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**An exploration of ‘choice’ in relation to
social care for older people in a rural
area**

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Professional Doctorate in Occupational
Therapy

April 2010

An exploration of ‘choice’ in relation to social care for older people in a rural area

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A thesis submitted in partial fulfilment of the requirements of the University of Northumbria at Newcastle for the degree of Professional Doctorate in Occupational Therapy

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Abstract

Social care is currently undergoing a transformation, driven by Government policy, and key to this transformation is giving greater choice to service users. This vision of choice is based on a market model of competing service providers; such a model can be difficult to implement in rural areas where problems of space, time and access hamper service delivery. This raises the question of whether policy is biased towards urban areas and highlights the important role that geographical gerontology can play in developing more person-centred social care policy and practice. This consumerist vision of social care has also fuelled a theoretical debate which underpins this research. The market model of choice has been located within a wider discourse which regards the self as a rational, self-sufficient individual. An alternative discourse has been posited from a feminist ontology in which interdependence and co-responsibility come to the fore; such a discourse emphasises the personal dimension to social care practice. This project forms the research component of a professional doctorate in occupational therapy and is concerned with the self-expressed views of rural older people in relation to the above social care theory and policy.

Taking a phenomenological approach, a narrative methodology was used to interview 11 older people who live in rural West Northumberland. Participants' narratives concerning social care re-affirm findings from previous gerontological research which assert low expectations, self-sufficiency and the crucial role of human relationships. Although at a superficial level, 'choice' is not a term participants relate to social care, it is revealed that they do make choices on a daily basis both in relation to social care and their home situation, but choice is a complex and ongoing process rather than a one off event. It is suggested that the way participants situate themselves within their network of care and their geographic location helps them to maintain coherence in their personal identity. The concepts identified above are used to develop theory from a postmodern and feminist perspective in the areas of social care and geographical gerontology, forming an original contribution at the interface of these two domains.

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Introduction and Aims

The chosen field of enquiry relates to social care for older people in a rural area. In the course of professional practice as an occupational therapist and care manager, the researcher relocated from a densely populated urban city to a vast rural county, comprising isolated settlements and small to medium sized towns. This highlighted the impact of geography on day-to-day practice, most specifically the apparent lack of services on the one hand but the flexibility, resourcefulness and innovation of staff on the other. In 2002 the researchers employer, Northumberland County Council social services department, became part of Northumberland Care Trust and subject to nationwide National Health Service targets and imperatives; this highlighted the disparity of a large rural county trying to implement health and social care policies, which seemed to be designed for urban areas. This disparity is exemplified by the recent firm and explicit Government commitment to widen personal choice in social care. The concept of choice critically highlights the conflict between a market driven approach and rural areas; the former envisaging a greater variety of providers close to home and the latter faced with overcoming problems of space, time and access in order to provide a service. The aims of the project can therefore be defined.

To explore:

1. What it means for older people who use social care to live in a rural area.
2. The concept of 'choice' from the point of view of rural older people who use social care.
3. The meaning of choice for rural older people who use social care in relation to social care theory and practice.
4. The experience of rural older people who use social care services in relation to national policy.

The chosen strategy to address these aims is a narrative study of a small group of older people living in rural Northumberland who use social care services; in order for the study to be valid, ethical and meaningful it must be grounded in existing gerontological and social care theory and policy. The first chapter of this thesis therefore critically outlines the relevant theoretical debates and policy context of the

research. This critique is divided into four sections; ‘choice in social care’, ‘creating and enhancing personal identity’, ‘a geographical gerontological view of place’ and ‘rural life for older people’. Although research into health and social care in rural areas is quite a recent phenomenon, a comprehensive debate around the commodification of community care has been ongoing since the introduction of the NHS and Community Care Act in 1991; this discourse has revealed ‘choice’ to be a contested and value laden concept. The history and philosophy of ‘choice’ in social care is therefore explored, along with alternative theories of care and practice which allow for non-rationalist models of identity and selfhood.

From a gerontological perspective, discursive and postmodern ideas of identity are critically examined, emphasising the important role that narrative can play in bringing coherence and continuity to the lives of older people. Exploration of the literature relating to ‘place’ reveals attachment to place as an important aspect of maintaining continuity in one’s personal narrative and gerontological research draws strong links between place and identity. Discussion of the current academic discourse of ageing-in-place, incorporating phenomenological and postmodern ideas about place, leads to the possibility that geography can shape older people’s experiences of social care and a rural location has specific features which justify ‘rural’ as a factor worthy of consideration in gerontological research. These features of rurality are critically explored, specifically in relation to the delivery and experience of social care for older people.

The research design is underpinned by the theory and policy outlined, adopting a phenomenological philosophy to understand the lived experience of rural older people in receipt of social care and employing a narrative methodology in order to give a meaningful voice to that experience. The chosen methodology and method are explained in detail in the relevant chapters with a careful and critical approach to justify each stage of the research process; population and sampling criteria are carefully addressed with reference to the aims of the study. The research has been subject to appropriate ethical scrutiny but as a piece of insider practitioner research there are specific issues that need to be explicitly considered in this project. Steps taken to address the two main ethical considerations of informed consent and

confidentiality are therefore outlined, followed by a discussion of the distinguishing features of practitioner research.

The findings of the research represent common narratives which are interpreted in relation to existing theory to give them coherence and generalisability. In keeping with the philosophy and aims of the project, the three main sections of the findings; ‘social care experience’, ‘sense of place’ and ‘meaning of choice’, explore in detail participants’ personal experiences and construed meaning. The implications of the findings are discussed in relation to practice, policy and theory. In relation to social care practice, specific focus is given to appropriately tailored intervention and the nature of the therapeutic relationship. In the policy section, the findings provide a geographical and gerontological lens through which to examine social care policy, facilitating critique and recommendations. The theory section brings together the three key concepts of place, identity and choice, which were introduced in the literature review and develops them from a specifically gerontological perspective. This theoretical development is underpinned by common threads of postmodernism and feminism throughout and culminates in an original understanding of choice in social care. Finally, in the conclusion of the thesis the aims of the research are revisited to critically evaluate the contribution and limitations of this project.

Introduction to Literature Review

Two pervading qualities which constitute the narrative approach in this research are the temporal dimension to human existence and the socio-political influences upon personal narratives. It is therefore crucial to locate the concept of choice within the current sociological and political discourses, as well as outlining the evolution of this term in social care policy. The historical dimension not only gives theoretical credibility to this work, but gives methodological validity to the interpretation of the narratives of older people. The literature review therefore begins with an outline of the current policy context of choice within social care and how this market-based model of social care has developed since the birth of the British welfare state. As one of the explicit aims of the research is to relate participants' understanding of choice to current social care practice and theory; the above discourse is critiqued firstly from the perspective of advocates of the therapeutic relationship and secondly from sociological criticisms of the ideology underpinning a market model of social care. This critique includes theoretical and empirical evidence of alternative understandings of social care, with specific reference to older people, providing a basis for analysis of findings and subsequent conceptual development.

This research has a phenomenological philosophy and seeks to explore and interpret the expressed life-world of rural older people. To interpret with authenticity the way that participants experience the world and explain why they construct the personal narratives they do, it is important to recognise features that enhance or maintain their core identity. The next chapter of the literature review therefore explores current theories about identity with specific reference to older people. This critique explicitly rejects a rationalist model of identity and explores postmodern and discursive ideas about identity which are specifically relevant in gerontology. This literature forms part of the theoretical grounding of the research which underpins the chosen methodology and method, as well as encouraging the theoretical development of more constructive approaches to ageing. From a professional practice perspective, exploration of this literature enables consideration to be given to therapeutic interventions which may preserve and enhance the personal identity of older people.

This research has a specific geographical dimension and the findings will therefore contribute to the body of knowledge within the discipline of geographical gerontology; part three of the literature review situates this research within that academic discourse. Current geographical ideas concerning the existential understanding of place are outlined and this leads to a critique of significant geographical gerontological literature. This literature has taken on board the phenomenological approach to place in trying to explain the temporal and emotional qualities which constitute the phenomenon known as ‘ageing-in-place’. For older people, especially those in need of care, the home environment is a central focus, therefore this critique includes theoretical expressions of the meaning of home for older people and how this relates to the home as a centre of care provision.

At the original planning stage of this research, the geographical dimension to the care of older people was brought to the fore by the apparent challenges and opportunities of service delivery in rural areas; the final section of the literature review justifies exploring this rural dimension in further detail. The social and demographic features which define an area as rural are critically outlined from academic and Government sources; such information helps to give an historical and policy context to the meaning of rural, but the importance of listening to the interpretations of rural people is emphasised. As the personal experiences of older people form a key aspect under investigation in this study, the gerontological literature specifically relating to rural areas is critiqued in detail. Little research has been carried out with rural older people in England, but qualitative studies from Scotland, Ireland and outside of the UK help to reveal some common features associated with rural ageing.

This insight into previous research helps to formulate the research, conduct the interviews in a focused manner and situate the findings within the context of relevant literature. Within the section ‘rural life for older people’, literature relating to service delivery of health and social care in rural areas is also critiqued; this includes consideration of the current and potential challenges faced, as well as suggestions for social care policy. This final critique situates respondents’ narratives within a specifically rural policy context and enables the policy implications of the research to be given a rural focus.

Literature review part one: Choice in social care

In order to understand the current theoretical debate surrounding ‘choice’ in relation to social care it is important to clarify what these terms mean in the context of current policy and how this meaning has evolved since the birth of the British welfare state. The historical link between a market model of choice and social care will therefore be discussed; focusing on the beginnings of the British welfare state, the new right government of the 1980’s and 1990’s followed by new labour in 1997. It is important to acknowledge that soon after the election of the labour government in 1998 legislation was implemented to devolve the design and delivery of public services in the UK through the creation of the Scottish Executive, the Cabinet of the National Assembly for Wales and the Northern Ireland Executive Committee.

The process of devolution itself can be seen as part of the evolutionary development of citizenship rights relating to social care (Stewart, 1995) and a move away from the ‘Nation State’ model of citizenship so closely allied with capitalism and modernity (Taylor-Gooby, 1995). Indeed, Wincott (2006) suggests that devolution in the UK may allow social care provision to respond more sensitively to local concerns and circumstances. In practice, from 1998 onwards the Department of Health and related policy documents referred to within this thesis actually refer to the Department of Health in England. The only two exceptions cited within this thesis are DoH (2003b) referring to Direct Payments which applies to England and Wales, and DoH (2003c) referring to Delayed Discharges act which also includes Wales, though the Welsh Assembly have not fully implemented provision (Dow, 2010). The research study that forms the core of this thesis takes place in England, therefore although the discussion of the earlier history of community care relates to the UK, reference to the later historical development relates specifically to England, where the ‘personalisation’ agenda has been particularly pronounced (Dow, 2010).

The Government’s current understanding of ‘choice’ in this arena is laid out in the Local Authority Circular, ‘Transforming Social Care’; this sets out a framework with a view to every person “having choice and control over the shape of his or her support” (DoH, 2008, p.2). Key to this transformation is the proposal that everyone

eligible for publicly funded social care will have an individual budget with which to choose how best to meet their needs. The Government is explicit that service users should be recognized as consumers and choice is equated to mean choice from a range of competing service providers, to be addressed through increasing the range of providers available (DoH, 2003a; DoH, 2005; DoH, 2006a). There is a clear adherence to a market approach of which choice lies at the heart; individuals are believed to be empowered by having choice between alternatives and the option of exit if dissatisfied, the total pattern of provision is thus dictated by the sum of consumer choices (Hoyes et al, 1993).

