of the literature on loneliness and isolation and on carer breakdown in section 4.4.

Carers²: what do we know?

- There are over 370,000 carers in Wales (Carers Trust Wales/ Cymru website).
- Carers can include:
 - Spouse/ partner (usually living together)
 - Other family carers (e.g. siblings, son/ daughter, in-laws) who may or may not be living with the cared-for older person
 - Friends or neighbours, e.g. Carr & Ross (2013) describe the provision of care by a circle of friends to an older gay man who has had a stroke and Bowers et al (2011) describe mutual support between an older woman and a young single mother living next door.
- Carer arrangements vary greatly and can be complex, e.g.:
 - Shared care by different family members or friends
 - Reciprocal care within a spouse/ partner relationship
 - Many carers are balancing work and/or other family caring (e.g. for disabled children or for grandchildren) (Carers UK 2014, Newbronner et al 2013)
 - Family carers may be very local or hundreds of miles away; caring at a distance creates different issues.
- There has been a significant increase in the numbers of older carers in England and this is likely to also apply in Wales. Analysis of Census and other data (England only, Carers UK/ Age UK (2015) shows 35% increase for carers aged 65+, and 128% for carers aged 85+ between 2001 and 2011
- These very old carers are also more likely to be male (59% men), caring for a spouse/ partner, and providing over 50 hours a week of care (Carers UK/ Age UK 2015)
- The UK census found that carers (of any age) providing care for over 50 hours a week are more than twice as likely as non-carers to be in bad health (Carers UK 2014)
- Changing family demographics and circumstances are reducing the availability of family carers (CPA 2014)
- Male carers may find it more difficult to adapt to the caring role and can be more reluctant to access services (Newbronner et al 2013)
- Nearly half (45%) of carers aged 75+ are caring for someone with dementia (Newbronner et al 2013).

² NB: We are using 'carers' here to refer to (usually unpaid) family members or friends, in contrast to 'care staff' (eg home-care assistants).

Strengthening networks and asking for help

A common theme in conversations with older people is that they fear ‘being a burden’ on family members, partners, friends and neighbours. Finding ways to make asking for and receiving help and support more psychologically palatable is likely to be a key task for preventative services.

Joseph Rowntree Foundation’s *Risk, Trust and Relationships* programme is seeking to better understand informal relationships in an ageing society. In their study of ‘kindliness’ in Hebden Bridge (West Yorkshire), Allen et al (2015) found that most people feel uncomfortable asking for or receiving help or identifying themselves as ‘lonely’. People were often more able to accept help when it was not explicitly framed as help or support and particularly where it included giving to others or making some form of contribution through a mutual relationship. They found that negative experiences of helping or prevailing messages of self-reliance can act as barriers.

We know that peer support can be extremely valuable to people with dementia (Weaks 2012; Chakkalakal 2014; Healthbridge 2013; Ward 2011), widows (Bennett 2015), carers (Charlesworth et al 2011) and others. However, Allen et al (2015) remind us of the different dynamics, issues and opportunities for men and women in linking into networks of support. Research evidence suggests that many men do not feel comfortable with mainstream (typically female dominated) older people’s clubs and ‘support groups’ (Milligan et al 2013). Evidence from evaluations suggests that loneliness interventions are more successful in reaching women than men³.

Initiatives such as ‘Men’s Shed’s’ (Milligan et al 2013), walking groups (NDTi 2014) and other activity-focused groups can provide a more comfortable way into building mutually supportive relationships than ‘support groups’ per se.

Relationships with professionals and paid carers

Older people with high support needs consistently tell us that they value friendliness from paid carers, opportunities to spend time building relationships with them, being treated with respect and having a laugh (Blood 2013, Andrews et al 2015). However, in this era of the 15 to 30 minute, task-focused care visits (usually drawn from a large pool of carers), this connectedness is illusive for many.

Our focus here is on people who are not (yet) accessing social care services. Phillips et al (2011 – p.61) found in their research with older people in Rhondda, Cynon Taf and Powys that few had a strategy in place for responding to sudden illness or disability - most ‘had difficulty picturing what kinds of services they would need’. We know from Burholt & Windle’s (2007b) research in North Wales that ‘no one wants to have to live in a residential home’, but we know less about how older people who are not (yet) receiving services perceive domiciliary care and the types of services which Social Services might offer them.

³ Dr David McDaid (LSE) speaking in April 2015 at a NIHR SSCR/ Campaign to End Loneliness event

Do these perceptions (perhaps fuelled by media reports) put them off approaching Social Services and, if so, what impact does this have?

Do they find their own sustainable alternatives or do they end up reaching a crisis that might otherwise have been averted?

How do relationships interact with and link to the other segments of our model?

Psychological resources: The literature emphasises the importance of relationships in promoting resilience - Blane (2011) argues that relationships are indeed the most important factor in this.

Finance: Lack of finance can cause older people and carers to cut back on social interaction. For example, in research conducted by IPPR (2009), many over-50s who were struggling financially reported cutting back on socialising and getting out and about.

Health: There is clear evidence of the link between loneliness and both mental and physical ill-health (e.g. Age UK Oxfordshire 2012, Holt-Lunstad 2010).

Home: Moving house in later life can mean a loss of friendship networks – or sometimes the beginning of new ones, especially when someone moves into retirement or extra care housing (Kneale 2013; Callaghan et al 2009).

Community: Local facilities, transport, and the accessibility of public places can enhance or reduce opportunities for social engagement.

Information: Not knowing about local activities is one clear barrier to participation.

Work and learning: Paid work (usually) provides social interaction and feeling of worth to older people and carers (plus other benefits such as money to pay for social activities, transport, etc). Retirement can reduce social contact, unless replaced by other activities (e.g. volunteering/ lifelong learning).

Evidence gaps and implications

- We have traditionally seen the ‘carer’ and the ‘cared for’ as distinct individuals, but the research reminds us that these relationships are often complicated and dynamic and are typically characterised by mutual care and interdependency
- Emotional support for all parties is often overlooked. Attachment theory may offer us a way of understanding historical and ongoing patterns and behaviours in family relationships: in some cases, this will be a necessary first step to supporting people to care and/ or be cared for and can be a core part of a strengths-based approach
- Practical support for carers is typically seen as help with personal care, practical tasks and/or respite, however, the importance of practical support with decision-making and with understanding and managing behaviour (especially for people with dementia) is highlighted in the research with carers

- We need to see the individual as part of their networks and, where networks are non-existent, weak or dysfunctional, we need to intervene (ideally ahead of a crisis) to help the individual develop or strengthen this. Models such as Circles of Support (NDTi 2014b) can provide a ‘person-led’ way of achieving this
- Friends can be just as important as relations. Bennett (2015) found (conversely to what professionals tend to assume) that older spousal carers value the support of strong friendships, more than they do strong family relationships
- The importance of time and continuity for paid staff to build relationships with older people emerges from the literature again and again (Blood 2013), yet our current system of quick, task-focused home visits by a frequently changing pool of carers rarely provides this (O’Sullivan et al 2011) (Sykes 2011) and the ‘emotional labour’ (Sawbridge 2011) required by health and social care workers to make this happen is often not recognised, valued or supported
- If we are to prevent carer breakdown and crisis, we need to build a better understanding of the types of transitions that can impact on the ecosystem of care and support.

There needs to be a shift in the work culture from a primary focus on only maintaining people’s independence to one of maintaining their connectedness” (Chakkalackal 2014).

Much of the research literature is for England only, or is UK wide but does not provide a breakdown of findings or statistics relating to Wales. Are the findings on loneliness and isolation and on carers equally applicable to Wales? Are there particular issues affecting relationships in some localities (e.g. incomers versus locals? Welsh language/culture?) and how much evidence is there of this? We return to some of these questions in the section on Community. Newbronner et al (2013) found a dearth of empirical research evaluating interventions developed to support carers of people with dementia. They found no evidence on interventions to help carers with the changing and sometimes difficult behaviour of people with dementia, despite the fact that this was identified by many as being the most difficult part of caring.

Implications for Stage 2

We might wish to:

- Explore transition points for older people, and their carers
- Ensure we include sufficient people with dementia and their carers
- Look at the experiences of older carers (especially the very old, many of whom will be male, as we know that this group may be most likely to break down, leading to crisis)
- Tease out carers’ needs, e.g. for emotional and practical support (e.g. in decision-making: Livingston et al (2010); in reablement services: RVS Cymru (2012,) as well as from formal services and social work contact
- Understand the relationship dynamics in becoming carer or cared for.

3.2. Community

Headlines

It has been estimated that people aged 70 and over spend 80% of their time either in their home or in the immediate surrounding vicinity (Phillipson 2015).

Feeling you belong to your neighbourhood and agreeing that ‘friendships and associations in my neighbourhood mean a lot to me’ increases strongly with age, and is slightly higher for women at every age group (ONS 2013). In the National Survey for Wales (National Statistics 2015), 88% of people aged 75 or over said that people in their local area treated each other with respect and consideration, compared to 68% of people aged 16 to 24. 83% of those aged 75 or over thought that their local area was a place where people from different backgrounds get on well together compared with 74% of people aged 25 to 44.

However, further analysis of the ELSA (England only) datasets suggest that some groups of older people are more likely to be ‘detached from social participation’ than others. These include: those who are poorer, less educated, without a partner, living with long term conditions, with poor access to transport, and men (Hennessy 2015).

The physical environment

Much has been written about how physical aspects of neighbourhoods play a vital role in supporting the well-being of older people in Wales and beyond, both in terms of practical access but also in terms of enabling and encouraging social interaction:

- The Older People’s Commissioner for Wales (2013) engaged widely with older people across Wales (though not through systematic research) to explore the ‘1000 little barriers that get in the way’. Many of the issues raised focused on the physical accessibility of local neighbourhoods: public toilets, pavements, public seating, bus shelters and timetable information, and disabled parking
- The Hebden Bridge research (Allen et al 2015) suggests that older people (and others) use a wide variety of ‘hubs’ to connect with their local communities. We know that older people can be particularly vulnerable to the loss of local resources. For example, Consumer Focus Wales (2010) highlights the impact on older people of the closure of local post offices; and ILC-UK/Age UK (2014) of pubs and local shops. Eynon (2014) demonstrates how libraries play a vital role in building community cohesion, social inclusion and contributing to the individual health and well-being of older people in Wales
- All 22 Welsh Local Authorities have signed up to the Dublin Declaration on Age friendly cities and communities, though there does not appear yet to be any published information about the practical steps taken or any formal evaluation of this in Wales
- There have also been two good studies on access to transport for older people in Wales:

1. WRVS (2013) research⁴ found that a lack of suitable transport had a huge impact effect on well-being. Six per cent of their respondents said they felt lonely because they could not get out and about (and we know that older people tend to under-report loneliness (Allen et al 2015)). Barriers to accessing transport included accessibility, safety and affordability. Community transport provides services where public transport cannot or does not (e.g. community bus and car schemes, minibuses and dial-a-ride schemes). In Wales, the community transport sector provides over 1.2 million passenger journeys each year (CTA, 2010). Some local authorities include community transport within concessionary travel passes but a pilot project (2015-2012) to extend this practice across Wales was discontinued.

Research on well-being in older people (commissioned by the WRVS and partners) found that reliable public and community transport could help overcome barriers to the involvement of excluded older people (Hoban et al 2011). The Older People's Commissioner (2010) found that, without the concessionary bus pass, many older people would be housebound and unable to access essential facilities and remain integrated in society.

2. Age Cymru (2013) research on older people's bus use in Wales included an evidence review, survey and case studies⁵. Previous research (Burnett 2005) had identified older people's most important bus use as being for food shopping, accessing the post office, bank and their GP's surgery. Obviously with the closure of local shops, post offices and banks, older people may have to travel further.

The Age Cymru (2013) survey and focus groups found a high level of reliance on buses, but a dearth of bus services in many communities and at certain times (especially evenings and Sundays), likely to be exacerbated by the 25% cut in support subsidies from 2013. They identified significant variations in the challenges faced in different communities (both urban and rural), but including:

- Problems getting to and from hospital, even in urban areas, and often having to use expensive taxis because of no/ poor connections to arrive in time for appointments (one example given is getting to the new hospital at Mountain Ash from Merthyr Tydfil)
- Poor/ lack of information about bus services on-line, in printed timetables (print too small) and at bus stops (especially when there is more than one operator)
- Poor or non-existent shelters, not even clearly indicated bus stops in some rural areas
- Buses not going to where people needed to go, or only to the edge of it (e.g. to a shopping centre, but not near to the entrance, which can be especially problematic for people with disabilities).

⁴ UK-wide, including interview survey of 300 people aged 75+ in Wales

⁵ Involving over 300 older people: all-Wales postal/ on-line questionnaire (48% of respondents aged 75+), eight focus groups and three case-studies: Aberystwyth, Merthyr Tydfil, Welshpool).

Social capital

A recurring theme from the Joseph Rowntree Foundation's *A Better Life* programme was just how much older people with high support needs value opportunities to make a contribution to their local communities (Blood 2013).

Analysis of SHARE (European dataset on older people) suggests that 10% of European older people do voluntary work, 17% give informal help, 5% care for someone sick or disabled (Roberts 2012). Many older people also act as the 'social glue' in their communities, even when they themselves are living with long-term conditions (WRVS 2011).

Analysis of English (ELSA) data on volunteering by the ONS (2013) shows that older people who volunteer have higher levels of well-being (in terms of reported quality of life, depression/ isolation levels) than those who do not – though the statistics do not explain the causal relationships here.

ScotCen Research's (2014) study of 'everyday' help and support in Glasgow reminds us that a 'community experienced by one person as supportive and close-knit may be experienced very differently by another'. It also highlights how shifting neighbourhood profiles (with lots of 'incomers' into an area) can cause feelings of insecurity and disconnect with the area. If people do not have the opportunity to get to know each other, they can develop ideas about each other based on stereotypes, misperceptions and projections. We can imagine this being an issue for many indigenous older people in Wales and also for older people who have moved to new communities (or into Wales) in order to retire ('incomers'), and also for older BME people.

The Hebden Bridge study (Allen et al 2015) also suggests that attachment to place can be as much about 'imaginative identification' with the idea of the community and the love of the landscape as it is about geographical rootedness. Sometimes this pride and attachment to place can drive mutual support and friendliness in communities.

Services may have a role in providing ways and means to build, enable and support older people's connections to social networks. This might be about facilitating groups, promoting the use of technology for communication, providing information and advice on volunteering, or reducing some of the practical barriers.

Evidence gaps and 'so what' implications

The evidence points to the need for a joined up neighbourhood approach to tackling barriers and promoting the social inclusion of older people. Practical solutions may need to involve transport providers, local businesses, highways, parks, and so on.

This may require someone 'on the ground' who is in touch with many of the older people in a neighbourhood and can link people into services, report and chase issues. The Gloucester Village Agents model (in which a local 'agent' is paid on a part-time basis to connect with local older people and link them into local groups and services – see Gloucestershire Rural Community Council 2010) offers one approach to this; Local Area Coordination (which is operational in Monmouth) offers another.

Although mutual support has a key role to play in promoting well-being and meeting ‘low level’ needs, we know that it can only go so far for most people. Dalley et al (2012) found that mutual support arrangements often break down where one party feels they can no longer reciprocate; few will develop to include, say, personal care. However, support from neighbours can provide the low level ‘eyes and ears’ type support of a traditional sheltered warden and can be a key part of a ‘package’ which makes continuing to live at home possible, even for someone living alone with high levels of need.

There are various initiatives and models which seek to build a community of support, ranging from Circles of Support (NDTi 2014b) – which aims to build an individual’s networks, through to Circle (<http://www.circlecentral.com>) – a mutually supportive membership model for the over 50s, which operates at a town or local authority level.

There is a challenge here for Social Services as to whether and how they can target this sort of initiative at certain ‘at risk’ individuals to build their networks and their resilience earlier on in the ‘pathway’. We cannot suddenly build these sorts of networks where they do not already exist in the middle of a crisis situation. Perhaps the only way to approach this is to move to a much more collective view (rather than a focus on the individual client). However, if these projects run in a particular area, there may be a risk that those who need them most (at least further down the line, potentially) – i.e. the ‘loners’ rather than the ‘joiners’ – will simply opt out or not come into contact with them.

There seems to be less evidence on:

- Whether and how living in a mutually supportive and/or age-friendly community changes older people’s access to and needs from public services and how formal and informal support mesh together
- Research in Welsh local settings: whilst it seems unlikely that ‘being in Wales’ is a significantly different variable from ‘being in England’ when it comes to understanding social capital, there are very distinct and diverse urban and rural communities in Wales and we do not seem to have much evidence on these questions in relation to them.

Implications for Stage 2

The Young Foundation has developed and piloted the WARM tool to measure well-being and resilience in local communities (Roberts 2012) – some parts of this framework may be useful for us in thinking about stage 2, e.g. we could incorporate some of their key questions:

- How many people can you rely on to help in times of need?
- Overall, how would you describe the quality of your life?
- In the area where you live, would you intervene to help a child who was being hurt in the street?
- How confident do you feel?

<http://youngfoundation.org/wp-content/uploads/2012/10/Taking-the-Temperature-of-Local-Communities.pdf>

Gender is a key here: how do we make sure we reach enough men (especially those living alone and those from working class backgrounds) through our fieldwork? We understand that the Older People's Commissioner for Wales has, for example, been using social clubs of former mining communities to engage with older men.

3.3. Finance

Headlines

The number of older adults living in poverty has fallen over the last two decades, but still remains high: 1.6 million older people currently live on or below the poverty line (Age UK, 2015).

The underlying issue for many individuals is that their savings and pension income fall a long way short of what they were previously earning from employment. Some may never have had much in the way of income when they were younger.

The overall policy framework for older people, whether working or retired, has evolved in a highly piecemeal fashion and much of it feels dated. The high levels of poverty in the 1980s and much of the 1990s still form the back-drop to the way older people are treated in the tax and benefit system.

Maximising the income of older people is a strategic objective of the Welsh Government. Ageing Well in Wales, 2014-19 (Welsh Government 2014), states this objective in the following terms:

“Older people in Wales benefit from maximised opportunities to increase their income (by):

- Increasing the numbers of people aged 50+ in Wales who are economically active
- Developing and improving older people’s financial inclusion schemes”.

This objective is understandable in the context of research evidence (Smeaton et al, 2009) in relation to older people, especially women, struggling financially to meet their needs:

- Twenty per cent of women and six per cent of men claim that their income is *completely* inadequate to meet their needs
- 24 per cent of men and 37 per cent of women have incomes that are less than adequate.

Research undertaken for Consumer Focus Wales (2010b) showed that a small but substantial proportion of older people in Wales have delayed their retirement because of the impact of the economic downturn. 42 per cent of people aged over 50, particularly those on a low income or state pension, were finding it harder to manage financially now compared to 12 months previously. A quarter of people in this age group think that their household’s financial situation will get worse over the following 12 months.

“I do think it is important people feel that they have got adequate means without having to worry.... I wouldn’t want a lot of money, but you need to feel that you have got adequate”.
Ward et al (2012)

The evidence base

A number of studies warn against using subjective measures of poverty as older people will often describe their incomes as sufficient when their actual levels of income are well below the poverty line and their circumstances are extremely meagre (Berthoud et al, 2006; Burholt and Windle, 2007; Consumer Focus Wales, 2010).

Consumer Focus Wales (2010) suggests that over-indebtedness and poverty among older people is likely to become a bigger issue in the future. This is because there will be more older people, living on less money than they expected, taking more debt into retirement and lacking the financial skills to manage their money effectively. The National Centre for Social Research (Barnes 2012) has identified different forms of poverty amongst older people – income poverty, wealth poverty, financial exclusion, material deprivation, debt and fuel poverty – and considered how these tend to cluster and interact for different groups.

There is evidence of increasing socio-economic inequality amongst older people. The Institute for Fiscal Studies (Hood 2014) predicts that the gap in weekly income between the poorest and the richest quintiles will double by 2022. The richest quintile will be over £1200 a week better off than the poorest as a result of the combined impact of earnings, private pensions and income from assets and property.

The likely impact of all this on well-being is less clear. As older people in the low to middle income group fall behind their more affluent peers, they are likely to experience severe consequences for standards of living in retirement (Analysis of Family Resources Survey 2009/10, Cory 2012). The majority of older people in this group may not be eligible for means-tested pension benefits yet are unable to build sufficient savings to maintain a comfortable standard of living in retirement.

Recent research from the Strategic Society Centre (Parry & Lloyd 2015) found that even when controlling for wealth, level of guaranteed income was significantly associated with multiple and varied outcomes in people's lives, such as:

- Spending habits
- Sense of autonomy and control
- Life satisfaction
- Participation in community and civic society.

Participatory research undertaken by Ward et al (2012) confirmed the importance of financial resources to older people. 'Having enough' without having to worry came up in many people's accounts.

"I never wanted to be rich....but I think it's nice to have enough and its nice not to have to worry....it is important to have enough".

Ward al (2012) note that for some people having enough money is linked to feeling independent, able to be in control and make choices. Well-being is not directly related to wealth or the material circumstances of people's lives, but anxiety about having enough money can detract from well-being as well as reduce the options available to people.

Worrying about money can have a considerable impact on well-being: in our UK-wide study of self-funders living in housing with care schemes (Pannell et al 2012), we were struck by just how far up the income scale worry about finances goes. A poll conducted for the Resolution Foundation found that more than one in three low to middle income households is worried about managing financially in retirement (unpublished: polling for Resolution Foundation 2012). Problem debt may affect only a relatively small number of older people, but the challenges they face can be disproportionate (International Longevity Centre and Age UK, 2014b).

Fuel poverty

In 2012, 30% of households in Wales (386,000 households) were estimated to be in fuel poverty; this was a significant increase from 2008 (Welsh Government 2013). Fuel poverty contributes to excess winter deaths: in winter 2012/13 there were around 1,900 excess winter deaths in Wales (ONS 2013b), with an estimated 1,700 deaths of people aged 65+ (Age Cymru 2014). Fuel poverty is defined in Wales as spending 10% or more of income on energy costs, including Housing Benefit, Income Support or Mortgage Interest or council tax benefits (Welsh Government 2013). Single person households have a higher risk of being in fuel poverty because fuel costs tend to be a bigger burden, relative to incomes (Welsh Government 2015b).

In their survey of over a thousand adults (nearly half of whom were over 50), Consumer Focus Wales (2010b) found that paying fuel bills was a particular concern for older people, and many had cut back because of money problems. Projects to encourage the take-up of benefits and offer advice on funding for home improvements (e.g. insulation, more efficient heating systems) can help older people experiencing fuel poverty.

How does finance interact with and link to the other segments of our model?

Psychological resources: There is some evidence that the attitudes held by the majority of older people in relation to money may help their overall resilience. Research undertaken by Consumer Focus Wales (2010b) identified that there were a number of general attitudes and behaviours displayed by people over 50 (this research included people over 75 years). They:

- Were more likely to budget
- Were more likely to save for a rainy day
- Would rather save up to buy something
- Only spend what they have at the time and
- Prefer not to borrow money.