In setting out an agenda to transform adult social care, there is an understanding that adult social care has historically been comprised of those services provided to meet long-term needs, which fall within the statutory remit of local government, for example, equipment, home adaptations, help with personal care and social support, (DoH, 2005). Although the Government's vision to transform social care proposes blurring the boundaries between local government, health, housing, transport and the voluntary sector in order to provide what is called a "personalised approach" (DoH, 2008, p. 2), there is still to this day a clear defining factor of social care that it is, and always has been, subject to means testing and charges upon the individual (DoH, 2009). This possible financial cost to the service user distinguishes 'social care' from health care which remains free at the point of delivery to the individual. 'Social care' previously came within the umbrella term, 'community care', but it has been necessary to demarcate that element subject to charging because of the increasing level of health and social care which now takes place within people's own homes; however its development in relation to market mechanisms can be followed within the context of 'community care'.

The link between market mechanisms and community care has been described by Lewis (1994) as promoting the mixed economy; this promotion seems to have been successful to some degree as adult social care is now delivered by over 25,000 providers, with only a small remnant of services being provided by councils directly (DoH, 2009). This goal of a mixed economy of welfare has a long history and can be traced back to the beginnings of the welfare state when Beveridge envisaged a horizontally layered mixed economy of welfare (Pinker, 1992); indeed Beveridge has

been described as a Liberal who believed strongly in a 'free society' and a market economy (Harris, 1977). There is some consensus that the formation of the welfare state did rely on the existence of a successful capitalist economy (Roche, 1992; Powell, 2000); however, Silver (1994) suggests that infiltration of economic philosophies into social care fail to acknowledge that the formation of the welfare state was part of a political, and not merely an economic, settlement. A key author on the welfare state in relation to citizenship rights, T.H Marshall perceived the mixed economy of the welfare state as a compromise, or reconciliation between socialism, capitalism and democracy, expressed in his term 'democratic-welfare-capitalism' (Marshall, 1981, p.104). Whilst wishing to deploy the capitalist economy, both Beveridge and Marshall appear to have acknowledged that market mechanisms may bring about efficient allocation of resources but they cannot be guaranteed to distribute them equitably. This point enjoys some economic consensus (Dasgupta, 1989; Helm, 1989; Levacic, 1991) indeed, Dasgupta (1989) has described the competitive market mechanism as being guaranteed to bring about disenfranchisement of a fraction of the population. For these reasons the post-war consensus pre-supposed a significant state role, exerting influence and control over, in particular, the market sector of the mixed economy.

In the first two decades of the welfare state, community based care services for older people were given a low priority (Scourfield, 2006), with an emphasis being on health care and retirement income (Roche, 1992). There was a minimal home help service led by the voluntary sector, but it was generally expected that responsibility for supporting older people would lie with (mainly female) relatives. Where families could no longer provide this support the older person would require long-term institutional care (Means and Smith, 1998; Leece, 2003). The first official use of the term 'community care' related to mental health and learning disabilities and came when the Royal Commission on Mental Illness and Mental Deficiency (1957) entitled a chapter 'The development of community care'. The policy was essentially one recommending a shift away from care within large institutions. This was made possible through pharmaceutical control replacing the need for physical restraint, but was given impetus by writers such as E. Goffman and W.Wolffensberger outlining the negative and de-humanising effects of institutional life. Institutional provision continued to be subject to criticism and periodic scandals right up to 1980 with the

publication of 'The Politics of Mental Handicap' (Ryan and Thomas, 1980), which included diary extracts of the regimentation, harassment and abuse that formed the daily life of residents in one institution. At the same time a Kings Fund document entitled *An Ordinary Life* (1980) listed recommended principles which included:-

1. Mentally handicapped people have the same human value as anyone else and the same human rights.
2. Living like others in the community is both a right and a need.

The rhetoric of pressure groups and academics was responded to with widespread support among politicians, who could scarcely do otherwise in the light of evidence presented. The subsequent political rejection of the institution *per se* contributed to the general endorsement of the idea of community care.

For older people, this idea of community care was only translated into social care support as we now know it, with the passing of the Health Services and Public Health Act in 1968 which gave local authorities the power to make arrangements to provide non-residential community care services (Scourfield, 2006). The implementation of this act was delayed until 1971 to coincide with the introduction of the post-Seebholm restructuring of social services departments, which saw a shift in emphasis towards co-ordinating resources within the community to meet identified need. However by the late 1970's the majority of care for older people was still being carried out by the informal sector and institutional budgets continued to dominate both health and social services (Leece, 2003); this painfully slow development of funded community care for older people has been recognised and attributed to sociological and structural factors. Resting as it did on a successful capitalist economy, the formation of the welfare state was closely allied to the notion of full male employment (Marshall (1981) and this influenced the way welfare services were structured and delivered. Gerontological theorists such as Estes (1979), Townsend (1981) and Walker (1980) argued that this link between chronological age and the political economy structured the roles and responsibilities of older people in a restricted and artificially dependent manner. This led Townsend (1981) to assert that the emphasis on residential care that was apparent in the 1948 National Assistance Act was a deliberate strategy to regulate society; maintaining values of self-help and domestic independence within the family.

Townsend's earlier work, *The last refuge*, detailed the rise in the number of residential establishments for older people owned and managed by local authorities, from sixty-three in 1948 to over eleven hundred by 1960 (Townsend, 1964). The publication of this work did create some appreciation of 'workhouse legacy' with its detailed accounts of the appalling conditions of some residential institutions for older people (Means and Smith, 1985). However, Means (1986) suggests its impact was muted because it did not encounter a climate susceptible to moral panic about welfare for older people; he asserts that welfare services for older people only achieve prominence on the political agenda during periods of demographic or fiscal crisis. The government's response to the publication of *The last refuge* was, according to Means and Smith, (1985) rather ironically a re-iteration of the need to build new residential care homes for older people.

The need to reform existing community care policy was given impetus by the election of the Thatcher Government in 1979. This signalled a firm ideological commitment to market mechanisms allied to the Hayekian economic tradition, in which the state's attempt to control the market are deemed futile and market failure is perceived as a lesser evil than Government failure (Helm, 1989); rather than the Keynesian approach of the 1960's and 70's which promoted the role of the state. At this time choice came to the fore of Government rhetoric in relation to community care, with the underlying philosophy of the White Paper, *Caring for People*, said to be "promoting choice and independence" (DoH, 1989, p.5). In this document increasing the number of providers is automatically equated with greater choice and local authorities are encouraged to stimulate the development of non-statutory providers and develop their contracting role (DoH, 1989). Underlying this firm commitment to choice and market mechanisms, the Government of the day appeared to have a strong belief in the ongoing support that the informal care sector could continue to provide:

"There is substantial possibility and indeed probability of continuing growth in voluntary care, neighbourhood care and self-help" (Social Services Committee, 1980, p.99-100).

"Primary sources of support for the care of elderly people are informal and voluntary; these spring from personal ties of kinship, friendship and neighbourhood" (DoH, 1981, para.1.9).

Despite, or because of, the greater reliance on informal care to support people at home, there is evidence to suggest that the reforms of the 1990's did lead to an increase in the number of people being cared for at home. The growth in institutional provision that had dominated the 1980's levelled out and the number of local authority funded home care contact hours grew substantially from 1.7 million in 1992 to 2.6 million in 1997. This growth in home care was largely due to an expansion of the independent sector, with its share of the local authority funded home care market growing from 2.3% in 1992 to 44% in 1997 (Government Statistical Service, 1998). However the reality of choice for service users was called into question by critics on two grounds; firstly, on the grounds of whether choice was actually created in the social care 'market place' and secondly, whether the legislative framework put service users in a position to make choices.

Early evidence following community care reforms suggested that economies of scale were resulting in large powerful private providers squeezing small specialist ones out of the market, causing an actual reduction in the range of services available (Hoyes and Means, 1991; Hudson, 1994). 'Cream skimming' was also identified as a major barrier to choice; in which independent providers were selecting which clients they would accept (Means and Langan, 1996). Such criticisms remain relevant to the current social care reforms; a number of authors have pointed out that whilst devolving purchasing power down to individual users of social care through facilities such as Direct Payments and personal budgets may offer choice and flexibility for some service users, this could be at the expense of wider goals of specialist, responsive services only available from a publicly funded common resource (Lent and Arendt, 2004; Spandler, 2004; Scourfield, 2006). Recent evidence suggests that economies of scale continue to be a feature affecting service user choice in the social care market; Patmore (2003) found that home care providers were less willing to supply individual older people, either privately or via a Direct Payment if it jeopardized larger contracts they had and Scourfield (2006) has expressed concern about whether the social care 'market' labour force actually has enough capacity at all to meet demand. The supposition in the community care reforms, both past and present that introducing choice would somehow create a multitude of providers for service users seems to fail to recognise the very market forces it advocates; the state's role in planning and co-ordinating services to meet need is replaced by the power of

capital which, it would appear, can be just as monopolistic and inflexible as that which it intended to replace.

The goal of “consumer choice” (DoH, 1989, p.18) in the community care reforms was called into question by critics because of the assessment framework laid down in the NHS and Community Care Act (DoH and S.S.I, 1991). The legislative framework and policy guidance for community care dictated that it was care managers, rather than service users, who were choosing services on their behalf. The expressed intention was for care managers to consult with service users and their carers in formulating a package of care but care managers had ultimate control and choice (Kenny and Edwards, 1996; Henwood and Wistow, 1994; Hardy, Young and Wistow, 1999). Indeed some evidence suggested that dimensions of choice actually decreased after the implementation of The Community Care Act due to financial restraints on local authorities (Hardy, Young and Wistow, 1999). This lack of control and choice led to a campaign by younger people with disabilities, for people who required social care to be given cash in lieu of services (Morris, 1994) culminating in the drawing up of the Community Care Direct Payments Act (DoH, 1996) which was implemented in April 1997, just prior to the change in Government on 2nd May 1997.

New Labour picked up the mantle of Direct Payments for social care and the facility was extended in 2000 to include older people, parents of children with disabilities, carers and young people. In 2003 local councils were no longer requested to offer direct payments to eligible individuals, but were ‘required’ to do so (Glasby and Littlechild, 2006). New Labour continues the goal to replace care with cash in its most recent Social Care Green Paper which emphasises the role of personal budgets in giving people more choice and control (DoH, 2009). New Labour’s rhetoric around choice and market mechanisms in social care sounds remarkably similar to that of the previous Conservative Government:

“A healthy range of providers offering diversity and good quality services will make individual choice a reality” and giving people more choice will “stimulate the social care market” (DoH, 2005, p.45).

Despite this similarity, New Labour claimed to be offering a ‘Third Way’ of politics; treading a path between the New Right ideology of Thatcherism and the old statist, bureaucratic style of government associated with old Labour (Giddens, 1998;

Scourfield, 2006). In order to distance itself from the previous Government it outlined a 'Modernization' programme for social care (DoH, 1998), involving further promotion of independence and choice for service users but with the added goal of increased regulation and inspection within social care services; this was implemented through a plethora of National Service Frameworks, performance indicators, a National Care Standards Commission, a General Social Services Council and a Social Care Institute for Excellence (Quereshi, 2002). When the Government later outlined its vision for the future of social care it was quite clear that all of these mechanisms were required in order for their reforms to be implemented: "Performance assessment, inspection and regulation are important levers to ensure that services are improved and appropriately focused on the right outcomes" (DoH, 2005, p.60).