The state of older people's finances will be influenced by the extent to which they have or have not been able to plan for their older age. Planning for the future suggests the importance of access to appropriate **information and advice**, including financial advice. Research undertaken by Consumer Focus Wales (2010b) suggests a clear need for financial planning and advice on how to prepare for retirement, among people reaching retirement age.

In addition, the findings from their research also show that many people (under 75 years) are facing a future retirement with less money than the current retired population because of the reduced returns on savings, investments and personal pensions, and less money put aside in savings for a rainy day.

Health: Debt problems are well known to be a strong risk factor for mental health problems at all ages (International Longevity Centre and Age UK, 2014).

In relation to the ‘physical health’ component, some older people express concerns in relation to the cost of funding care services if required due to physical needs. Ward et al (2012) undertook participatory research with older people and identified that many participants were worried about the cost of care services. People described their uncertainty and anxiety about meeting eligibility criteria, and although many were planning financially this did not always give a sense security because of fears that expenses may be beyond their control. The charging framework for adult social care is significantly different in Wales than in England and there seems to be an evidence gap in relation to how this affects people’s worry levels, spending and help-seeking behaviours.

Relationships/ community: Socialising and getting out and about can be an increasingly important part of ageing, especially post-retirement. It can help prevent feelings of loneliness and isolation, particularly for people living alone. Research undertaken by Consumer Focus Wales (2010b) suggests that people aged over 50 are socialising less as a result of the economic downturn, with nearly a third (32 per cent) of over 50s and a quarter of over 65s having already cut back on going out.

Access to employment and being able to plan and save pre-retirement may affect financial resilience. Importantly, for many older people, the majority of their saving for retirement is done after they turn 50 which makes the later working years critical if sufficient savings are to be built up to avoid poverty in retirement (Cabinet Office, 2000).

This is especially important because income from the state pension is low relative to other comparable countries (OECD 2012) and two in three are not contributing to a private pension⁶ (Analysis of Family Resources Survey 2009/10 Cory, 2012).

In fact, only one in four people in work aged between 50 and state pension age (SPA) are likely to be able to meet their target income in retirement if they stop working at SPA (Pensions Policy Institute 2012).

In relation to the ‘home’ component, research done by Consumer Focus Wales (2010b) indicated that the general cost of living, gas and electricity and food bills are amongst the biggest concerns for people over 50, and many had cut back on their expenditure as a result. This raises concerns about the well-being of older people on a low income, particularly when combining the likelihood to self-disconnect from gas and electricity supplies and to reduce food spend.

⁶ Private pension refers to personal or occupational pension

Evidence gaps and implications for Stage 2

Regardless of age, there are ‘triggers’ which can cause a household to struggle financially. A change in circumstances such as a bereavement, redundancy or divorce, can lead to financial hardship, particularly when moving from a two-income to a one-income household (Consumer Focus Wales, 2010b). These and other issues will need to be considered as part of better understanding the role which financial factors play in promoting and maintaining resilience and the ‘triggers’ that can affect the finances of older people.

More specifically it will be necessary to understand better:

- How financial factors and older peoples’ well-being are related, e.g. does having a certain level of income correlate with older peoples’ own sense of well-being?
- More precisely and in what ways differing levels of income may act as a barrier to well-being
- How older people manage barriers to well-being and resilience that may result from financial factors
- The extent to which financial factors affect other components of the ‘anatomy of resilience’
- Older peoples’ experiences and perspectives about how financial factors influence and/or affect factors that may lead to a crisis.

3.4. Health

The Welsh Health Survey 2011 found that health problems or disability lasting (or expected to last) at least 12 months limit the day-to-day activities of 36% of people aged 65 and over in Wales (Welsh Assembly Government 2012).

Dementia is one of the main causes of disability later in life, ahead of cancer, cardiovascular disease and stroke (Walker 2013).

In 2013 there were estimated to be 45,529 people living with dementia in Wales. Of those people, only 17,661 had received a formal diagnosis. By 2021 it is estimated that over 55,000 people in Wales will have dementia (Welsh Government, 2014).

Older people often develop multiple health conditions, requiring different treatments and medications, which may interact with each other. Between 2003 and 2012, the proportion of the oldest old diagnosed with three or more selected major chronic diseases increased from a third to more than a half (Milligan 2015).

Whilst the incidence of health problems varies enormously between individuals, there are some clear patterns of health inequality linked to socio-economic background, gender and ethnicity. For example, multiple conditions are more common amongst women and those living in the most deprived areas; the latter group may develop multiple health problems a decade earlier than those in more affluent areas (Milligan 2015).

According to Deary (2015), less is known about why some individuals show much greater physical and cognitive resilience than others. Of particular interest to us here is why and how health links to a wider sense of well-being and whether and how social care crises arising from changes in health can be reduced.

The relationship between health and well-being is not as clear-cut as we might imagine it to be. According to the National Survey for Wales (National Statistics 2014), 70% of people (all adult age groups) in very good health (compared to 31% in very bad health) said they had been 'calm and peaceful' most or all of the time over the previous 4 weeks. 88% of people in very good health (compared with 36% of people in very bad health) said they had been happy most or all of the time over the previous 4 weeks. Clearly health is a significant determinant of feeling good but it is striking that about a third of those with the poorest health still feel calm, peaceful and happy most or all of the time.

Participatory research conducted with and by older people (Ward et al 2012) found that:

'A combination of factors can make a difference in living with health conditions. These include the amount and type of support that is available, as well as managing the psychological aspects of ill health, such as fear, anxiety and vulnerability, and the extent to which these can be shared with others or are shouldered alone.' We consider each of these three points: support and treatment; psychological aspects; and social networks and relationships below.

Support and treatment

The ways in which health and support services are delivered and the ways in which care from family, friends and neighbours is experienced, profoundly affect how much being unwell or in need of care and support, compromises well-being (Ward et al 2012). Good care and support takes account of people's individuality and diversity; occurs within a positive relationship (which requires a certain amount of time and consistency to achieve); and gives people choice and control over how they want to be helped (Blood 2013). Often it is the little things that matter the most to people – being able to listen to your favourite radio channel or eat your favourite food (Andrews et al 2015).

When it comes to accessing health services, older people tell us that it helps to have:

- The necessary information to be able to understand and manage your health condition (Ward et al 2012)
- Good access to GPs – in terms of both location and appointment systems (Ward et al 2012)
- Medical staff that listen properly (and do not just assume they know better) (Ward et al 2012)
- Some continuity of health professionals (Ward et al 2012)
- Workers who speak your language and are not too busy (Parry et al 2009)
- Transport to hospitals (especially in rural areas; though some hospitals on the edge of towns can also be hard to reach by public transport (Age Cymru, 2013; Parry et al, 2009).

Psychological aspects

Welsh older people interviewed by Parry et al (2009) often described themselves as ‘quite fit for my age’. The participatory project at the University of Brighton identified ‘learning to be well enough’ as a key task of ageing for many – this can include both emotional and organisational aspects (Ward et al 2012). For those living with long-term conditions, this often involves adjusting to uncertainty and dealing with fluctuations in health.

Fear of a future deterioration in health, of becoming dependent on others, of being ill or falling (especially if you live alone), or of ‘losing your mind’ were all recurring themes in the Gwydir University study (Parry et al 2009). Whilst a certain level of fear may prompt people to take preventative measures such as fitting telecare, we also know that loss of confidence in itself can trigger a crisis for some older people.

Social networks and relationships

Pain, treatment, problems with breathing, memory, continence, mobility or sensory impairment can of course have a massive impact on how much people feel able to get out and about, mix with other people (Katz 2011) or participate in learning activities (ONS 2012). Health may impact on relationships, communication and, ultimately, your identity:

“I don’t like being deaf at all and I feel I’m half what I used to be in a sort of way in a group situation”. (Ward et al 2012, p.36)

However, simple steps – like being able to use your hearing aid properly (Croucher 2012), knowing that there is good seating, public toilets or accessible transport – can make a huge difference here.

For some people, health problems can trigger positive life changes. In ScotCen Research (2014), we meet a woman for whom getting a long-term health condition was the trigger for her to build and deepen her social network. Before this, she did not have the time; since her diagnosis, her house has become full of ‘waifs and strays’ (such as neighbours’ children) that she is looking after. In our study on housing with care (Pannell et al 2012), we often heard how health problems had triggered a move to housing with care schemes which, for some, had brought new relationships, networks and a whole other phase of life. This was typically facilitated by positive resources from other ‘segments’ of our model: personality and psychological resources; supportive relationships with partners and family; and having enough financial resources and information to make a positive move.

There is some evidence to suggest that peer support groups can help to improve well-being for those affected by long-term conditions. Chakkalackal (2014) and Marshall (2014) have both identified positive benefits from peer support for people with dementia. Agnes Houston, Chair of the Scottish Dementia Working Group describes “the magic synergy that happens in the room when you get people with a diagnosis together” (Weak, 2012).

Links to other aspects of resilience:

Links to housing: Is your house warm, safe and in good repair? Do you need people to come in and help you just because the house is not accessible? Can you call for assistance if you need it?

Links to information and advice: are you able to coordinate all the information, medication, health appointments for yourself – or do you have someone who is willing and able to help you with this (relationships)? Do you understand how to promote your own health through diet, hydration, and exercise?

As Roberts (2012) argues:

“For an older person, prevention is about both slowing down the physical and psychological decline that may be compounded by depression, isolation and a sense of one’s own vulnerability and avoiding, where possible the circumstances and crises that can deplete resilience and well-being as well as cause damage to health”. (p.42)

3.5. Home

Headlines

Around one-third of all homes in the UK are headed by a person over current retirement age.

- By 2033, 59 per cent of households will be headed by someone aged 65 or over, and 21 per cent by someone aged 85 years and over
- 90 per cent of older people live in mainstream housing and 75 per cent are home-owners (Age UK, 2015).

In the Welsh context, the Older People’s Commissioner for Wales (2015) notes the scale of the challenge in relation to housing and older people’s well-being:

- 28% of older people say that they will need their home adapting as they get older
- 6% of older people say damp is a problem in their home
- 4% of older people say they do not keep their home adequately warm
- 33% of older people live in one room to reduce heating costs.

Wales follows an ‘ageing in place’ approach to housing older people; the challenge is to ensure that the supply of suitable and affordable accommodation and service options is increased, whether it be so that older people can choose to age in place and ‘stay put’, or age in place by ‘moving on’.

Poor housing for older citizens can present significant costs for public spending due to falls caused by factors such as poor housing design (Fisk & Raynham, 2010) and diminished social outcomes for those whose ability to engage in community life is compromised.

In their 2010/11 survey, the Wales Rural Observatory (2013) found that rates of outright home ownership among those over 75 had increased dramatically since 2004, where the rate for all other age categories had decreased.

Stirling (2012) notes that home-owners make up two-thirds of all older low income households (after housing costs), yet they are much less likely to be ‘in the system’ and aware of their entitlements to benefits and services than those in the social rented sector. She also draws our attention to the increasing number of homeowners aged 75 and over who are living with serious disrepair and have few options to tackle this.

The evidence base

“A house can be a home full of memories, suiting our preferences and adapted to our needs, and often our single most valuable (economic) asset. But as our needs (and preferences) change, it can also become physically more hazardous, or isolating, and the financial resources tied up in it may be hard to release”.