This regulatory and contractual framework is the focus of a key critique of the current social care vision. Although Quereshi (2002) recognizes that some form of standardization of services is required in the quest for quality, he suggests that in the United Kingdom the balance has gone too far in the direction of control and standardization to allow for the development of care relationships, which many older people want. The professional/service user relationship and its inherently moral nature is at the heart of the criticism of the regulation imperative. The assertion that clearly defined outcome measures, regulation and inspection are all required to deliver a quality social care service suggests that the "once lauded public service ethic" can no longer be relied upon (Crimson, 2005, p. 513); as incentives and contracts become the driving force in human affairs (Harrison and Smith, 2004). The Government has been quite explicit that all of the mechanisms and frameworks are designed to restore confidence, as outlined in their Modernising Social Services White Paper: "People should be able to have confidence in their local social services, knowing they work to clear and acceptable standards, and that if these standards are not met, action can be taken to improve things." (DoH, 1998, 9:para. 1.8). However Harrison and Smith (2004) draw a clear distinction between confidence and trust; they contend that while confidence relies on rules and contract to be assured, trust is inherently moral in nature due to the characteristic of risk, vulnerability and uncertainty. The critical role that trust plays in social care has been evidenced by Ungerson (1997; 1999) in her qualitative research with people receiving Direct payments. She found that within

these apparently commodified relationships, the potential conflict between command and obedience on the one hand, and sensitivity to feeling on the other is made more complex by the management of risk; placing the relationship within a context of trust is regarded as vital in the management of this risk.

Trust has been recognised as an intrinsic part of the therapeutic relationship in social care; Cole and McLean (2003, p.44) define the therapeutic relationship as “a trusting connection and rapport established between therapist and client through collaboration, communication and mutual understanding and respect”. They form part of a school of thought which refutes the technical, rational approach to social (and health) care practice and instead advocate for an understanding of professional practice as artistry, acknowledging the creative and uncertain dimensions of health and social care practice, (Fish, 1998; Fish and Coles, 1998). This association between creativity and trust echoes Giddens’ thoughts on ‘Ontological Security’; trust is deemed by its very nature to be in a certain sense creative, because it entails a leap into the unknown. To trust is to face the possibility of loss and this generates effort, relations that sustain trust are ‘worked at’. This creative involvement with others is deemed by Giddens to be a fundamental component of psychological satisfaction and moral meaning (Giddens, 1991). Professional practice as artistry recognizes that professionals have to make appropriate judgements in situations where there is no ‘right’ answer and where a moral dimension is involved (Fish, 1998). Nowhere is this more apparent than when care managers have to exercise discretionary power in their assessment process; interpreting eligibility criteria and performance management tools at the same time as advocating for the service user (Milner and O’Byrne, 1998; Beresford and Croft, 2004).

A key mechanism in the regulation and control of social care services has been the introduction of eligibility criteria which must be interpreted and implemented by front line staff; this is most explicit in the Fair Access to Care Guidance which provides local authorities with a framework to determine people’s eligibility for adult social care (DoH, 2002). Although the current Government claims to be a firm advocate of preventative services in maintaining health and well-being (DoH, 2005); there is evidence that there has been an incremental targeting of services on those in greatest need (Ware et al 2001; Daly and Lewis, 2000). In practice this has meant a larger role

for professional discretion and gate keeping in determining who receives services (Daly and Lewis, 2000; Glendinning, 2008). There is some evidence that care managers have difficulty coping with this type of role; either offering care beyond budgetary constraints or being so focused on cost implications that they lose their caring role (Humphrey, 2003). Other authors have suggested that practitioners' discretionary powers can be used positively to support choice and utilise a personal assessment and care management process (Clapton and Kendall, 2002; Evans and Harris, 2004). Crucially, the practitioner role has been found to be particularly important in giving due consideration to the time involved in supporting older people with the assessment process; Foster et al (2006), in their study of the care management assessment process, found that older people did not articulate issues as readily as younger people. Tanner (2001), from her small scale study of older people who require social care, has stressed how important it is for care managers to engage with potential service users and listen to their narratives when assessing for and arranging social care, to enable them to maintain coherence and continuity of the 'core self'.

Despite the apparent neglect of human relationships in the Government's vision for social care (Jordan, 2005a), older people have consistently been found to place a high regard on the quality and continuity of the relationship they have with social care professionals and carers. The Government's own consultation exercise found that older people place a higher priority on continuity of professional, rather than 'choice', believing that this is safer and more effective because the person knows them and their care needs better (DoH, 2006b). When receiving a social care service older people have been found to value qualities such as confidence, trust and sensitivity rather than choice (Hardy, Young and Wistow, 1999; McCann, Ryan and McKenna, 2005); indeed having to make choices may even contribute to feelings of anxiety and confusion when first contact is made with social care services (Barnes and Prior, 1995). In-depth studies of older people's understanding of the quality of their social care service revealed this to be underpinned by the relationship they have with their care assistant; in some cases the social contact with this person was more important to them than the actual task (Netten et al, 2005; Clark and Spafford, 2001; McCann, Ryan and McKenna, 2005; Vernon and Quereshi, 2000). Such findings are unsurprising when placed alongside research evidence and theoretical understandings

of the human endeavour for a sense of well-being. Argyl (1999) and Myers (1999) in their search for the causes of human happiness found that it is the quality of relationships, both personal and communal, which most influence subjective well-being. Theoretical attempts to explain the ways in which people maintain a positive and coherent sense of self have emphasised the fundamental human motivation for connection, attachment and routine interaction with a network of others (Ezzy, 1998; Anderson and Chen, 2002; Sneed and Whitbourne, 2005).

The above critique has highlighted the impact that the regulatory framework for social care has upon integral professional relationships; a second area of critique concerns the ideology which underpins the discourse of ‘choice’ and how appropriate such an ideology is to both human services and public policy. Placing choice at the centre of social care reform could be perceived as a cunning strategy if it were carried out with full understanding of its meaning and implications. Clark, Smith and Vidler, (2006) have suggested that the term ‘choice’ contains such a variety of meanings that it has the capacity to mobilise concerns for greater control, aspirations to define one’s own needs and a wish to shape personal outcomes and relationships. For a term loaded with such complexity it is crucial to try to unpack its meaning within the current social care discourse to determine the impact of its use at a policy and personal level.

The current Government’s faith in a market driven model of choice has already been referred to. There is a clear understanding that the use of market mechanisms in social care will improve quality and more effectively meet people’s needs than traditional routes of care provision:

“Giving people an individual budget should drive up the quality of services. The ability of people to ‘buy’ elements of their care or support package will stimulate the social care market to provide services people actually want and help shift resources away from services that do not meet needs and expectations” (DoH, 2005, p.35).

Social care as part of the public sector as a whole, is consequently aligned with the goals of the wider economic market:

“Choice acknowledges that consumers of public services should be given the kind of options they take for granted in other walks of life” (Blair, 2002, p.3).

This inherent belief that individual choice should be the driving force behind public sector provision has consistently been referred to as Liberalism (Smith, 2005; Jordan,

2005a; Jordan, 2005b; Scourfield, 2007; Glendinning, 2008). Liberalism advanced the view that individuals are free and equal, capable of determining and justifying their own actions and capable of entering into self-chosen obligations (Held, 1987). It drives a political orthodoxy in which autonomy and choice are endorsed as the basis for maintaining social order (Jordan, 2005b) and it has a cultural ideal of the self-actualizing, rational individual (Ermarth, 2001).

This ideal of the autonomous individual certainly seems to be confirmed in social care rhetoric and policy which asserts independence and self-sufficiency as laudable goals. There is an expectation that people using services should be responsible for their own health and social care, with reference to Direct Payments, “the person using the service should remain in control and is accountable”, (DoH, 2003b, p.6) and “Individuals should accept that they should have responsibility for their own health and safety” (DoH, 2003b, p.26). Within a discourse of personal responsibility, illness and disability are regarded as a “burden” (DoH, 2006a, p.16) and dependency is something to be avoided at all cost. Lloyd (2000, p.180) has criticised the Royal Commission on long-term care for promoting the view that “dependence is an abyss into which each of us must avoid falling rather than an aspect of the normal human condition”. McCormack (2001) has suggested that in caring for older people, rather than demonizing dependence per se, it is important to understand what ‘dependence’ means to that particular person. In his research with older people requiring health care, he found that the focus on self-determination had been taken on board by staff and led them to perceive any intervention as “paternalistic”; when in reality older people struggled to reach appropriate decisions on their own and they required a supportive, honest relationship with staff to assist them. The College of Occupational Therapists has expressed concern that older people themselves could take on board this ideal of self-sufficiency, leading them to feel a failure or guilty when they require support (COT, 2005); this is particularly pertinent to older people who use social care for whom care needs are anticipated to increase (Quereshi, 2002).

The discourse of the self-sufficient individual has been accused of ignoring the political and relational ontology of social care and an alternative conceptualization comes from a feminist ethic of care. The ethic of care framework refutes the independence/dependence dichotomy and emphasises the interdependence of the

human condition (Daly and Lewis, 2000; Williams, 2001). There is an assertion that vulnerability is an essential part of the ordinary human condition and individuals can only exist because they are members of various networks of care and responsibility, (Sevenhuijsen, 2000; Henderson and Forbat, 2002). There is recognition that people are constituted as more or less vulnerable at different times in their life (Williams, 2001) and this point is particularly pertinent to social care for older people. The welfare state was originally formed on the basis of an inter-generational contract and although this may have been removed from current social care discourses, it is still within the memory of current older people. The closest acknowledgement of this comes from Fine and Glendinning (2005), who suggest that rather than an expectation of direct and immediate reciprocity between care giver and care receiver, the exchange may be delayed, or in a chain of obligation linking a community.

Ethic of care theorists have rejected notions of independence and choice which assume ‘the unencumbered self’ (Sandel, 1996) so central to a market philosophy. However it is important to acknowledge that collective struggles for people with disabilities placed a premium on independence and choice, in their challenge to welfare policies which undermined their human rights. Indeed, the term ‘care’ so very central to the ethic of care philosophy, has been seen as embodying an oppressive history:

“Disabled people have never demanded or asked for care! We have sought independent living which means being able to achieve maximum independence and control over our own lives. The concept of care seems to many disabled people to be a tool through which others are able to dominate and manage our lives” (Wood, 1991, p. 199).

‘Care’ is an emotionally loaded and contested term and the apparent clash of ideologies outlined above highlights the way that a prevailing discourse can influence interpretation. There is clearly a prevailing discourse within social care of self-sufficiency and independence, which Jordan (2005b) suggests does not value informal care, political and collective co-responsibility. This leads to the paradoxical situation in which care is liable to be degraded in our society if it does not attract monetary value and yet also degraded if it does (Daly and Lewis, 2000). Perhaps the resolution is to acknowledge our commonality as human beings in order to create space for political dialogue. Hogget (2001, p. 43) expresses this succinctly:

“The fact is we are natural and corporeal beings, we have bodies which do cause suffering and do decay and die. Western culture seems to be in flight from an acceptance of the limits that nature provides and this is true of the promptings of nature in our bodies as it is of the capacity of the natural eco-system to withstand the ravages that capitalist modernity inflicts upon it.”

As well as contesting the notion of ‘care’ disability activists have taken issue with and sought clarification of the terms choice and independence. Morris (2006) has argued that choice is fundamental to achieving citizenship, social inclusion and human rights; Wood (1991) has defined choice as one of the key components of empowerment for people with disabilities. Choice within this discourse is closely allied with control and when the two concepts are found together they are said to result in a greater sense of well-being and self-determination (Witcher et al, 2000; Morris, 2006). This model of self-determination is translated into an interpretation of ‘independence’ which values decisional autonomy rather than physical self-reliance (Parry et al, 2004; Boyle, 2005). Evidence in support of this theoretical understanding of choice and independence has come largely from small scale studies into the positive benefits of service users who receive direct payments (Witcher et al, 2000; Glendinning et al, 2000; Davidson and Luckhurst, 2002). This positive feedback could be seen as reflecting the success story for disability campaigners who saw individualized funding schemes as meeting their goals of empowerment, choice and control (Scourfield, 2007).

Although the success of direct payment schemes seems to drive the Government’s agenda to roll out individual budgets to all service users:

“It is clear that direct payments give people choice and control, and we think that is a mechanism that should be extended and encouraged wherever possible”, (DoH, 2005, p. 33).

The actual proportion of social care users who receive direct payments is very small. In 2007, direct payment users made up 2.5% of all adults receiving community-based social care and although older people are by far the largest group of adult social care users, only 1.3% of those aged over 65 used direct payments (National Statistics 2007). However the themes that emerged from the literature relating to disability campaigners have been repeated in older people research to some degree. The

beneficial features associated with direct payments of empowerment, choice and control have been found to be of value amongst older people who have used direct payments (Clark, Gough and Macfarlane, 2004). The notions of independence and choice have also been recognised as important to older people in maintaining a meaningful social role and sense of fulfilment (Bland, 1999; Tanner, 2001; Secker et al, 2003). For older people, the notion of independence does seem to be a very broad concept that encompasses not only the qualities of choice and control that is evident from younger people's interpretations, but also what Secker et al (2003, p. 378) refer to as "richer" ideas about independence encompassing ideas about personal growth, self-determination and continuity of one's identity.

Literature review part two: Creating and enhancing personal identity

The rich and diverse ideas of older people, highlighted at the end of the last chapter, particularly in relation to ‘continuity of the self’, could be explained by their positive sense of self and identity which has been evidenced in gerontological research. Even though older people themselves have been found to take on board some negative stereotypes associated with ageing, they have demonstrated remarkable vigour of the self-esteem and stability of personal identity (Coleman, Ivani-Chalian and Robinson, 1998; George, 1998; Sneed and Whitbourne, 2005). This phenomenon has been referred to as a paradox of well-being by Mroczek and Kolarz (1998), which serves to reinforce negative attitudes to ageing; highlighting the contradiction that older people could possibly be happy and fulfilled. George (1998) has suggested that this restricted view of ageing has led researchers to focus only on how older people might ‘protect’ the self, rather than looking for self-enhancing behaviours. The starting point for such an endeavour must be a theoretical understanding of what ‘the self’ actually means in relation to older people’s well-being.

A number of terms can be used to describe the self but for the purposes of qualitative research, Ezzy (1998) draws a useful distinction between selfhood and identity. Selfhood is characterized by its ability to reflect upon itself whilst identity is a narrative construction that is the product of this reflective process; identity is the story one tells oneself or others about oneself. This would imply that as researchers we can only access identity and not selfhood, though the two concepts are intimately connected. Before outlining a relevant understanding of what identity means, recourse will be made to Taylor’s seminal work, ‘Sources of The Self’ to discount a rationalist model of identity. Taylor has suggested that the vast majority of insightful philosophy of the twentieth century has refuted this idea of the disengaged subject; importantly he asserts that the achievements of modernity which this model brought can still be valued as a developmental process, even as they are now displaced (Taylor, 1992).

In leaving behind the modernist view of atomistic identity, postmodernism has been described as offering opportunities to be either liberating or disturbing depending on

the make up of the perceiver (Wilson, 1997). There is some consensus that a postmodern perspective emphasises the fragmented and multiple view of the self (Taylor, 1998; Ermarth, 2001; Tanner, 2001); indeed, it can be perceived that the whole point of the postmodern imperative is that it restores legitimacy to the contradictions, irrationalities and genuine dilemmas that we all hold within us (Taylor, 1992; Bauman, 1993). Although Tanner (2001) translates this postmodern perspective into a vision of identity which is diverse and fractured rather than stable and continuous, others regard ‘identity’ as the very core of a human being which synthesizes the complex machinery of who we are (Coleman, Ivani-Chalian and Robinson, 1998; Holstein and Gubrium, 2000; Nikander, 2009). The way that coherence is re-imposed on the postmodern self by identity is summed up succinctly by Brah (1996, p.123):

“Identity may be understood as the very process by which multiplicity and instability of subjectivity is signified as having coherence, continuity, stability; as having a core – a continually changing core but the sense of a core nonetheless – that at any given moment is enunciated as the ‘I’.”

Brah’s suggestion of the continually changing core of identity is reiterated elsewhere; Ermarth (2001) regards postmodern identity as a moving nexus, while Giddens (1991) describes self-identity as something that has to be routinely created. These ideas echo one of the original forerunners of postmodern thought, Lyotard (1984), who located the self at ‘crossroads’ or ‘nodal points’ of discourses in practice. The notion of discourse is crucial in formulating an understanding of identity which can take account of agency as well as context. Holstein and Gubrium (2000) regard agency as a crucial feature of the postmodern condition in dealing with the competing demands of discourses at any given time. Agency has been defined as “the meaning, motivation and purpose which individuals bring to their activity” (Kabeer, 1999, p.438). A postmodern understanding of agency acknowledges the contradiction and paradox it can hold within it to express the impulsive and passionate nature of human beings (Bauman, 1993; Hoggett, 2001; Ermarth, 2001).

In her exploration of ethnic and cultural difference in relation to ‘successful ageing’, Wray (2003) found that agency for her participants was generated through a continuing desire to engage with the social world and ‘successful ageing’ was

associated with a sense of belonging and a collective identity; there is then an inseparable association between agency, identity and discourse. Nikander (2009) translates this understanding into a 'discursive gerontology' to tread a middle ground between macro-social theories and a postmodern approach; preserving older people's agency and meaning while laying out the dynamics through which ageist notions surface in and through discourse. Nikander is not alone in attempting to resolve the apparent contradiction between a postmodern understanding of identity and universal welfare. There is some consensus that a postmodern approach does pose a challenge to social policy because it threatens to undermine the political and structural dimension to welfare (Taylor, 1992; Carter, 1998; Taylor, 1998; Orme, 2001), however even extreme postmodern political theorists recognised the important role of discourse in defining identities (Laclau and Mouffe, 1985; Young, 1987; 1989). The postmodern challenge is regarded by some as an opportunity to question taken for granted paradigms which may reinforce relations of privilege or oppression; an understanding of identity which embraces notions of individual agency as well as exposing the roots of welfare discourses is deemed to offer more opportunities for empowerment of service users (Wilson, 1997; Carter, 1998; Hendricks, 2004).

Charles Taylor interprets the discursive aspect of identity as "one is a self only among other selves"; he asserts that the modernist, independent view of identity ignored our "embedding in webs of interlocution" (Taylor, 1992, p.35). Gerontological research confirms the significance of meaningful social relations in maintaining a positive sense of identity. Qualitative studies have found that relationships of reciprocity and continuity can help sustain a positive sense of identity in older people, and this sense of identity is more resilient to change when it is based upon a wider range of interpersonal contacts (Clark, Dyer and Horwood, 1998; Coleman, Ivan-Chalian and Robinson, 1998; Tanner, 2001). It is pertinent to note that reciprocity in the relationships older people sustain can be maintained in what appear to be objectively adverse circumstances (Nolan, Grant and Keady, 1996). In response to older people's apparent desire to seek out emotionally-rich interactions, Anderson and Chen (2002) developed a theory of 'relational self' based upon the fundamental human motivation for belonging, connection and attachment. This theory sits comfortably with the discursive nature of identity; it regards the self as being shaped by interactions with significant others represented as relational norms in the long-term memory. Aspects

of identity which relate to the significant other exemplars are triggered by cues in the current environment, thus emphasising the unique and motivational nature of identity.

If the postmodern, discursive ideas of identity present a reflexive and fluid notion of the self, coherence and continuity comes from our personal biography or 'narrative'; "life is an activity and a passion in search of a narrative" (Ricour, 1992, p.29). A number of theorists have argued that the story or narrative of our lives is a fundamental characteristic of identity (Bruner, 1986; Taylor, 1992; Poiana, 1999). In his account of 'Ontological Security', Giddens (1991) recognises that a feeling of biographical continuity is crucial to a stable self-identity; however he outlines in detail the way that early trust relations form an underlying protection against future threats to self-identity. This theory asserts the important role that the psychological make up of the individual plays in developing ontological security in an existential sense, implying there is a limiting framework or resource which is presupposed by other facets of identity. Recognition of such parameters is crucial in any therapeutic intervention or public policy.

There is consensus that narrative provides coherence and continuity in people's lives but it is deemed very much to be a 'work in progress'; the formation of narrative identity can be seen as "a time based historical process, an unceasing dialogue between the self and the social" (Hearn, 2006, p.112). Stories are actively composed and edited throughout life (Holstein and Gubrium, 2000) and we draw upon a wide range of pre-existing and already constructed narratives to produce our own personal narrative at any moment in time (Kerby, 1991; Ricoeur, 1992). This complex nature of narratives has led Ezzy (1998) to assert that self-narratives can sometimes appear confused and even chaotic, but this should not be interpreted as absence of a plot, simply that the narrative may not have been fully worked out.

Gerontological research has emphasised the importance of this coherent dialogue in forming integrity to one's life, in terms of bringing consistent meaning to one's past and present life (Dalby, 2006). Qualitative evidence suggests that older people do construct a narrative identity through maintaining major themes in their lives (Coleman, Ivani-Chalian and Robinson, 1998; Philipson and Biggs, 1998; Tanner, 2001); it is understood that these themes are constructed within the context of

prevailing discourses and social encounters (Hendricks, 2003; Nikander, 2009). Keeping a particular narrative going, which Giddens, (1991) regards as crucial to sustaining a coherent sense of identity, does not rely on consistency or sameness; indeed, preserving continuity of one's narrative can come from a diverse array of sources and even catastrophic changes in one's life can be incorporated into the narrative if the major themes are retained (Tanner, 2001). It is important to recognise that not all older people have a past with which they wish to connect, but they can still retain continuity from major themes in their life and construct a meaningful narrative from this (Coleman, Ivani-Chalian and Robinson, 1998). There is some evidence that practical initiatives can be valuable in helping older people to construct and articulate their life story in a personally meaningful manner (Kenyon and Randall, 1997; Freeman, 1997).

Literature review part three: A geographical gerontological view of place

One important way that older people maintain continuity in their personal narrative is through attachment to place, indeed place has been described as an essential aspect of our identity (Peace, Holland and Kellaheer, 2005; Andrews et al 2006; Ruston 2009); it is therefore important to understand the current academic discourse of 'place' and how this sits within gerontological research. Cutchin (2008) regards place as one of geography's most complex concepts, it is perhaps therefore unsurprising that current ideas about place are rooted in a phenomenological philosophy and a postmodern theoretical perspective. The artist and commentator, Lucy Lippard has observed that the 'pull of place' operates in all of us as the "geographical component of the psychological need to belong somewhere" (1997, p.7). This succinctly reflects the shift in geographical thought from a positivist understanding of place to one which draws on the work of Heidegger (1962) and Husserl (1980) to bring to the fore the existential qualities that places possess. From Heidegger's understanding of dwelling as 'being in the world' geographers come to recognise that human beings can only think and act through their physical situations; our knowledge is always seen as 'em-placed' (Crang, 1998). From this philosophical basis, Cutchin (2008) suggests that geographical inquiry should focus on the experiential needs of people in places; where experience is perceived as a process with dynamic and temporal qualities. In this way place attachments are not static, but "change in accordance with changes in the people, activities or processes and places involved in the attachment" (Brown and Perkins, 1992, p.282).