(Knapp, M. in Age UK, 2015)

Aspects of housing that are highlighted by older people as important include comfort, convenience, neighbours and perceptions of safety. Feeling safe at home is important and having someone, like a neighbour who will notice if anything is not quite as it should be, adds to people’s sense of security (Ward et al, 2012).

However Parry et al (2009) note that older people are mindful of their changing needs in relation to housing as they age:

“it’s probably too big now really, but the girls come and stay a lot so that’s fine...location’s great, near to the train, buses, village, so that’s good...it’s a bungalow, we’ve got a bathroom on the ground floor and the shower upstairs...”.

Ward et al (2012) describe how older interviewees place importance on keeping their home in good order and the ways in which they did this, often in the face of increasing difficulty due to mobility or health problems. Keeping things going and having a degree of control over the living environment were recurrent themes in their research. However, maintaining the home is a source of anxiety for some older people. Finding trustworthy trades people to carry out repairs, being able to pay for structural work, and finding ‘that bit of help’ with smaller tasks (Raynes et al 2006) are a challenge for many older homeowners.

Concerns about not being able to manage the home and garden may shape decisions to move to a more manageable home (Ward et al, 2012).

Specialist housing communities, such as extra care housing or sheltered accommodation, have also been shown to reduce social isolation. Callaghan et al (2009) studied nearly 600 residents of extra care housing. Some 82 per cent described their social life as ‘good’ or ‘as good as it can be’ and many had made new friends. There is considerable evidence in relation to promoting well-being through social interaction in housing with care settings (such as extra care housing) (Callaghan 2010). Many residents’ social lives are based on the friendships and acquaintances that they develop in the scheme where they live. For others, the ability to maintain social networks in the wider community is at least as important.

Older people’s housing environments can influence their engagement in their local communities and their sense of autonomy and independence (IPC, 2012).

Where older people live, and how their accommodation encourages or inhibits their sense of being an integral and valued part of their community also impacts on well-being. The Housing Our Ageing Population Panel for Innovation (HAPPi) visited several inspirational housing developments in the UK and the rest of Europe, including Darwin Court in London. A resident said:

"I love it. It's got the security. It's got everything I would want, the IT room, the restaurant, the swimming pool, everything ... Grandchildren come and go ... There's a park opposite ... I couldn't move out of here. I love it".

(Roberts, 2012)

How does home interact with and link to the other segments of our model?

Having access to a range of housing options can be important in terms of managing physical health challenges and maintaining relationships. Most older people prefer to remain living in their own homes. Others may consider 'downsizing' as their family home becomes difficult for them to manage and some might choose specialist housing due to problems such as mobility, loneliness and the need for care and support (Age UK, 2015).

There is evidence of the importance of maintaining and managing physical health in relation to housing. Anyone can have a fall, but older people are more vulnerable to falls than other age groups. Around one in three adults over 65 who live at home will fall at least once a year (NHS Choices website). Falls may result in broken bones or other injuries and affect self-confidence, limiting well-being and independence.

It is vital that older people are provided with safe, comfortable and affordable housing (Older People's Commissioner for Wales, 2015), however, current statistics show that the housing needs of many older people are not being met and they reside in accommodation that can have negative impacts on physical and mental health.

As Porteus notes, at any age, we look to our home as a place of security. As we get older, what we need from our home – and the type of housing that can meet those needs – changes. Living in housing which is appropriate to their needs can help older people remain independent and maintain a good quality of life (Age UK, 2015).

Many older people told Parry et al (2009) that their biggest concern related to the prospect of entering residential or nursing care. All respondents wanted to remain living at home and were prepared to tolerate minor inconveniences (size of accommodation, location etc.) in order to do so.

The desire to remain in your own home can be impacted by wider changes in the neighbourhood, which can affect feelings about belonging – or even safety. As people move on and neighbours change, some people may feel a loss of connection and increased isolation:

"...you see, I mean all the ones that were in where I lived, they've all gone. ... I would just like to have a few more friends or a few more people to meet and discuss things, unluckily as I say in my flat now everybody that was there when I went there twenty years ago they've more or less all died". (Ward et al, 2012)

In rural parts of Wales, there may be additional challenges to sustaining well-being, such as higher living costs and housing that is hard to heat. Wales has the highest percentage of homes with solid walls compared with England and Scotland (solid walls let through twice as much heat as cavity walls) and a lower number of households on mains gas in comparison with England (alternative forms of fuel are more expensive) (Older People's Commissioner for Wales, 2015).

Evidence gaps and implications for Stage 2

There is evidence that housing and how older people feel about their home does affect well-being outcomes. There is evidence at a 'macro' level of the need for a wider mix of housing options that reflect the wishes of the majority of older people to live in their own homes, rather than residential accommodation. Roberts (2012) notes that if housing does not change, some forecasts say that long term care expenditure will rise by around 325% from 2002 to 2041 due to falls, delayed discharges and premature moves into care.

At a 'micro' level there is evidence of the importance that 'home' plays in the well-being of older people. Ward et al (2012) identify that confidence and feeling in control of the home environment is important to many older people – being able to keep things 'up to standard' is an important aspect of maintaining well-being.

These and other issues will need to be considered as part of better understanding the role housing related factors play in promoting and maintaining resilience and the barriers that can affect the well-being of older people.

More specifically, it will be necessary to understand better:

- How housing-related factors and well-being outcomes are related in the eyes of older people
- What the most important characteristics of a 'home' in relation to achieving well-being outcomes and maintaining independence are
- What the relationships between home and the other segments of our model are, from the perspectives of older people and
- The housing-related factors that can act as barriers to older people achieving their well-being outcomes.

3.6. Psychological resources

Headlines

Bowling and Illife's (2011) follow up survey of 287 people aged 65+ across Britain asked them about their perceived quality of life, their physical and mental health, psychological outlook, social and environmental factors. The study found that psychological resources were the strongest predictor of quality of life and concluded that:

"Policy makers aiming to promote well-being, successful ageing and quality of life in ageing populations should consider people's psychological resources, rather than only their health, functional, activity levels or social circumstances (which deserve attention for other reasons)".

The enhancement of well-being requires interventions to encourage positive attitudes and behaviours over the life course. However, evidence indicates that self-efficacy and reliance can also be nurtured in later life.

The Institute of Welsh Affairs (2010) proposes the concept of the ‘resilient personality’. While the report acknowledges that the concept is hard to define, as it encompasses a range of psychological attributes, current research has shown that there is a strong correlation between resilience and well-being, and that this correlation is essential for ‘successful ageing’.

Resilience is variously defined as:

- Applying to everyone because it is "the ability of people to resist adversity and flourish under it ... resilient older people are more satisfied with their lives and had a better quality of life than non-resilient people". (Demakakos et al (2012) cited in Hampton Trust 2015) or
- Only applying to those who have experienced adversity: “the capacity of springing back or rebounding after a negative force or effect. In physics, it describes the power of an object to resume its previous shape after being subject to pressure. It is different from coping, as it can denote getting back up on your feet and even flourishing”. (p.80, Age UK 2015).

Resilience is linked to older people’s resources and research has identified at least 19 different resilience ‘scales’ (Windle 2011). Resources can be classified as:

- Internal resources (psychological, financial, health) and
- External resources (friendship and family networks; services from private, public and voluntary institutions) (Age UK 2015).

How do psychological resources interact with and link to the other segments of our model?

Blane (2011) argues that our relationships are the most important factor in building our resilience. Attachment theory can give us a model for understanding the way in which our relationships, especially (but not exclusively) our formative relationships with our parents, can help or hinder us in building a healthy and secure sense of self (Jackman & Hambleton 2011).

Roberts (2012) argues that our ‘self-concept’ becomes particularly important as we get older and are faced with negative and ageist assumptions and expectations. Working therapeutically with older people to help them strengthen their sense of self may therefore be a way of building resilience. For example, a meta-analysis of twenty studies found that interventions targeting social cognition – a person’s thoughts about themselves and others – were more effective than strategies such as increasing social support and creating opportunities for social interaction. They found that cognitive behavioural therapy worked particularly well in this setting (Masi et al 2010).

There are strong links here with work and learning. Roberts (2011) also describes theories of ‘cognitive reserve’. Contrary to ageist assumptions of inevitable cognitive decline, it is possible for many people to build up their brain power as they get older, and this may act as a ‘buffer against ageing’.

The participatory research into older people and well-being conducted by the University of Brighton (Ward et al 2012) identified a number of themes in relation to ‘psychological resources’ and the impact they can have on the experience of ageing:

- Some people described how they had learnt to accept themselves and become more tolerant of others, and how this had had a positive impact on their relationships and daily life
- Memories can generate a sense of pride at past achievements and can positively contribute to identity as an older person
- Some people had developed resilience having come through difficult situations in their past – World War 2 was a recurring theme for the oldest cohort
- Faith and spirituality played a key role for many
- Learning to adapt and change (e.g. to health problems) was a key challenge
- Some described having to motivate themselves during this phase of life (having been carried along by the demands of education, work, child- and other caring up to this point): this brought great freedom but also psychological challenges for some.

3.7. Information

Headlines

“You don’t know what you don’t know until you need to know it! We are awash with information and good advice, but most of the time it is like water off a duck’s back … until you need that piece of information or advice. That’s when you should be able to find it but can’t!”.

(Older participant, Rhondda Cynon Taff, in Dunning 2005)

“Many older people depend on other older people like us to get things going and take it to them. If there’s no one here like us doing it, they won’t get what they want. There are more of us out there who could make a go of things – with a bit of help and encouragement”.

(Older participant, Rhondda Cynon Taff, in Dunning 2005)

In Wales, access to information and advice is a priority for the Older People’s Commissioner and in the Strategy for Older People in Wales 2013-2023 (Welsh Government 2013b). With the Social Services and Well-being (Wales) Act access to information, advice and assistance (IAA) is key and the SSIA have produced an overview of local authority IAA services in Wales and are leading on the development of a citizen social care and well-being information portal.

The main advice agencies have agreed definitions of what is meant by information, an information service, an advice service and an advice service with casework (advocacy), referrals and signposting (Age UK 2012); this is important so that a service is clear what it can and cannot offer, and for liaison between different services in a locality. However, Age UK (2012) also comments that older people are less interested in the distinctions and more interested in getting the right information and advice that meets their needs, and when they want it.

Good information and advice is especially important at times of change, including welfare reform and cutbacks in services. A recent example (which received little publicity) was the change to Pension Credit entitlement for mixed-age couples. A claim before the deadline could have made a significant difference to benefit entitlement and hence income into the future. After the change, both partners had to be over pension age whereas previously, entitlement to Pension Credit needed only one to be over pension age.

Older people themselves value good information (Horton 2009). IPPR set up focus groups (in England, reported in McCormick 2009, with peer researchers): participants were forthright that some older people also needed individual advocacy, especially those on their own: "You've nobody to fight, there's nobody to fight your corner"; "Age Concern can fight for me".

The evidence base

Older people often seek advice at times of crisis (Age Concern England 2008) and good advice can avoid or minimise later problems. They need information to help them exercise choice, know about services, and participate in decision-making over a range of issues:

- Income and benefits, and especially for benefits take-up
- Financial advice and retirement planning
- Social care, and how to negotiate the system (Horton 2009)
- Healthcare, especially with the increasing emphasis on patient choice
- Housing advice, whether to stay put or move to more suitable accommodation
- Energy efficiency and keeping warm
- Legal advice (more difficult to access since changes to legal aid and advice)
- Consumer advice, especially to avoid scams and rogue traders.

Age UK (2012b) found that the following three principles for providing good information and advice to older people were identified in most of the studies they reviewed:

- The importance of personal contact, especially face-to-face interactions
- Involving older people in service design and
- Using a range of channels and formats.