Building on the early work of Tuan (1977), who acknowledged the important role that emotion plays in shifting undifferentiated 'space' to value laden 'place', Crang (1998) regarded places as a combination of essences, personal attachments and emotions. This emotional and existential understanding of place leads to geographers thinking of place as a web of social relations (Massey, 1999) and as such it involves situated human intention within it (Andrews, 2003). Although many geographers do recognise that a large proportion of these social relations are constructed on a larger scale than the place of reference itself (Massey, 1999; Valentine, 2001; Cutchin, 2008), a more

political interpretation of this understanding of place comes from Gregory (2000) and Agnew (1993). They agree with the aforementioned geographers that place is represented within language meaning and subjectivity, but make recourse to the 'culture' of place which emerges from the broader discourses and power relations in which place is situated. Utilising this cultural understanding of place, Poland et al (2005, p.177) draw on the work of Foucault, to show that power relations are a key feature of place; they assert that revealing the "messiness and uniqueness of place" can be an important tool in challenging bureaucratic systems which are predicated on spatial uniformity.

The challenge to spatial uniformity is undertaken in research and practice relating to older people with a geographical gerontological approach, Wiles (2005a, p.100) defines this as the "spatial and environmental contexts of ageing; the ways that space and place are related to the experiences and needs of older people". The emerging interest in the association between place and ageing can be perceived as driven by the policy of 'community care'; there is an implicit assumption that living at home for as long as possible equates with 'successful ageing' (Martin et al, 2005; Wiles, 2005b). The place and space in which people age therefore become crucial as a context of care networks and service provision (Wiles, 2005b; Hanlon et al, 2007) and the phrase 'ageing-in-place' encapsulates the belief that "older people, particularly as they grow more frail, are able to remain more independent, and benefit from, ageing in environments to which they are accustomed" (Rowles, 1993, p. 65). As with any gerontological work, there is an implicit understanding that older people are certainly not an homogenous group (Day, 2008); however, they are likely to experience a range of health-related challenges which increase with age (Pawelec, 2006) and result in their local and immediate environment playing a more significant role than other age groups (Kellaher, Peace and Holland, 2004; Philips et al, 2005).

Early gerontological work looking at the relationship between the older person and their environment adopted a behavioural psychological approach to explain the way in which older people cope with functional decline in relation to their immediate environment. Lawton and Nahemow (1973) in their ecological model of ageing introduced the concept of environmental press, where the competence of the individual could be considered alongside the immediate and wider environment.

Central to this 'ecological model' of ageing was the proposition that older people who function at a higher level of competence, can adapt to a wider range of environmental press and have a greater likelihood of experiencing favourable adaptive outcomes (Schwarz, 2003). Within this model, 'competence' is defined in relation to biological health, sensori-motor function, cognitive skills and ego strength (Peace, Holland and Kellaher, 2005).

Although Lawton's later work, for example Lawton and Parmlee (1990) did recognise the dynamic and inseparable nature of person-environment relations, he continued to be concerned with documenting behavioural competencies, and much of his work embraced the need to identify independent and dependent variables in order to construct hypothetical relationships that could be tested (Moore et al, 2003). This approach, particularly in his later work, was motivated by a desire to enhance the design and practical considerations of housing for older people, especially in relation to dementia care (Schwarz, 2003; Moore et al, 2003). Whilst acknowledging the valuable contribution of this body of work to gerontology, its input into this particular study which has a phenomenological philosophical basis, is limited.

Environmental psychological theories of ageing have traditionally adopted a positivist approach (Seaman, 1982) and this has led some to suggest it has offered an incomplete perspective on housing in old age, due to its neglect of the experiential and emotional dimensions of ageing in place (Wahl, Scheidt and Windley, 2004; Oswald et al, 2006). It has been suggested that Lawton did not explicitly address the concept of 'self' at any great length (Schwarz, 2003) and Burholt and Naylor (2005) have suggested that an older person's environment at the level of the community plays a significant role in self-identity. The ensuing geographical gerontological literature has taken on board phenomenological and postmodern geographical ideas about place and explored the meaning of ageing-in-place in relation to older people's quality of life and personal identity.

In a seminal work of geographical gerontology, Rowles (1978) drew a relationship between place and identity with his description of the term 'geographical fantasy' as one aspect of the geographical experience of older people. He suggested that the creation of fantasies, through recollection and imagination could instil place with

“depth of meaning inasmuch as the stream of its past was incorporated within its experienced identity” (p.183). In his later work, Rowles (1993) strengthens the link between identity and place for older people with a temporal dimension which he refers to as “time-depth” (p.67). He suggests that as we grow older, our sense of identity is inextricably linked with places which we remember and which become a part of who we are. Andrews et al (2006) make similar recourse to the temporal dimension of place attachment in their request for attention to be paid to the oral histories of older people. They suggest that places form a vital source of biographical development and as such contribute to the construction of our identity; they assert that attachment to places over time can serve as an “experiential anchor” for our personal narratives and lead to our identities being “historically emplaced” (p.154).

The work of Rowles (1993) and Andrews et al (2006) can be seen as emphasising the constancy of ageing-in-place, indeed Rowles (1993, p.67) suggests our sense of attachment to place “may as we grow older, become increasingly significant in preserving a sense of identity and continuity amidst a changing world”. More recent work has also highlighted the way that place attachment for older people can strengthen self-identity and feelings of security through the continuity it provides (Mowl, Pain and Talbot, 2000; Peace, Holland and Kellaher, 2005; Dahlin-Ivanoff et al 2007). However Malcolm Cutchin, in his expressed desire to point out “the complexity of person-place relations pertaining to older people” (Cutchin, 2005, p.125), acknowledges that although continuity of person and place is paramount to successful ‘ageing-in-place’, change is ever present in experience (Cutchin, 2003) and experience is a dynamic process, constituted by interactions between the person and their physical and social environment (Cutchin, 2008). In keeping with this theoretical approach, other gerontological studies have accentuated the dynamic nature of identity in relation to place; place has a social and cultural dimension and the way in which older people interact with this impacts on their self-identity and well-being (Mallett, 2004; Wiles, 2005a; Day, 2008). Indeed, Wahl and Lang (2006) regard every older person’s sense of self as being positioned within a dynamic and socially created place.

The term ‘social space’ has been used by Wiles et al (2009) to denote the “complex emotional and symbolic connections to places and people across time and space”

(p.666); these connections are seen as ‘elastic’ in the sense that they can stretch and alter outside of expected parameters. Their study of older people’s attachment to place in New Zealand provides qualitative evidence in support of this proposition; although most participants had acquired empirically smaller social circles as they aged, their responses were qualitatively different, with some remaining highly socially connected whilst others were relieved at the freedom from social demands. This fluid nature of identity in relation to place has been examined in depth by Manzo (2003) and her work can add theoretical depth to existing geographical gerontological literature. Manzo (2003) recognises that in the context of our everyday lives we often relate to place in an unconscious way; this idea sits comfortably with Rowles’ concepts of physical and social “insideness” (Rowles, 1993, p. 68). Rowles uses these terms to describe the implicit affinity and familiarity with place, which we develop over time and which leads to a sense of belonging. Manzo (2003) goes on to suggest that there are times when we grapple with identity and self-development through our relationships to places and our feelings about places then become conscious, particularly where change occurs; we are then required actively to construct and re-construct identity in spatial terms. This supposition is manifest in literature exploring older people’s understanding of ‘home’ as a site of empowerment and identity construction.

There is some consensus that ‘home’ is an important and meaningful place for older people (Moore, 2000; Oswald and Wahl, 2005; Schenk, Kuwahara and Zablotsky, 2004), with the home environment perceived as a site of emotional and ontological security (Rowles, 2000; Martin et al, 2005). As the home increasingly becomes a place of care provision, it has also been recognised as potentially a therapeutic environment for older people (Williams, 2002). However Mallett (2004, p.69) reminds us of the need to develop a “complex view of the home that takes into account the interactions between place and social relationships”. Such a view can be elicited from gerontological research which highlights the creativity, emotion, capacity and resistance associated with older people’s understandings of home. An understanding of home as a place of creative thought and action can be seen in the sense of freedom to be alone and reflect or to engage with one’s social network (Dahlin-Ivanoff et al, 2007; Peace, Holland and Kellaher, 2005); it is also evoked in a desire to maintain competence and control over one’s environment (Cutchin, 2003;

Peace, Holland and Kellahe, 2005). This desire to maintain competence or 'independence' can translate into the home becoming a site of resistance or struggle in the face of ill-health associated with ageing (Mowl, Pain and Talbot, 2000; Imrie, 2004; Haak et al, 2007).

There is some evidence that older people's idea of 'independence' within the home does not necessarily equate to the policy ideal of functional independence; their interpretation within this context relating more to being able to govern one's life within a familiar environment (Martin et al, 2005; Haak et al, 2007). However, older people's experiences of the home cannot be dissociated from their corporeal reality and at a practical level Peace, Holland and Kellahe (2005) have urged the development of 'enabling' home environments through the use of adaptations and technology, to facilitate a positive self-identity and well-being. This idea of enabling environments can be directly related to the 'usability' dimension of Oswald et al's (2006) four component model of perceived housing. Oswald et al (2006) use the term, 'perceived housing' to describe a more comprehensive understating of housing in old age, than traditional psychological or functional perspectives. This integrative model comprises the four dimensions of housing satisfaction, usability in the home, meaning of home and housing-related control beliefs. Usability in the home relates to the usefulness of the home for the older person in relation to personal function, adaptive strategies and environmental barriers. Usability does articulate the corporal reality for the older person at a practical level, but it is only one dimension of the perceived housing model (Oswald et al, 2006). Housing satisfaction also relates to physical conditions within the home but is concerned with the older persons' evaluation of such; meaning of home and housing-related control beliefs are used to describe subjective meanings, goals and beliefs that determine the older persons' degree of attachment to their home.

For older people then, the home can be seen as a site of fluctuating negotiation between bodily impairment, environmental restrictions and self-identity (Imrie, 2004; Haak et al, 2007). In some cases a strong attachment to the home can contribute to an older persons' ability to deal with practical problems of daily living, but in other cases it may hamper their willingness to acknowledge problems and face the possibility of re-location (Oswald et al, 2006). Their capacity to define themselves differently in the

face of health changes can be reinforced by a strong sense of attachment to place beyond the immediate home environment and they take steps to reinforce this attachment through engaging with the wider material and social environment. This relates closely to Manzo's (2003) theoretical understanding of place in relation to identity; our feelings about places are brought to a conscious level when we grapple with our self-identity through our relationships to places, this may lead people to choose environments that are congruent with their self-identity. Peace, Holland and Kellaher, (2005) assert that in implementing strategies to reinforce their points of attachment to place, older people may opt to re-locate to a new home within a highly valued location.