We also know how important being able to receive information and advice in Welsh language is for many older people. Findings from the National Survey for Wales (Welsh Government 2015c) suggest that 21% of those aged 65 and over in Wales can speak Welsh (13% fluently, 8% non-fluently), though there are significant regional variations here. 51% of this age group who are fluent, said they felt more comfortable using Welsh than English – with most of the remainder being equally comfortable with either language. A recent study by Citizens' Advice Cymru (2015) confirms that 'many Welsh speakers feel more comfortable expressing themselves in Welsh, feel more confident communicating their needs in Welsh, think and live their lives in Welsh..... This is especially the case in some service contexts or where consumers are vulnerable' (p.8).

Local Age UK charities are collectively the biggest provider of independent information and advice to older people. In 2012, it was estimated that Age UK in England and Age Cymru in Wales answer around 850,000 information and advice enquiries from older people every year, with enquiries about benefits being the largest area of work (280,000 enquiries per year) (Age UK 2012b). Age Cymru provides a bi-lingual telephone helpline for information on most issues, especially benefits. However, local Age Cymru charities vary in different locations and not all will have a full information and advice service.

Face to face advice and information can be provided through a range of models, including: neighbourhood wardens, local area coordinators, village agents, wayfinders or community hubs. These services can provide trusted information and a gateway to other services, and face-to-face contact; by knowing the older person they should be able to facilitate access to the right information and signposting; however, they are not trained advisers.

Telephone advice can be the next best solution after face-to-face contact (and more cost-effective, especially in very rural areas). In 2012, Age UK commissioned research on older people using call centres for advice (Age UK 2012). The aim was to establish advice line standards for Age UK, the advice sector and businesses to use to develop services. The majority of older people wanted to speak to a 'real' person, which made the process less stressful. This was especially important if seeking advice during a financial, social or emotional crisis. Unsurprisingly, automation was not popular.

In Wales, an initiative where all GP practices were linked to an adviser found that 62.5 per cent of GPs felt that patients who had received advice experienced an improvement in general health (Age Concern and Help the Aged 2009). GP surgeries provide an obvious link with older people who may face a crisis if their need for information and advice is not met: they are the service that many older people have the most contact with (because of check-ups, flu jabs, etc. as well as consultations for specific problems).

Dunning (2005) featured the Rhondda Cynon Taff Better Government for Older People pilot project, which aimed to build an integrated information and services network.

McCormick (2009) refers to other recent initiatives, including:

- The use of smart cards (such as the Oyster card) to facilitate access to information: for example in Derbyshire, smartcards are used for library registration, access to information and discounts with local businesses to encourage take-up; the Welsh Assembly Government was reported to be looking at this option for older people in Wales at the time of the report (McCormick 2009)
- However, although new IT-based initiatives are helpful for families and professionals, they will not help older people who are digitally excluded because of age, impairment or other reasons: 37 per cent of people aged 65–75 and 71 per cent of people aged 75 and over in the UK have never used the internet (Age UK 2012). This point was also raised forcefully in the focus groups referred to above
- Traditional methods of communication are also important (phone, local press, TV and radio) and for some, face-to-face contact will be needed. Posters and leaflets in settings such as GP surgeries are less effective than someone suggesting a local service (e.g. a lunch club or sport activity) tailored to that person's interests: but that requires someone to take the time to get to know the older person
- The development of comprehensive services for information, advice and advocacy by making existing services more older-person friendly, and improving awareness and signposting and training outreach staff from both statutory and voluntary organisations, with older people's groups involved in the design of these services.

Evidence gaps and implications for Stage 2

Good information and advice supports older people (and their carers), helps them with planning and decision-making and can help to avoid or minimise crisis. However, it can only go so far: if there are no suitable services, or people cannot afford or reach what is available, information and advice will not meet their needs.

There is not a lot of evidence that is specific to Wales or hard-to-reach people. Also there is not much that is new; it is already well known that information and advice is important for older people.

3.8. Work and learning

Headlines

Promoting opportunities for learning and employment for older people is a strategic objective of the Welsh Government (2014). Ageing Well in Wales, 2014-19, states that:

“It is good for the individual, the community and the economy for older people to be engaged in some form of employment, education or training. Learning for older people has a range of benefits, such as:

- Promoting full economic and societal participation
- Contributing towards personal well-being and fulfilment
- Supporting creativity and innovation, and
- Increasing efficiency as workers or volunteers”.

However it is important to understand the ‘pathway’ that older people take up to age 75 years and the role that work and learning can play in supporting individual resilience.

The importance of work for older people changes over time. Smeaton et al (2009) identified that the main reason for working changes as workers age:

- Basic financial necessity is the most important reason for working for around half of 50–59 year olds, one third of 60–64 year olds and just one in seven of those aged 65 or over
- Instead, enjoying work becomes increasingly important, rising from one in ten of 50–55 year olds to one quarter of those aged 65 or over.

The same study also identified that underemployment increases at older ages – mainly due to stress and excessive workloads in previous jobs or caring responsibilities. Two fifths (42 per cent) of 60–64 year olds and over half of those over State Pension Age (SPA) (57 per cent) are ‘underemployed’. Caring responsibilities were a fairly common reason for working below potential – mentioned by 16 per cent of employees overall, but far more frequently by women (28 per cent) than men (three per cent) (Smeaton et al, 2009).

Financial concerns and age discrimination are the most widely cited issues that need to be addressed before older workers can achieve their work aspirations in larger numbers.

Tinsley (2012) applied for over 1,200 jobs using CVs that were identical but varyingly gave the date of birth of a 25 year old and a 51 year old. The older ‘applicant’ got fewer than half the positive responses of the younger one.

The evidence base

There is limited evidence on the role of work and learning in promoting resilience amongst older people. Most research focuses primarily on employment preferences and barriers to employment. A key issue for consideration is the extent to which work and learning preferences both before and after age 75 years help to promote the well-being of older people.

There is evidence that a fairly large minority of men and women above SPA would like a paid job: 32 per cent of 65–69 year-old men and 20 per cent of 65–69-year-old women. Nearly one fifth of men aged 70 plus are definitely or potentially interested in getting back to work (17 per cent) – a higher proportion than women in the same age group (13 per cent) (Smeaton et al, 2009).

Compared with older workers under SPA, those above SPA are less likely to want employment to pay for basics and are more likely to be interested in working in order to pay for extras. They are also notably more likely to be seeking the company of other people and to want to work as a means of keeping busy and to use skills developed over a lifetime. Those in employment wanted to carry on working as long as they could (albeit with a reduction in hours). This was irrespective of level of job satisfaction. In addition to the income provided, benefits of work included social contact and keeping busy (Parry et al, 2009).

However many older people have busy retirement lives with various leisure and voluntary activities, travelling and spending time with friends and family. Smeaton et al (2009) found that these activities mean that 11 per cent of men and 17 per cent of women are too busy to (want to) return to work. Many older women are performing caring roles – seven per cent are caring for adults and eight per cent for grandchildren.

There is some evidence on the impact of learning on the well-being of older adults.

Jenkins and Mostafa (2012) distinguished between formal and informal learning. Formal learning involved obtaining qualifications and/or participating in formal education or training courses. Informal learning consisted of participation in education, music and arts groups and evening classes, or participation in sports clubs, gym and exercise classes.

Learning was associated with higher well-being after controlling for a range of other factors. The authors concluded that the impact of learning could be “at least sufficient to offset the gradual decline in well-being as people become older” (Jenkins & Mostafa, 2012 p.5).

The level of prior qualifications was found to have a significant impact on both formal and informal learning participation. Those with more education were much more likely to participate, and participation rates for both formal and informal learning were about three times as high amongst those with a degree compared to those with no qualifications.

How does work and learning interact with and link to the other segments of our model?

Access to employment has a direct impact on finance. Many older retired people, especially women, are struggling financially to meet their needs – one quarter of men (24 per cent) and over one third of women (37 per cent) had incomes that were less than adequate (Smeaton et al, 2009).

Employment opportunities also link with physical health; unemployment among people aged 50+ is primarily due to poor health, however, for women, this is also because of caring responsibilities; hence there is also a link to relationships.

Access to appropriate information and advice about employment and learning may be relevant to some older people. However this may be as much about cultural and attitudinal change on the part of both employers and older people themselves.

Good health was strongly related to participation in informal learning (Jenkins & Mostafa 2012).

Evidence gaps and implications for Stage 2

Research in this area has tended to focus on older people below 75 years of age, i.e. below the age of primary interest for this research, however the available evidence does suggest that access to work and learning opportunities in the period *before* an individual reaches 75 years of age may be important in helping to promote their resilience once they do reach that age milestone. Therefore the relationship between access to work and learning and resilience is as much about the ‘pathway’ that an individual takes in later life that may help to equip them to be more resilient from age 75 years.

However the available evidence indicates that there are very real barriers to older people accessing employment (Cory, 2012, Tinsley 2012). The two key changes that would help older people, cited by the vast majority, are greater availability of part-time or flexible jobs (mentioned by 85 per cent) and a more open policy toward the recruitment of older workers (mentioned by 79 per cent of the retired) (Smeaton et al, 2009).

However whilst longer working lives may carry benefits for society, employers, the economy and individuals, for some less advantaged and less skilled older people, the expectation to work until 65 and beyond, with access to occupational and State Pensions withheld until much later in life compared with recent years, may not be realistic and may negatively affect well-being. Taylor (2008) observes that the ‘active ageing’ agenda in terms of prolonged labour market participation is undignified and unfair for those with few prospects for meaningful work.

The Welsh Government (2014) wishes to see more older people accessing employment and learning opportunities. Older people require access to learning for a number of reasons. With an increasing number of older people unable to afford retirement at State Pension age, the provision of learning and skill development opportunities to improve their employment prospects becomes ever more important. For other older people who are able to retire when they choose, access to learning is a key factor in maintaining their well-being. Learning and skills development in this context includes financial and digital inclusion, helping older people to become more resilient in later life (Ageing Well in Wales, 2014-19).

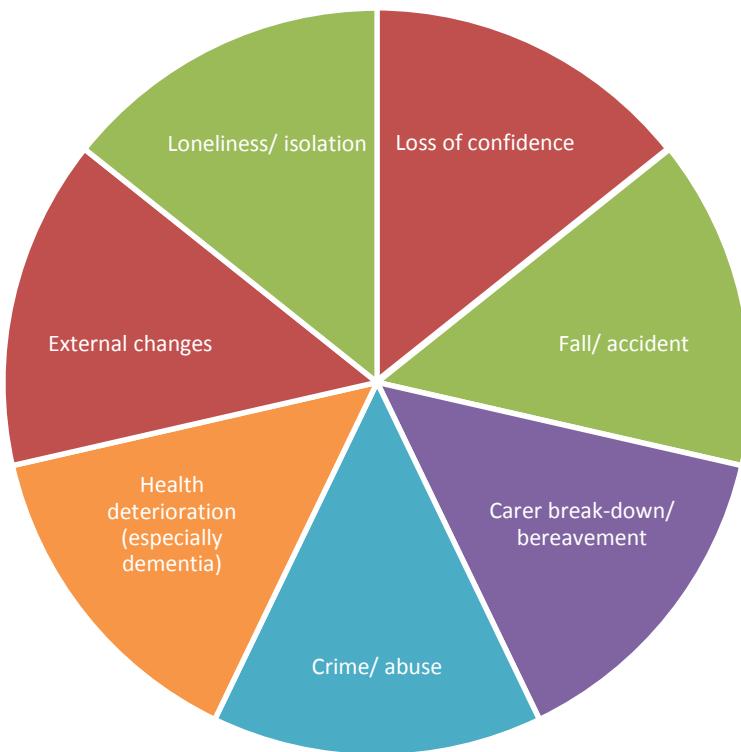
Planned increases in the state pension age over time, particularly for women, will create new financial incentives for older workers to remain in employment. However, without parallel changes to tackle the other barriers to older employment, this change will hinder rather than help some older women who are unable to find or keep employment. Many older people provide informal care and need flexible working arrangements to enable them to work. However, flexible working options are limited and harder for lower income older people to access.

Whilst there is indirect evidence of how access to employment and learning can promote the well-being of older people and support individual resilience, there is a lack of understanding of a causal relationship between employment amongst older people and well-being.

4. Understanding the crisis triggers

One of the aims of this project is to try and understand the experiences and pathways of those who may be on – or approaching - the *cusp* of needing statutory services. In the previous sections, we have considered the different segments of our ‘anatomy of resilience’ model, but how can this help us to understand the crises that typically lead people into what has sometimes been described as ‘serviceland’?

We tried to identify the most common pathways that lead older people (unplanned) into long-term care and developed the parallel model shown below – effectively an ‘Anatomy of Crisis’. We have tried to resist thinking about this in terms of service pathways (e.g. hospital discharge, which we know is a common route into long term care) but rather to focus on the key events and circumstances from an older person’s perspective.



Some of the segments of this model describe *incidents* – falls, accidents, bereavements, or experiences of crime - that may change a person’s resilience and well-being overnight. Others are typically *gradual processes* – for example, loneliness and isolation, loss of confidence and health deterioration. There may however, be sudden declines here, sometimes as a result of an incident (for example, you may suddenly lose a lot of confidence as a result of a bad fall) or because a health condition reaches a new phase.

As before, the segments interact and may compound each other: a bereavement may not bring you into service land if you have a wider network of support but if you and partner were already isolated from the wider community, it may well do. Sometimes an incident will act as the ‘straw that broke the camel’s back’: sometimes it is when two or more of these problems occur at the same time that people seem to end up at Social Services’ door.

Note that we are using ‘external changes’ as an umbrella for a number of changes which might occur within an older person’s environment, ranging from a trusted neighbour moving or dying, the cancellation of a local bus service or the closure of a local shop, to a leaking roof or broken boiler.

In the following section, we draw together the evidence on a number of these segments: carer breakdown, falls and accidents, crime and abuse, and loneliness and isolation and consider what the evidence base tells us about the incidence, causes and impact of these.

4.1. Carer breakdown

Carers may find themselves unable to cope for a wide range of reasons. The carer’s own health may fail, or other circumstances that affect their capacity to care may change: for example, a daughter or son caring for an older parent may experience relationship breakdown or a problem related to another family member and no longer manage to juggle the demands placed on them.

The literature suggests a number of risk factors for carer stress, which may or may not ultimately lead to ‘breakdown’. These include: caring for a loved one with dementia, caring in relationships that have been historically challenging, or transition points. The literature also suggests some of the gaps in preventative services, which may make carer breakdown more likely.

Research on carers (including two studies in Wales⁷) shows the impact of dementia on both the person cared-for (confusion, anger, memory loss, challenging and distressing behaviours) and on the carer (guilt, confusion, resentment, helplessness, grief, sadness and fear).

Professionals should not assume that existing family dynamics will support the easy transition from husband and wife, mother and daughter, etc. to ‘carer’ and ‘cared-for’. People may need space and therapeutic support to unpick problematic relationships first, especially where domestic violence (Blood, 2004) or abuse has been present. Attachment theory may provide a framework to help us contextualise and understand a person’s ‘difficult’ or uncooperative behaviour within their life and relationships (Jackman and Hambleton, 2011).

Carers’ roles are further complicated as they take on an “altered role of patient manager while still a family member” (p1, Livingston 2010). Our research in housing with care schemes identified the ‘ringmaster’ role which family members were often playing (Blood, Pannell & Copeman 2012), coordinating the input of a large number of different health, social care and housing agencies.

⁷ Newbronner et al 2013 included Welsh survey responses, and interviews and focus group in the Vale of Glamorgan; Cascioli et al 2008 was Wales only)

Carers' expertise and knowledge of the cared-for person are not always recognised (Chung et al 2008) and their needs are often not met, especially in relation to support to deal with the emotional aspects of caring, and practical support with decision-making (Livingston et al 2010).

Over a third of carers in Wales reported that they did not get enough emotional support from service providers: the most important thing for them was human contact with people who could empathise as well as provide advice and assistance (Cascioli et al 2008). Relationships with other family members, and with the cared-for person, are often damaged or destroyed (CPA 2014).

Changes in one part of the caring 'mix' can lead to breakdown; O'Sullivan (et al 2011, in Outside the Box 2015) looked at the experience of more frail and vulnerable older people with higher levels of use of health services:

"People's situations were fragile and could worsen through one change, such as one older person in a couple becoming unwell or a relative no longer being able to drive. The **transition points** had a big impact for older people. These include changes that services may see as less significant, such as no longer being able to drive and moving house through choice...".

4.2. Crime and abuse

We know how important personal safety is to older people, and how common fears such as doorstep crime, street robbery or burglary can affect older people living in the community (Moore 2010, Gorden & Buchanan, 2013). Here we consider briefly the evidence from Wales and the UK on scams and fraud, elder abuse, safeguarding and advocacy.

Scams and fraud

Older people are more likely to be targeted for scams and lose more financially than other victims - nearly twice as much per scam (Office of Fair Trading (2006). Age Cymru (2015b) found that between February 2012 and February 2013, more than 2,500 scams were reported to trading standards departments. Nearly 1,000 of these were doorstep scams/frauds. Although over half were investigated, there were only 19 prosecutions. In the same period, more than 1,650 mail/phone/online scams were reported. The Office of Fair Trading (2006) believes that only 5% of scams are ever reported.

Age UK (2015b) has found that over half of people aged 65+ believe they have been targeted by fraudsters and an estimated half a million older people have fallen victim to losing savings. Recent private pension changes mean that people retiring will be at risk of targeting by fraudsters. Older people are at special risk:

- Of certain types of scam (e.g. doorstep crime, bank/ card account takeover, pension liberation scams, investment fraud: the proportion of older victims of account takeover has increased substantially)
- At particular times because of personal circumstances (e.g. social isolation, cognitive impairment, bereavement, financial pressures)

- Of being put on so-called ‘suckers lists’ (used and shared by fraudsters in the UK and overseas)
- Of finding it harder to recover from a significant financial loss as a result of fraud (because of being on fixed incomes).

The evidence review highlights key gaps in current information and research, especially the absence of a sound and comprehensive UK evidence base on the prevalence of fraud against individuals, and an up-to-date evidence base on the experiences and circumstances of fraud victims, including older people. The financial impact may be clear but the psychological effects can also be severe: stress, anger, loss of self-esteem, shame and upset. The report comments (page 22): “The negative impact of financial abuse, regardless of the source, can result in someone becoming in need of support from social services, having not previously required such help”. (from SCIE 2011)

Elder abuse, safeguarding and advocacy

In their report for Help the Aged (2008), the Centre for Policy on Ageing found that between 0.5 per cent and 2.5 per cent of older people in the UK have experienced financial abuse or exploitation, mostly from family members (70%) and most often by adult sons and daughters (50%). Older people with dementia were especially vulnerable to financial abuse.

Age Cymru (2015) points out that the impact of abuse on an older person can lead to social isolation, poor nutrition, fuel poverty and debt. Many victims abused by a family member fail to get justice or are unaware of support from local services.

Age Cymru (2013b) research into advocacy provision for older people in Wales found that 84% of advocates had supported an older person who had been abused, and almost 70% of respondents had dealt with a situation of financial abuse.

Services may be more tuned into safeguarding scenarios which involve other forms of abuse, or the impact of crimes on older people which are more violent or involve a break-in; but the evidence suggests that scams and financial abuse are much more widespread and may, certainly alongside other challenges, create pathways, for some, into services.

4.3. Falls

Injuries from falls are by far the greatest cause of hospitalisation among older people, the leading cause of death from injury in older people aged 75+; and the primary cause of over 40% of admissions to a nursing home (Age Concern Cymru 2008). Approximately 1 in 3 people aged 65 and over fall at least once a year away from home, with many suffering multiple falls. Men are more likely to fall outdoors than women (Age Cymru 2014).

However, falls are not an inevitable part of ageing (Roberts 2012) and much can be done to prevent them, particularly in relation to exercise and learning (e.g. understanding posture and the safest ways to move) (Age UK 2013) and housing (NHF 2013).

4.4. Loneliness and isolation

We have seen in sections 3.1 and 3.2, just how important relationships and communities are in supporting older people's well-being. Victor et al (2005) define loneliness as: the 'deprivation of social contact, the lack of people available or willing to share social and emotional experiences, a state where an individual has the potential to interact with others but is not doing so and there is a discrepancy between the actual and desired interaction with others'.

Loneliness is defined by Beaumont (2013) as a "complex and usually unpleasant emotion, which typically includes anxious feelings about a lack of connectedness or communality with others" and can be felt among people in couples and families as well as those living alone (Peplau et al, 1982 in Beaumont). It is subjective; if a person thinks they are lonely, then they are lonely.

Analysis of ELSA data 2009-10 showed that in England, more people aged 80+ felt lonely than younger groups; people who felt lonely were less satisfied with their lives overall; limitations in daily activities (ADLs) together with other changed circumstances (e.g. loss of partner or losing touch with friends) contribute to increased feelings of loneliness in the oldest age groups.

Both the quantity and quality of social interactions are predictors of well-being: regular contact with family can reduce stress and anxiety, provide practical and emotional support and boost self-esteem and respect (Fiorillo & Sabatini, 2011). Those who are more isolated are less likely to engage with services – certainly health services – preventatively. Older people living alone are much less likely to visit a doctor after a fall; those living alone are less likely to have someone to notice a deterioration in their condition (WRVS 2012c).

Victor (2015) argues that:

'Vulnerability in later life is experienced by those who lack... social resources in terms of either group-based relationship networks (the socially isolated) or strong inter-personal relationships (the lonely)'.

Her key points here are that:

- Loneliness and isolation are neither a normal nor an inevitable part of ageing: around 70% of older people are neither isolated nor lonely
- It is important to distinguish loneliness from isolation (since they require different interventions: to tackle isolation, our approach might be to boost the *number* of contacts, for loneliness it may be more about boosting the *quality* of relationships)
- It is important to distinguish whether loneliness or isolation are recent or lifelong phenomena.

On this last point, an interview study of older people aged 50-91 (Parry et al 2009) looked at perceptions of well-being in a purposive sample (39 participants) in nine counties across Wales. They found that in terms of social participation, respondents were either 'joiners' or 'loners'. Relationships with family, friends and neighbours were especially important for the 'loners' who often lived alone, and were clear they were not interested in joining groups. Older female respondents in small close-knit communities were the most frequent 'joiners': chapel was important in rural areas, as well as women's groups.

The WRVS Shaping our Age project (Hoban et al 2013) also found many older people who were not interested in joining groups: often this was because they had negative stereotypes, expectations and perceptions of traditional services, especially amongst people who did not wish to be identified as old or who preferred to mix with all ages. Given Parry's comment about 'loners', WRVS (2012c) research on the levels of contact which people aged 75+ and living alone have with their families is especially relevant. Half of respondents whose nearest child lived more than an hour's drive away, received only one visit every 2-6 months. Labour market changes are likely to be especially relevant in parts of Wales (e.g. the Valleys, rural areas in the south west, mid- and north Wales): overall, 82% of children who had moved away had left for work reasons.