Thinking the unthinkable and pointing out possible benefits of relocation for older people recognises the danger of romanticism of ageing-in-place (Rowles, 1993) and reification of 'the home', understood as one's residence as necessarily therapeutic (Martin et al, 2005). A phenomenological understanding of 'dwelling' leaves open the possibility for places outside of one's residence to be of central emotional importance (Manzo, 2003), this is reflected in older people's relationships with their neighbourhood and the wider 'natural' environment. Ruston (2009, p.266) usefully refers to the neighbourhood as a "resource space" which can help protect individual identity and qualitative studies have revealed that for the older people, actual engagement with the material and social neighbourhood is essential to well-being and self-identity (Young, Russell and Powers, 2004; Peace, Holland and Kellaher, 2005; Bowling and Stafford, 2007). In seeking to use the philosophical discourse of Dewey to inform geographical inquiry, Cutchin (2008) articulates the view that human experience is unified with nature, "nature and our experience of it is a continuous flow of unfolding processes" (p.1560). This inherent link between people and their natural environment is supported by research into the restorative aspects of people's relationships with nature (Kaplan and Kaplan, 1989; Korpela and Ylen, 2007). Looking specifically at older people's experience of their local environment, Day (2008) revealed that the aesthetics of the natural environment could impart a sense of comfort and peace; even in inner city neighbourhoods participants expressed strong emotions about the need to have green spaces and nature around them.

It is important to acknowledge the role played by emotion in constructing a broader and more discursive meaning of home (Gurney, 1997; Burholt and Naylor, 2005; Martin et al, 2005; Dahlin-Ivanoff et al, 2007). This can be expressed in an attachment to the material landscape and community (Laviolette, 2003). The emotional attachment at the level of community is summed up succinctly by Burholt and Naylor (2005, p.117); “communities are not just settings; they play a significant role in self-identity and are a vital source of emotional and experiential meaning for the inhabitant”. Such a broad understanding of attachment to place also shapes an understanding of ‘emplacement’ that is framed by family and intimate social relationships both past and present (Andrews et al, 2006; Mallet, 2004; Wiles, 2005a; Wiles, 2005b). Past relationships can contribute to an attachment to home through memories; a number of studies have revealed that memories make a crucial emotional contribution to the experience of home as one which sustains a coherent sense of identity (Rowles, 2000; Hepworth, 2000; Peace, Holland and Kellaheer, 2005; Andrews et al, 2006; Dahlin-Ivanoff et al, 2007). It is important to guard against positioning older people’s past as ‘their finest hour’ and consequently undermine the importance of their present lives (Andrews et al, 2006), but within the discursive meaning of home, memories are important because they “illuminate and transform the present” (Massey, 1992, p.14). In this way memories contribute to a complex experience of home encapsulated by Rapport and Dawson, 1998, p.8: “Home brings together memory and longing, the ideational, the effective and the physical, the spatial and the temporal, the local and the global”.

The emotional aspect of past and present relationships forms a major point of attachment in older people’s experience of ageing-in-place, but current relationships can have pragmatic as well as emotional implications. Having friends and neighbours close by to turn to for help has been recognised as an important reason for older people wishing to remain in their current home (Dahlin-Ivanoff et al, 2007; Wiles, 2005a; Hanlon et al 2007). This has implications when the home is understood as a place of care provision for older people (Cutchin, 2005; Wiles, 2005b) and brings into focus the way that “social care is embedded in place” (Hanlon et al 2007, p. 466). It has been suggested that an awareness of this dynamic and evolving attachment can be used to enhance the autonomy of older people, as well as supporting their formal and informal carers (Guberman and Maheu, 2002). However it has also been recognised

that 'who provides what' in terms of care is part of an ongoing process of family life, influenced by pre-existing geographical proximity as well as expectations of future needs (Shelton and Grundy, 2000; Walters, 2002). Understanding this network of care within the context of its geographical setting and inherent meanings, is seen as crucial to provide community-based care in an effective manner for older people (Wiles 2005a; Wiles, 2005b; Hanlon et al, 2007).

Community care policy recommendations as a result of the above debate around the meaning of 'ageing-in-place' are sparse but the following warrant consideration within the context of this study. As early as 1993, Rowles recognised that greater knowledge of the meaning and process of 'ageing-in-place' may be happening at a time when the role of place within ageing is changing. He suggested that, as a concept, 'ageing-in-place' is embedded in the realities of rural and pre-industrial America where people lived all of their lives in the same geographic vicinity. Such residential inertia is said to be characteristic of the current 'old-old' (i.e., those aged over seventy-five), particularly those in rural areas; in contrast Rowles suggests that for younger generations, attachments to places may have less temporal depth and involve more diverse settings. In conclusion, he recommends that a better understanding of the complex meaning of 'place' for older people should assist them to be enabled to retain a sense of 'ageing-in-place', even when physical relocation is required. Cutchin (2003) also looked at policy implications of retaining a sense of 'ageing-in-place' outside of the home environment, from his study of day centres and assisted living residences in The United States. His recommendation is that the policy goal should be re-integration of the person-place whole, based on "local, place-based values and morals" (p.1078); this should encourage flexibility and attention to contexts, processes and meanings within the resources under scrutiny. With a greater focus on policy objectives to enable people to remain in their own homes, Wiles (2005a) stresses the importance of acknowledging geographical proximity as a factor shaping older people's experience of care. She suggests that understanding 'place as a process', rather than simply a background feature, should encourage the building and maintaining of relationships in community care, rather than a fragmentary approach. She emphasises that continuity of care is a crucial aspect in the dynamic and complex understanding of place and suggests this has implications, not only for individual

practitioners, but also at the level of policy which drives the quality and effectiveness of the care.

Literature review part four: Rural life for older people

Although little of the theory relating to ‘place’ has the UK as its focus, some of the literature with a specific rural dimension to ageing-in-place has been carried out within the UK and Ireland. Woods (2006, p.589) has suggested that “rural identity is defined by a rootedness to place”; this could explain why ageing-in-place has been examined with a rural focus but other, more pragmatic reasons have been outlined to justify ‘rural’ as a factor worthy of consideration in gerontological research. First among these is the feature of population ageing across all rural areas, which is proportionately greater than that in urban areas (Joseph and Cloutier-Fisher, 2005; Giarchi, 2006; Chapman and Peace, 2008). There is an expectation that this trend will continue, with Government statistics for England indicating that over the next twenty-five years, the population of those aged over 75 will increase by 90% in rural areas, compared to an increase of 47% in urban areas (Commission for Rural Communities, 2008). The reason for this trend is understood to be threefold; younger people tend to migrate to urban areas for employment opportunities, older people are more likely to age-in-place within rural areas and there is a migration of people to more desirable rural areas (King, 2000; Wenger, 2001; Lowe and Speakman, 2006). Although it is acknowledged that rural areas and the older people who habit them are as diverse as their urban counterparts (Wenger, 2001), there are common features to rural areas which lead to the assertion that the ageing of rural areas will pose specific challenges to health and social care services (Mosely et al, 2005; Manthorpe et al, 2008).

The second feature which is said to justify a rural focus of gerontological study is the ‘invisibility’ of disadvantage in rural areas, caused by the urban bias of national policies (Williams and Cutchin, 2002; Milne, Hatzidimitriadou and Wiseman, 2007; Scharf and Bartlam, 2008) as well as, in England in particular, a lack of research evidence about the lived experience of rural older people (Milne, Hatzidimitriadou and Wiseman, 2007). A further overriding influence which justifies the current relevance of rural as a dimension of gerontological study can be summed up as ‘globalisation’; the socio-economic and political factors associated with globalisation have been described as having a greater impact upon rural areas which have undergone a more radical period of change (Joseph and Cloutier-Fisher, 2005;

Woods, 2006; Giarchi, 2006). These social and economic changes in rural areas have been described as potentially increasing and perpetuating the vulnerability of older people in these areas through the depletion of local services combined with the increased expectation of mobility (Joseph and Cloutier-Fisher, 2005; Scharf and Bartlam, 2008). Although the forces of political and economic restructuring associated with globalisation are perceived on the one hand as heightening the relevance of rural as an analytical dimension; they are also on the other hand seen as disturbing the very essence of what defines 'rural'. The emphasis on mobility, marketisation, deregulation and public devolution of risk, can all be regarded as contradictory to an understanding of rural regions as places of stability, coherence and stability (Commission for Rural Communities, 2008; Woods, 2006); it is therefore important to examine the way that 'rural' is defined in the context of gerontology.

There is consensus across the 'rural' literature that defining rural is problematic and that statistical approaches alone are inadequate. Even the UK Government has attempted to diversify its definition of rural since the implementation of the 'Rural Strategy 2004'; within this the Government claims to recognise the differences within and between rural areas and move away from a crude rural/urban split. This recognition is reflected in an extension of the previous land use based definition to include rural settlements of different sizes and kinds. Within this paper there was an appeal for new approaches and methodologies to understand rural areas; however this was disappointingly followed by a raft of quantitative targets, largely relating to economic regeneration and employment (Defra, 2004). Although much of the gerontological or health and social care literature pertaining to rural areas acknowledges and even refers to some statistical information in describing features that define rurality, there is a warning against using quantitative characteristics alone (Craig and Manthorpe, 2000; Williams and Cutchin, 2002); there is instead broad agreement that defining rurality in gerontology should be based upon locally contingent and subjective perspectives (Craig and Manthorpe, 2000; Williams and Cutchin, 2002; Manthorpe, Malin and Stubbs, 2004). This way of defining rural can lead to the conclusion that there is no, single, clear entity called 'rural' which would react to external pressures in a uniform way (Woods, 2006), indeed Pratt (1996) has cautioned researchers in their use of the term as it could orientate readers towards a demarcatory division between localities. However, Pratt (1996) also stresses that the

definition of 'rural' is interrelated to the subject under investigation and if that subject is 'older people' it makes sense to listen to their interpretation and defining characteristics of rural (Scharf and Bartlam, 2008).

Although all contributors recognise the diversity of life for rural older people, qualitative studies have revealed common aspects associated with rural ageing. Key amongst these aspects is the high value given by rural older people to the characteristics associated with rurality, such as beauty, peace and quiet and the natural landscape (Manthorpe, Malin and Stubbs, 2004; Chapman and Peace, 2008; Scharf and Batlam, 2008). This attachment to the physicality of their rural location becomes an embedded part of their identity and a strong influence in rural older people wishing to age-in-place (Woods, 2006; Chapman and Peace, 2008). It is therefore unsurprising that rural older people have consistently been found to be more satisfied with their location than urban counterparts (Stratford and Christie, 2000; Manthorpe, Mailn and Stubbs, 2004); however, it is important to situate this attachment alongside other features of rural ageing in order that the overly simplistic myth of the rural idyll is not perpetuated. The Government has recognised, that whilst prosperity in rural areas is generally increasing, there are a minority of areas experiencing disadvantage (Defra, 2004) and older people in these areas are at particular risk of poverty and social exclusion (Scharf and Bartlam, 2006; Manthorpe et al, 2008). The physical isolation of some rural settlements combined with the increasing expectation of personal mobility can exacerbate the exclusion of some older people from social support and appropriate services; evidence suggests that in the UK, family and neighbours often play a crucial role in overcoming such exclusion through providing social and practical support (Manthorpe, Malin and Stubbs, 2004; Scharf and Bartlam, 2008; Dobbs and Strain, 2008). Although support from family and neighbours may be a nationwide phenomenon for older people, Wenger (2001) from her comprehensive study of rural ageing in the UK found that rural older people across the UK do have more contact with neighbours and receive more informal non-family support than their urban counterparts.