The evidence base

The evidence base is weak on:

- Which *individuals* are at risk and why – e.g. why some widows become lonely where others do not?
- Patterns of loneliness amongst older people from different ethnic groups.

The evidence base is stronger on the greater risks of loneliness and isolation for men, people living alone, those who have been recently widowed, and for much older people (Victor 2015). Recent analysis of the CFAS data for Wales by Burholt⁸ shows that disability or ill-health may act as a trigger for loneliness, by changing the way people can access their networks.

Research exploring causes and experiences of loneliness between men and women (WRVS 2012b, which covered England, Wales and Scotland), found that many men became lonely following death of their partner (62%) or loss of companions their own age (54%). Men were also less likely to confide in friends and family about their feelings (11% men, 24% women).

Another WRVS (2012c) survey on contact with family found that if relatives lived further away, older men were much less likely than women to keep in touch by daily telephone calls (71% of women compared to 29% of men). This reflects other research on phone use: women use the phone much more than men, especially for 'small talk and emotional sharing', whereas men usually need a reason to call (Boneva, Kraut & Frohlich, 2001). The vast majority of WRVS (2012b) survey respondents (95%) never used Skype to keep in touch with their children, because 42% didn't know how to use Skype or email. Skype use was greater in Wales than in England, although Scotland had the highest use: 36% of Skype users lived over 200 miles away from their nearest child, and 39% contacted their children every day.

⁸ As yet unpublished but a video of Burholt's talk at the April 2015 showcase of the latest research on loneliness, isolation and well-being in old age hosted by NIHR and the Campaign to End Loneliness is available at: <http://www.campaigntoendloneliness.org/blog/loneliness-isolation-wellbeing/>

Exploring the barriers to and potential benefits of using technology (like having a cordless phone with family's numbers stored in, or being set up to use Skype) to promote older people's social connectedness may be an important research question for us in the next phase of this project.

What works in tackling loneliness and isolation?

JRF's *Neighbourhood approaches to loneliness* programme worked with existing networks and organisations in four areas over three years. The programme recruited community researchers who helped others talk about loneliness in their own lives and in their communities, so as to identify and implement neighbourhood solutions (Evaluated by Collins and Wrigley, 2014).

Since the WRVS (2012a) research emphasising loneliness risks for men, the charity has invited rugby clubs (including Cardiff Blues) to get involved: Welsh International player, Josh Turnbull, commented:

“Sport has a great way of bringing people together in camaraderie and joint passion. Many older men miss out on supporting their local team as they don't have a companion to come along to a game with or a friendly face to chat about their hobbies. I would encourage men to sign up as volunteers to help older men across the country rediscover their love of sport”.

5. Prevention

5.1. Prevention: in the context of this research

The Social Services and Well-Being (Wales) Act 2014 provides both the context for this research and reframes the responsibilities of local authorities and their statutory partners in Wales. It emphasises the promotion of well-being and the prevention or delay of need necessitating formal social and health interventions.

Ageing Well in Wales, 2014-19 sets out the broad objectives for a preventative approach:

“....the Programme will focus on preventative actions and interventions. Preventing frailty and preparing older people to sustain their independence will, in turn, support them to take ownership of their health and wellbeing.

Ageing Well in Wales, and its preventative approach to supporting older people to retain their independence and health, will also act as a cost containment programme for costs sustained by the NHS and other public and third sector service providers. People who fall will increase visits to their GPs and other health providers, depending on their friends and family for transport and support, thereby resulting in greater amounts of public spending”.

This research is intended to explore directly the real and everyday barriers that prevent older people attaining their well-being outcomes. Specifically, it is seeking to better understand the experiences of older people and carers, who are just beginning to experience challenges to their independence and well-being. This will improve the evidence base to support system-wide attention on what might be most effective in early prevention.

This section is intended to summarise briefly:

- Key themes from the evidence review in relation to prevention in the context of the proposed anatomy of resilience model
- Approaches and prevention ‘models’ in Wales and the UK and
- The implications for Stage 2 of this research.

The evidence review has identified a number of evaluations in relation to the effectiveness of ‘preventative’ service interventions that are relevant to our understanding of resilience.

At the April 2015 NIHR SSCR/ Campaign to End Loneliness event, three reviews of interventions to improve independence and mental well-being and their cost-effectiveness were outlined. A wide range of services focused on communication and friendship, including arts and cultural activities, volunteering, sign-posting support, life-long learning, support for carers, with some interest in digital inclusion and intergenerational activities. The evidence base for successful interventions is patchy, and most services were reaching women but not men.

An evaluation of the development of Community Hubs in Gloucestershire (Kearsley & Gilmour, 2015) found significant improvement on six measures of health and well-being. By providing a broad range of activities within a safe, comfortable environment, Community Hubs engender an ethos of active ageing.

There are 19 Community Hubs for Older People in Gloucestershire, in purpose-built (extra care housing schemes) or in traditional sheltered housing, village halls and day centres. They offer drop-in, half and whole day opportunities.

Many older people withdraw or desist completely from attempting new activities, but the range of activities on offer can encourage participation: the report comments that “Every type of activity including one-to-one and group afforded the prospect of social contact. It is obvious that the social contact is the catalyst for recruitment and participation in structured group activity. Social contact is also proving invaluable as part of the grieving process”.

The Hubs are also helping unpaid carers, tying in with the Gloucestershire Health and Wellbeing Strategy of helping to manage dementia and giving support to carers; one carer commented: “I have a day to myself knowing that he is in safe hands – Worth every penny!”. However this approach assumes that an older person can afford this, is able to get there and is willing to pay.

Dorset Partnership for Older People Programme (POPP) projects included Wayfinders (people working 9 hours a week in 33 localities, providing signposting and support to older people with information or activities to support health promotion and independence). An evaluation (Harflett & Bown, 2014) estimated that if Wayfinders’ interventions prevented the need for GP treatment for mental health problems in at least 82 of the 11,373 contacts made to “address social isolation” the investment would represent value for money.

‘Nest’ is the Welsh Government’s scheme to tackle fuel poverty in Wales, offering a ‘whole house’ approach (free home energy improvement measures to households receiving a means tested benefit and living in a very energy inefficient home, and advice and referral to alternative schemes to all householders). An evaluation (Marrin et al, 2015) found that the scheme has been successful in reaching older people, although the criteria excluded pensioners with very little or no savings who do not receive pension credits.

The following case study shows the effects of fuel poverty and the preventative impact that such a scheme can have:

Mrs Leigh (70s) lived in Denbighshire in a house built 50 years ago with an ineffective heating system. Her husband’s health condition required a certain level of temperature in every room, and his bedroom was quite cold so they often used a convection heater in the room to top up the heating. To balance their budget, they avoided driving in winter to pay for heating. They had a new boiler, thermostats and radiators installed: *“The house will be warmer, so I won’t have to worry about my husband’s health all the time! In the past, I’ve had to put him on a nebuliser when he woke up with a coughing fit in the middle of the night when the weather was cold”*.

The examples presented above tackle one or more of the segments from our ‘anatomy of resilience’ model (on p 10): housing, advice and information, relationships, physical health, etc. The preventative models which have the most potential seem to be those which can straddle service boundaries (or segments of our model) and which are able to work holistically with people, enabling them to identify their own goals and the resources they need to mobilise to achieve them.

ADASS in England sponsored a series of examples of local authority interventions that are preventative and described as ‘community based’. They all emphasise the importance of local authorities taking a preventative approach in which “at every interaction with a person, a local authority considers whether or how the person’s needs could be reduced or other needs could be delayed from arising”.

An example of an attempt at whole system change to a ‘strengths based’ model is the Community Social Work approach being implemented by Shropshire Council. An initial point of contact provides basic screening and signposting and, if further support is required, the person is passed to a team of social work assistants who engage in a solution-based conversation, which explores the person’s own assets and other community based support and resources. Other than in a crisis or safeguarding situation, one-to-one assessments with social care professionals are only undertaken if these other types of approaches have not been able to resolve the issues.

5.2. Summary of prevention ‘models’ and approaches in Wales and UK

‘Prevention is not just about providing the same service in similar portions at an earlier stage, it is about equipping people with skills, coping techniques and circumstances to remain independent. It is a responsibility that extends well beyond Social Services’

Roberts (2012)

In relation to health and social services in Wales specifically, the recent policy emphasis has manifested in the development of a preventative agenda by the Welsh Government. This is also reflected in government policy in England (the Care Act) and in Scotland. Prevention models typically seek to achieve a successful model of ageing which involves developing mechanisms that allow older people to live a good life in the community.

Traditional prevention ‘models’ have typically been service based approaches and interventions whereas more recent approaches use the language of ‘community asset based’ approaches and/or ‘individual strengths based’ approaches.

Research undertaken by NIHR School for Social Care Research (2013) analyses the more traditional approaches adopted by local authorities; it highlights how local authorities have pursued the most effective ‘preventative’ interventions to reduce demand on social care. The approaches adopted are usually based on a range of interventions that were seen as being effective locally in preventing older people from requiring any or additional social care service. This research identified that the ‘top 3’ preventive interventions that local authorities typically deploy are:

- Reablement/re-enablement services
- Telecare and equipment services
- Providing information and advice.

All of these interventions have been the subject of major evaluations or research, which have demonstrated that they can have a positive impact for older people and determine service priorities. However, these are limited in number and there is much that is not known – for instance, what difference do they make over longer time periods, what are the experiences of older people with different backgrounds and/or conditions, have there been social or economic impacts for family carers?

The evidence base on prevention is often skewed towards interventions that have received central government interest and financial pump-priming such as reablement and telecare (Miller & Whitehead, 2015).

There is some emerging evidence (e.g. Thurrock 2014, Fox 2013) that taking a community based approach which builds on social capital and local assets is an essential component of a sustainable and progressive model of adult social care. However, at this stage, the evidence is of 'micro examples' rather than 'whole system' approaches to community-based prevention grounded in the views and lived experiences of older citizens. There are also anecdotal examples of good practice on asset-based approaches to community development from within a housing setting (Shiland 2015 on the work of Cartrefi Conwy housing association, Miller & Russell 2012, and Miles & Williams 2014 on Hazel Court in Swansea).

In Wales, the introduction of a statutory duty requiring local authorities to ensure that older people have access to preventative services has renewed attention on the need to promote health and well-being. However, there is a risk that local authorities have the opportunity to rebadge existing services as preventative rather than adopt an alternative approach based on how 'prevention' can operate from an older person's perspective.

In the current financial environment for public sector organisations, it may be necessary to accept that local authorities will be unable to fund early intervention prevention strategies; it therefore becomes a financial imperative to seek out community based partnerships and opportunities that are consistent with what older people say is important to them in managing the barriers that may prevent them from maintaining their independence.

5.3. Implications for Stage 2 of this research

The focus of this research is to understand what prevention means from the perspectives of older people and carers. Through this research we are seeking to develop deeper understanding and insights into the following:

- The barriers that prevent older people from achieving their well-being outcomes and maintaining independence, and
- How to prevent these barriers from leading to a crisis that then leads to formal services; i.e. these are the crises that can trigger an older person 'falling' into formal services.

This research is grounded in gaining this understanding and insight through conversations with older people and carers. Stage 2 of the research is an opportunity to identify what 'works' in prevention from older people's and carers' perspectives.