Rural older people clearly place a high value on local support from family and neighbours in evaluating their quality of life (Manthorpe, Malin and Stubbs, 2004; Milne, Hatzidimitriadou and Wiseman, 2007; Scharf and Bartlam, 2008) but there is

some debate as to whether this finding is by necessity or by design. Rural areas have historically been under serviced from both public and private sector providers, compared with national standards and availability in urban areas (Gibson et al, 2002; Joseph and Cloutier-Fisher, 2005); indeed Heenan (2006) refers to the phenomenon of ‘distance decay’ to describe the inverse relationship that can be observed between remoteness and usage of services. At the same time as under-utilisation, rural communities consistently exhibit a culture of stoicism and self-help (Heenan, 2006; Parr and Philo, 2003; Innes et al, 2005) and tend to downplay and minimise any disadvantage they face (Harrop and Palmer, 2002; Scharf and Bartlam, 2008). These two features of under-utilisation and self-sufficiency form a cause and consequence dilemma, but the outcome is always a greater reliance on informal support in rural areas. Some authors have suggested that rural older people are well aware of the disadvantages that their rural location may bring and they are willing to accept compromise in order to age-in-place (Manthorpe, Malin and Stubbs, 2004; Chapman and Peace, 2008). Whatever the root cause of under-utilisation of services and the corresponding reliance on informal support in rural areas, this feature has major and growing implications for the delivery of health and social care services to rural older people.

Studies into the health and social care experience of rural older people in the UK have revealed that the prevailing culture of self-reliance and independence has a twofold impact upon service use. Firstly, the lower levels of utilisation which are exhibited when compared to urban counterparts and secondly, people delay seeking formal help until there is a crisis (Morgan et al, 2002; Lowe, 2003; Asthana and Halliday, 2004; Innes et al, 2005). This attitude of only dealing with formal services on an absolutely ‘need to know’ basis can exacerbate pre-existing problems accessing appropriate information about services (Craig and Manthorpe, 2000; Heenan, 2006). When rural older people and their carers do eventually accept and receive a formal social care service, their reported evaluation is generally positive, largely due to the nature of the relationship they have with formal carers. Studies of the social care experience of rural older people in the UK and Canada emphasise the close relationship that is often formed between service users and formal carers; there is an assertion that the rural location strengthens this bond because formal carers often have an intimate knowledge of the older person’s community and have a greater role in alleviating

social isolation (Innes et al, 2005; McCann, Ryan and McKenna, 2005; Sims-Gould and Martin-Matthews, 2008). This intimate knowledge and the close-knit nature of rural communities can however also pose challenges to client confidentiality and privacy (Sims-Gould and Martin-Matthews, 2008) and means that staff often have to negotiate dual working and personal roles (Parr and Philo, 2003). Despite these problems, feedback given by older people about rural service delivery is generally positive, with the main negative comments relating to services being inappropriate to meet specifically rural needs (Innes et al, 2005; Heenan, 2006) and problems accessing centralised services. Centralisation of health and social care services has been reported as an increasing national and international trend, which increases the problems that rural older people have accessing the support and information they require (Sherwood and Lewis, 2000; Asthana and Halliday, 2004; Joseph and Cloutier-Fisher, 2005; Manthorpe et al 2008).

Centralisation of services has also been highlighted as a barrier to effective delivery of health and social care in rural areas; it is seen as undermining the capacity of organisations to justify small scale services that are tailored to meet rural needs (Sherwood and Lewis, 2000; Milne, Hatzidimitriadou and Wiseman, 2007). A policy drive to centralisation has also been described as hampering co-terminosity between organisations and thus undermining joint working between health and social care; such joint working is regarded particularly crucial to meet the challenge of delivering services to a geographically dispersed population (Craig and Manthorpe, 2000). The development of Care Trusts, which combine health and social care over a designated area, has consequently been heralded as holding particular potential for rural areas (Milne, Hatzidimitriadou and Wiseman, 2007). The need for joint working amongst all sectors of health and social care provision, along with creativity, innovation and greater flexibility in professional roles, are all deemed to be required specifically in rural areas to offset the problems that health and social care providers face in delivering services in these areas (Asthana and Halliday, 2004; Innes et al, 2005; Manthorpe et al, 2008). Foremost among such problems is the distribution and supply of providers across a wide geographic area (Williams and Cutchin, 2002); indeed the greater the distances involved the greater the costs and problems of service delivery (Giarchi, 2006). It has been suggested that small rural towns can help offset the

problem of distance, forming important intermediate hubs between city and countryside to facilitate delivery of health and social care services (Giarchi, 2006).

The professionals involved in delivering health and social care services in rural areas have been described as having a tradition of demonstrating greater flexibility in roles, and a broader skill base because of their requirement to substitute for other professionals and meet a variety of specialist needs (Bushy, 2002; Parr and Philo, 2003; Farmer et al, 2003). This flexibility can either be seen as covering up for a well recognised deficit of specialist services in rural areas (Craig and Manthorpe, 2000); or a creative and cost effective use of a scarce resource (Innes et al, 2005), which takes into account the unproductive staff time and travel costs associated with delivering services in rural areas (Asthana et al, 2003; Manthorpe et al, 2008). If Asthana and Halliday (2004) are correct, then the introduction of a sparsity allowance for the NHS in England is improbable and the existing sparsity allowance paid to rural local authorities, though many of them deem it inadequate (Craig and Manthorpe, 2000; Hale, 2006), is also unlikely to increase; therefore such creativity and flexibility will continue to be required to meet the challenge of delivering health and social care in rural areas (Healthcare Commission, 2006).

Flexibility in roles is not a strategy that can offset the lack of availability of paid carers in social care; evidence suggests that they are in particular short supply in rural areas (Craig and Manthorpe, 2000; Innes et al, 2005) and rural care managers can face a long uphill struggle trying to secure appropriate care (McCann, Ryan and McKenna, 2005; Heenan, 2006). Reasons for this problem have been listed by The Commission for Rural Communities (2008) as limited access to transport, low wages or simply the fact that local people may not wish to do this type of work. Just like their larger health and social care counterparts, rural care organisations struggle to achieve economies of scale and meet the extra travel costs incurred; they inevitably pass on extra costs to their commissioning authority and this leads rural local authorities to report that financing social care in rural locations is a major problem (Craig and Manthorpe, 2000). The anticipated absence of a major political transformation that will suddenly increase the monetary and social value of care work, has led most commentators to emphasise the important role of informal care and community based resources in maintaining quality of life for rural older people (McCann, Ryan and McKenna, 2005;

Innes et al, 2005; Milne, Hatzidimitriadou and Wiseman, 2007). Indeed, rural older people themselves also form an important sector of community support in rural areas, as informal carers, volunteers and members of social organisations (Shucksmith, 2000; Le Mesurier, 2006). It is regarded as crucial to utilise and build on existing skills and resources in rural community and voluntary groups and not unintentionally undermine them, when planning health and social care delivery (Manthorpe, Malin and Stubbs, 2004; Asthana and Halliday, 2004).

The role of such non-governmental organisations may become even more important with the personalisation of adult social care. The Commission for Rural Communities (2008) has explored the potential impact of these reforms on rural areas and, although it is evident that problems around recruitment and costs of formal carers persist, there is potential for wider community facilities to be used more and therefore become more viable. The same report also suggests personal budgets hold potential for more flexibility and creativity in rural areas (The Commission for Rural Communities, 2008); however other evaluative studies of similar welfare reforms in rural Canada and New Zealand have been rather more negative, particularly in respect of their impact upon older people. Government priorities in those countries to introduce competition and choice into welfare provision are described as perpetuating vulnerability of rural older people; the primacy given to the market meant that private providers struggled to deliver services in rural areas, increasing the burden on informal carers and the earlier prospect of residential care for rural older people (Joseph, Lidgard and Bedford, 2001; Joseph and Cloutier-Fisher, 2005). Governments implementing such reforms of marketisation, privatisation and centralisation, nationally and internationally are accused of adopting urban led priorities (Sherwood and Lewis, 2000; Williams and Cutchin, 2002; Milne, Hatzidimitriadou and Wiseman, 2007).

In the UK, Government attempts to overcome such urban bias through 'rural proofing' (Defra, 2000) have been described as largely ineffectual (Asthana and Halliday, 2004; Countryside Agency, 2004). In a review of the 2000 rural white paper, the Government succinctly expresses the conundrum it faces in trying to implement national health and social care policy in rural areas, with the assertion that regional variations must be accepted but services must be held to account against

national standards (Defra, 2004). There is indeed a challenge to be met in balancing universal service provision at the heart of health and social care, with meeting locally specific needs (Manthorpe et al, 2008). There is some consensus that rural older people feel their voice has not been heard in policies which directly impact upon them (Heenan, 2006; Milne, Hatzidimitriadou and Wiseman, 2007; Manthorpe, 2008); surely the first step in developing a locality-based interpretation of health and social care is to listen to what they have to say and eliminate what Milne, Hatzidimitriadou and Wiseman (2007, p.491) refer to as the “invisibility of rural elderly”.

Methodology

In this section the design of the research is outlined and justified. This involves relating the chosen methodology and method to the theory and philosophy underpinning the research, as well as outlining and explaining the rationale behind each stage of the research. Narrative methodology is at the heart of the research design therefore a separate section is dedicated to the key reasons which explain and justify the approach to this particular project.

Research Design

The process involved in designing the research can be depicted as follows:

Theory → Philosophy → Research Questions → Methodology → Method

The theory underpinning this research is concerned with existential understandings of 'place', as well as discursive ideas about identity which draw attention to the "constitutive or reflexively constructive nature of consciousness" (Holstein and Gubrium, 2000, p.86). A phenomenological philosophy is therefore appropriate because it has an explicit goal to access the essence of that human experience (Edwards and Titchen, 2003); to "understand the lived experience of individuals and their intentions within their lifeworld" (Miller and Crabtree, 1999, p. 28). This can be contrasted with philosophical approaches such as positivism or realism which emphasise causation, observation and empiricism in understanding the social world. Phenomenology recognises that human beings are active constructors of meaning, rather than recipients of objectively defined meanings (Crotty, 1998).

From a gerontological perspective the theoretical basis to the research is concerned with the sociological and political influences upon ageing and being an older person, highlighting the contextual and interdependent nature of human beings. The phenomenological philosophy articulated by Schutz (1970) is therefore most appropriate because it has been described as 'social phenomenology' (Holstein and Gubrium, 1995); concerned with investigating meaning and interpretation as social

constructions. Schutz (1970) built on Edmund Husserl's (1970) existential phenomenology, concerned with the lived world of conscious experience and he noted that individuals approach their life world with a 'stock of knowledge' comprising images, theories, values and ideas which are social in origin and allow intersubjective understandings to be achieved (Schutz, 1970). This social phenomenology therefore presumes that within the context of research, exploring subjective meanings can help to understand the social structures and discourses in which they are situated.

From the gerontological research on identity discussed in the literature review, it is clear that older people use narrative to articulate important themes in their lives therefore a narrative approach in this project is indicated; the specific qualities of narrative methodology which justify its use in this project are discussed separately at the end of this chapter. A phenomenological philosophy and narrative methodology recognize that research findings are a creation of interaction between researcher and participant, indeed, "the genuine and respectful relationship that can develop during encounters culminates in depth and richness of data" (Appleton and King, 1997, p.20). In keeping with this the chosen method is one of in-depth interviews; this allows exploration of participants' own constructs and meanings at the interview stage itself through active listening, probing and encouragement (Holstein and Gubrium, 1995). An interview guide (Appendix 1), drawn up on the basis of the comprehensive literature review, is used to facilitate the flow of narrative whilst simultaneously keeping the conversation focused on the research objectives. McCance, McKenna and Boore (2001) support this approach to narrative research in suggesting that several broad questions should be used as a template for data collection to focus on participants' experiences. The aims of the research are led by the experiences of the older people themselves therefore it is appropriate that interviews are carried out until saturation is reached, although pragmatic and ethical considerations also influence the end point of data collection.