We are seeking to understand and reveal the nature of a whole system approach to prevention that is grounded in the outcomes that matter most to older people in relation to their personal well-being and the everyday barriers that prevent them from attaining these outcomes.

6. Discussion and conclusions

We set out to consider what makes up the ‘anatomy’ of resilience: what are the vital parts that make up an independent and fulfilling later life and how do these relate to each other?

Having proposed a simple model (on p. 10) to help us organise our review and this report, we have, in the preceding chapters, summarised the existing evidence base on each of the ‘segments’ in our model, considering how these fit together. Throughout the report, we have drawn out key evidence gaps and questions to consider in the next phase of this project – our focus groups and interviews with older people and their carers across Wales.

In this final section, we present and reflect on some of the cross-cutting and recurring themes which have emerged from our review of the evidence base. We will then draw together a series of key questions that we hope to explore in our conversations with older people and through our analysis of them.

So what are the *qualities* of their relationships or the homes and communities they live in that the older people interviewed in previous studies really seemed to value? Is there a common denominator running through each of our segments? What is it that really makes the difference between coping and crisis, between flourishing and struggling?

The following five themes have come up time and time again throughout our review and we will discuss each briefly in turn in the following sections:

- Having choices and being in control (including having the right to take risks)
- Having a strong sense of identity, continuity and belonging
- Coping with worry and uncertainty
- Planning for change and transitions and
- Feeling socially connected.

6.1. Having choices and being in control (including having the right to take risks)

Being able to choose how you live your daily life, and take a few risks to do the things that matter to you is fundamentally important to adults of all ages. It sounds obvious, but losing this level of control explains most people’s fear of ‘ending up in a home’: it is the fear of being dependent on others, of having to fit into the routines of an institution, and of losing control over the little daily choices that make us who we are.

Staying in your own home represents being in control for many and, for these people risking getting into difficulties alone in your home is a price worth paying to retain this. This fear of others making decisions for you – of relinquishing control or being ‘taken over’ – may be what puts some people off seeking timely assistance from Social Services or other agencies.

Older people talk about the importance of having enough money to be able to make choices – to do the things that make day-to-day living manageable and good. They also need to understand their rights and options if they are to make informed decisions.

6.2. Having a strong sense of identity, continuity and belonging

Another reason people give for wanting to stay in their own homes and communities as they age is that this is where their memories and connections are located – the things that anchor them: the shopkeeper that recognises them, the garden that reminds them of their partner. Our relationships also give us a sense of belonging to groups and networks; of where we fit in.

Many of the older people in the research we have reviewed (or previously conducted ourselves) want to maintain their identities – for example, as someone who is self-sufficient, keeps their home in good order, or is a good grandparent. A key theme from the evidence is how much being able to make a contribution matters to our sense of self as we age. Interviewees fear becoming ‘a burden’, more often than not they want to continue to be someone who looks after others, the person who fixes things or the one who stands up for other people and they get depressed or frustrated if they cannot find a way to do this. We have also heard how important it is to adapt your sense of self as you get older and to learn to ‘live with being well enough’.

Often it is the changes in role and identity which present the biggest challenges in later life – the move from partner to ‘carer’ (or ‘patient manager’), from ‘carer’ to ‘cared for’, from abused or abuser to ‘carer’ and so on. People may need emotional and practical support and information to help them take on these new roles.

6.3. Coping with worry and uncertainty

A key theme from the qualitative research is how older people cope with worry and uncertainty. Common uncertainties in later life tend to focus on:

- Health and health conditions, particularly memory loss – many describe worrying that they are starting to ‘lose their minds’; health conditions which fluctuate or have an unpredictable prognosis can be much more difficult to live with than those which are constant
- Money – whether you will have enough, how much you should or will be able to leave to your family. In our research with self-funders in extra care housing (Pannell et al 2012) we were struck by how those with substantial savings often worried (more than those with modest incomes) about how to pace their spending, given that they did not know what the future might hold
- Whether and when you should move somewhere else – in our many conversations with older people on the subject of ‘downsizing’, people often say how hard it is to know when the ‘right’ time is to do this, i.e. while you can still de-clutter, move and settle into a new place
- Whether, how and when you might ‘need help’ and how you will negotiate this on your own terms.

Individuals respond very differently to uncertainty: some need to plan ahead and get information in advance; others are happy to take it a day at a time; some ‘take the plunge’; while others procrastinate decisions, deny the need for them or agonise over getting it wrong. This is an aspect of ‘personalisation’ that is often overlooked. It is interesting that practical help with decision-making was a theme that emerged from the literature on what carers want and need.

Just as professionals may need learning and development to undertake positive risk assessments (Morgan & Williamson 2014); so may older people and carers themselves.

6.4. Planning for change and transitions

In our previous research with older people, we have met ‘careful planners’ – those who make sure they are living in an accessible property as they age, who build up their social networks in early retirement, who carefully research the health conditions they or their loved ones are diagnosed with, or who save effectively for their retirement. In our research with older people with high support needs living in extra care housing, we also met another group of ‘crisis movers’ (e.g. Pannell et al 2012). Moving as a result of crisis is a huge upheaval at any age but some older people never seem to fully recover or settle following this – not least because they have felt they have little control over the move.

However much we plan though, nothing can fully prepare us for traumatic incidents and losses – bereavements, relationship breakdown, serious accidents and the diagnosis of terminal conditions. In our recent research with older people in care homes (Blood & Litherland 2015), we met several older people for whom the death of an adult child seemed to have been a key trigger on their pathway to residential care. Retirement is another key transition experienced by many younger old people and we have considered how the nature of this ‘pathway’ and our adaptation to it can shape our subsequent financial, social and psychological well-being.

There are of course many smaller ‘external changes’ (as we call them on our ‘anatomy of crisis’ model on p.40) over which we have no control – local shops or facilities closing down, bus routes changing, etc – and which can have a huge impact on our ability to live independently as we age. Changes which (as we saw in the section on carer breakdown) may seem small in the eyes of services can have a huge impact on the well-being and independence of older people. No longer having access to a car – because you or someone else is no longer able to drive – may be such a change. In an engagement project we did in Anglesey, professionals and older people told us of a relatively common pattern in which people moved to the island to retire and, when they could no longer drive, found themselves isolated, with few local contacts.

6.5. Feeling socially connected

Although we have included ‘relationships’ and ‘community’ as segments within our model, feeling socially connected seems to run through all the other segments so strongly that we have included it here as a cross-cutting theme in its own right. A need for connection with others often drives the way in which older people shop, bank and go about their day-to-day lives; the way they prefer to access advice and services; their decisions about where to live, whether to work, whether and from whom to ask for support.

6.6. Implications for service providers and policy makers

These cross-cutting themes suggest a number of key questions from the perspective of Social Services:

- How can we help people stay in control and take ‘positive’ risks?
- How can we support people to make a contribution and to maintain a good sense of self?
- How can we best enable people to make their own decisions and to plan for change and transitions?
- How can we support people’s need for social connection?

We will endeavor to draw more evidence to answer these questions through the next phase of this project.

The evidence review has also reminded us just how interconnected the different aspects of our well-being are and how interconnected our lives are with those of families, friends, neighbours and partners. This may sound obvious but Social Services has traditionally not been good at seeing and supporting people holistically and within these networks.

6.7. Implications for the next stage of our research

So, knowing what we do (and what we do not) about what makes older people resilient, and having started to consider the key questions and implications of this for service providers and policy makers, what does this mean for the next stage of our research?

What should we explore (and with whom) if we are to build an evidence base for a new preventative model to promote well-being, based on the voices and experiences of older people and carers in Wales?

Groups of older people to ensure we include:

Our brief is to speak to at least 100 people aged 75 and over and at least 30 family carers who are not (yet) receiving assistance from Social Services. Our aim will be to recruit as diverse a group of older people as possible, in relation to gender, ethnicity, health and disability status and geography (including a mix of urban/ rural, deprived and less deprived as well as covering as many of the Welsh regions as possible).

However, our review of the evidence has highlighted the importance of us also ensuring that we seek out input from the following groups, who risk being overlooked, who may have significantly differently experiences and/or for whom there is less existing evidence:

- Men – especially male carers and/ or men from working-class backgrounds
- Older carers – we must be aware that ‘older people’ and ‘carers’ are overlapping groups
- Welsh speakers – who we know may face particular barriers accessing information, advice and other services

- Low income owner occupiers – who may face particular challenges in relation to housing and finances and may not understand or be reluctant to access benefits and statutory help – home improvement agencies and handypersons services (e.g. Care & Repair Cymru) may be useful gatekeepers here
- Older people from BME (Black and Minority Ethnic Groups) – particularly from Polish and Somalian backgrounds
- People with dementia and those caring for them.

Topics to explore

Drawing on the findings and gaps highlighted by our review of the evidence, we have, in conjunction with our steering group, identified a series of possible questions to explore in the next phase of the research (shown in the table below). Although these will shape our conversations and our analysis of them, it is important to note that we do not intend to work through these exact questions in our interviews but will, in practice, use much broader and more widely accessible questions which will allow participants to steer the course of the conversations onto topics that matter most to *them*.

Topic	Possible questions (see note above)
Help-seeking in the broadest sense (informal & professional)	<ul style="list-style-type: none"> • How do people view this? • Under what circumstances might they seek help from these sources and how? • What puts them off (and what do they do instead?)?
Self-concept and ageing	<ul style="list-style-type: none"> • How do people view themselves as they age? • How do they cope with role change? • How do they explain the source of their ‘concept of self’ and impact on their resilience and well-being?
Information and advice	<ul style="list-style-type: none"> • Do people feel they have the information they need to make decisions/ promote their own independence and well-being moving forwards? • Have they sought advice on anything in the last 5 years? What? How? What difference did it make? • Where and how might they access advice in future? • What puts them off/ makes this easier?
Character (and impact) of people’s relationships and networks	<ul style="list-style-type: none"> • To what extent do people rely on key relationships for support? • Who can you rely on to help you in times of need? • What are the relationships dynamics, the practicalities and the risks here? • Where are the gaps/ potential boundaries of/ challenges to informal/ mutual support?

Feelings about neighbourhood	<ul style="list-style-type: none"> • Do people feel safe in/ connected to their neighbourhood? • What impact does this have on their general confidence/ day-to-day lives?
Technology: use, barriers, opportunities	<ul style="list-style-type: none"> • Do people use technology (in the broadest sense) to keep independent/ maintain well-being? • Would they consider more? What gets in the way? • Are there simple things that might make a big difference here, e.g. hearing aids, cordless/ large button phones with numbers programmed in, etc?
Ill-health & disability:	<ul style="list-style-type: none"> • Which strategies do people develop to cope with ill-health and uncertainty around health? • How do they maintain confidence: how do they lose it and what is the impact? • How far do people feel able to manage their own health and fitness, and what might help them to do this better?
Planners v. procrastinators: transitions	<ul style="list-style-type: none"> • How do these two types deal with and experience transitions? • Is this a helpful way of thinking about pathways or are many people a bit of both/ somewhere in the middle? • How can we empower both of these groups?
Work, retirement and learning	<ul style="list-style-type: none"> • How do these pathways promote (or threaten) well-being: financial, social interaction, sense of sense, etc?
Money	<ul style="list-style-type: none"> • Do people avoid doing things for financial reasons that could improve their well-being and sustain their independence for longer? • How much do they worry about money?
Local services/ transport	<ul style="list-style-type: none"> • How do older people manage where local services have been shut (or have never been there) and/or public transport is poor? • What is the knock-on effect on them and their networks? • How might this affect outcomes/ potential demands on services?

We look forward to sharing the findings of this next phase of the project in or by early 2016.

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