The use of narrative is inherently intended to generate voluminous, rich data and therefore the sample size is usually small and the sampling strategy purposive, with the objective of identifying information-rich cases for in-depth analysis (Appleton and King, 1997). This is appropriate in this project to address the research aims as the population from which the sample is drawn is by its nature very specific. The research

takes place in west rural Northumberland because this incorporates the most sparsely populated region in England (Defra, 2004) and will therefore allow exploration of the rural dimension. The exploratory nature of the research means that the size of the sample could not be defined from the outset, though professional experience and knowledge of the local population suggested no more than 20 interviews would take place.

As a key focus of the research is the social care experience, participants need to be in receipt of any form of social care service; the host organisation is therefore Northumberland Care Trust which provides and commissions social care services on behalf of Northumberland County Council. For ethical reasons, participants are accessed via their care managers in accordance with the following specific inclusion criteria:

1. The person is over the age of 65 years
2. The person is in receipt of a continual social care service from Northumberland Care Trust.
3. The person has a named care manager and is currently allocated to the XXX Team.
4. The person lives either in a small village or an isolated location.
5. The person does not currently have involvement from Audrey Bell, occupational therapist.
6. The person is regarded by their care manager to be physically and psychologically well enough to consent to and take part in the research.
7. The person is regarded by their care manager to have capacity to understand the information given and on this basis, to choose whether or not to participate.

The detailed steps involved in conducting the interviews and carrying out analysis are described in the method section but the methodology is inherently one of continual reflexivity and continual interpretation. Preliminary analysis therefore begins as the interviews are being transcribed in order that the point of saturation can be established; where saturation is defined as “full immersion into the phenomenon in order to know it fully, comprehensively and thoroughly as possible” (Leinenger, 1994). Within this study the end point of gathering data is also influenced by ethical

and pragmatic factors as outlined within the methods and limitations sections. When all of the interviews have been carried out, detailed analysis of the transcripts takes place, this involves using all of the data to find common themes and collective stories (Holloway and Freshwater, 2007; Crabtree and Miller, 1999). Key to the research aims in this project is the relationship of any findings to policy, theory and practice therefore the final stage of the project requires contextualizing the original ideas generated within existing theory to formulate theoretical, professional practice and policy implications.

Narrative

Four clear qualities of narrative methodology can be identified which lend the approach specifically to the research questions in this project.

Accessing people's experienced reality

The research is concerned with exploring the meaning that older people attach to their situation and how they articulate their personal experience. As a method of qualitative inquiry, narrative methodology allows participants to use their own accounts to describe their experienced reality (Leiblich, Tuval-Mashiach and Zilber, 1998; Gordon and Paci, 1995). There is an assumption that people organize their significant experiences in terms of stories and that recounting such stories is a way for people to give meaning to events in their lives (Muller, 1999). Whilst some autobiographical narrative approaches may advocate that the recounted narrative presents and equals the inner reality (Polkinghorne, 1991; Rosenthal, 1997), a narrative provided in an interview setting requires interpretation to access the individuals systems of meaning. Ezzy (1998) refers to the hermeneutic circle of narrative to explain this interpretive process. The narrative imagination of the participant prefigures lived experience by providing symbolic structures and temporal schema, these events are configured into a story or plot; this story or narrative text encounters the lived experience of the listener who refigures the story (Ezzy, 1998).

Cultural and political context of narratives

One of the aims of the project is to situate older people's understandings within their sociological and political context; there is some consensus that personal narratives are formulated within a cultural context (Muller, 1999; Gubrium and Holstein, 1998; Leiblich, Tuval-Mashiach and Zilber, 1998). At an interpersonal level, Gergen (1991) and Van-Langenhove and Harre (1993) refer to this as a constructivist narrative approach, in which individuals are understood to construct their self narratives with a specific interpersonal context. People compose their own unique stories but they compose them from 'building blocks' available from within their culture and social world (Leiblich, Tuval-Mashiach and Zilber, 1998). This means that through studying and interpreting personal narratives, the researcher can access not only how people give meaning to events in their lives, but how individual stories intersect with larger social and political narratives (Poiana, 1999).

Temporal dimension

A narrative methodology incorporates within it a temporal dimension (Muller, 1999; Hearn, 2006); the stories told can be seen as 'knitting together' the past, the future and the present (Brock, 1995; Frank, 2009). This research is grounded in a phenomenological philosophy and from a phenomenological and existential point of view, time is fundamental to an understanding of human existence (Crossley, 2003), therefore it should be conceived as an integral part of the research methodology. Gerontological evidence suggests that this temporal aspect of narrative is particularly important for older people in bringing consistent meaning to one's past and present life (Dalby, 2006), highlighting the value of narrative methodology to this specific project. This research is seeking to explore the experiences of older people who use social care and the very nature of this client group means they will have encountered disability and illness; a number of studies have emphasized the central importance of narrative in recounting the health and social care journey as a chronological process (Garro, 1994; Davies, 1997; Crossley, 2000). The temporal dimension of 'place' is also a further consideration in this chosen methodology; Andrews and Kearns (2005, p.2697) suggest "there is general agreement that time as well as space contribute to the experience of place".

Narrative as a voice

The specific group of people to whom this study relates can be regarded as invisible or ignored in the public arena on two grounds. Firstly, the urban bias of national policies has led to the invisibility of disadvantage in rural areas (Williams and Cutchin, 2002; Milne, Hatzidimitriadou and Wiseman, 2007; Scharf and Bartlam, 2008). Secondly, an incremental rationing of social care services means that older people who require social care in Northumberland are defined as having ‘critical’ needs, potentially positioning them as “vulnerable and often ignored stakeholders” (King and Appleton, 1999). Adopting a narrative methodology gives people an opportunity to tell their story and provides an avenue for people who are oppressed or powerless to express their values and aspirations (Poiana, 1999; Hearn, 2006). Narratives have been described by Arthur Frank (2009) as the best weapons of the powerless, providing a media through which people position themselves in the world. The task of narrative research is to ascertain how that adopted position arises, what are the consequences for the person and their peers and what lessons can be learned from that process of giving ‘voice’.

Method

The method can be described in three stages; sampling and participants, interviews and transcription, analysis and theory development.

Sampling and participants

As the researcher is employed by Northumberland Care Trust careful consideration was given to the options regarding access to the sample, particularly in relation to any possible practitioner/researcher conflict. Access via local social care providers or voluntary organisations was considered but, because of the potentially vulnerable nature of older people who use social care, it was felt important that access needed to be via their named Northumberland Care Trust care manager. Any older person in Northumberland receiving a social care service has been assessed as having a 'critical need', according to Fair Access to Care eligibility criteria (DoH, 2002). This Government guidance identifies four bands of need; critical, substantial, moderate and low, leaving councils to decide which needs they are able to meet within budgetary constraints. Northumberland Care Trust has determined to meet only those needs defined as 'critical', therefore social care services are delivered only to those older people with the most severe need. This places them in a potentially vulnerable situation and it is deemed ethical that care managers can identify potential participants, not only on the basis that they meet the specific aims of the study, but also that they have the capacity to consent and are well enough to participate. This method of sampling selection has been supported by the previous research of McCann, Ryan and McKenna (2005) and Hardy, Young and Wistow (1999).

Defining rurality is in itself an area of much academic debate, but there is some consensus that the discourse and context in which the term is situated plays a crucial role in its meaning (Pratt, 1996; Neal and Walters, 2006). This research is situated within the field of social care and previous research in both health and social care has highlighted geographical area and population density as meaningful factors in service delivery, for example, Asthana and Halliday (2004) and Asthana et al (2003). These factors are therefore used to determine 'rurality' for the purpose of sample selection, with a strong proviso that the service user's own perception and meaning of rurality is critical in the analysis of the results. Northumberland Care Trust provides social care

on behalf of Northumberland County Council which is the sixth largest council in England and has the lowest population density (CSCI, 2006). The population is largely concentrated in the South-East, and the research takes place in the West of the County because of its geography and population. At the time of the research, the corresponding district Council, Tynedale, was the largest geographical district council in England covering 858 square miles with a population of only 58,000 (Defra, 2004). The area comprises vast open space, isolated settlements and small to medium sized towns; in order to exemplify the feature of interest i.e., rurality, only service users who live outside of the main towns will be considered. A local government re-organisation on 1st April 2009 has subsumed all district councils in Northumberland into one Unitary Authority, named Northumberland County Council.

The care managers of older people in Northumberland includes social workers, occupational therapists and care managers without a professional specialism; initial access involved the researcher attending one of their regular team meetings in the two area teams within the study area to explain what the research was about and answer any questions. At this stage it was emphasized to care managers that they should reassure potential participants that the research is not related to service delivery and that confidentiality is paramount. Care managers were asked to initiate contact with clients selected using the inclusion criteria, to ascertain if they would like to receive further information about the study. Those clients who agreed were forwarded the client information sheet (Appendix 2) and invitation letter (Appendix 3) by the researcher. The client letter and information sheet re-iterates that participation is entirely voluntary and consent can be withdrawn at any time. Potential participants were given at least a week to consider the information and discuss with friends/relatives before being contacted by telephone and asked if they would like to meet up to discuss further. Clients who agreed to be visited were assured that agreeing to a visit did not equate to consent to participate; although alternative venues were offered if required, all chose to meet up in their own homes.

In total 14 clients were contacted by the researcher and 11 agreed to a home visit, all of whom proceeded with the interview. The clients who refused to proceed with a visit at the telephone stage all gave reasons of it being “too much”; one client had just taken part in some other research and did not want to go through the whole process

again. Respondents all met the inclusion criteria and their characteristics are outlined in Table 1.

Table 1: Participant characteristics

Client reference	Gender	Living status	Location	Carer present at interview
A	Female	With husband	Remote	No
C	Male	With wife	Remote	Yes
D	Female	Alone	Remote	No
E	Female	Alone	Remote	No
F	Female	With son	Village	Yes
G	Male	Alone	Remote	No
J	Male	Alone	Village	Yes
K	Female	Alone	Village	No
L	Female	Alone	Village	No
M	Female	Alone	Remote	No
N	Female	Alone	Village	Yes

In defining the original sampling strategy at the planning stage of the research, the incessant organizational re-structuring of the NHS was not accounted for and this placed limitations on the potential sample size. When the initial sample was defined Northumberland Care Trust's social care services were divided into specialist areas including older people's services (over 65) and younger people's services (aged 18-65). Also at that time all service users had a named care manger. By the time potential interviewees were being recruited a new 'team caseload' had been created to accommodate those clients who had 'stable' care plans; these clients had no named care manager but were dealt with on a duty basis. Unfortunately clients in rural areas are renowned for their low expectations, self-sufficiency and resourcefulness (Innes at al, 2005; McCann, Ryan and McKenna, 2005, Parr and Philo, 2003) and this raised concerns that they would readily be labelled as 'stable'. It was important for ethical reasons that any potential interviewees should have a named care manager, therefore it had to be accepted that the potential population from which to recruit had possibly been reduced. As the research is qualitative and not quantitative this does not lead to a methodological flaw in the research, however it may have contributed to the time and effort required to identify potential interviewees and subsequently to the small sample size.

The merging of services into all age adults meant that care managers would need to check the date of birth of clients to identify potential interviewees and it became apparent that any additional tasks asked of them could be enough to dissuade them from co-operation. As a member of the practitioners' team in west Northumberland, the researcher had anticipated that the good working relationship with care managers would facilitate an eager response, however it became apparent that their weariness from increasing levels of performance indicator driven paperwork and their ever-changing working environment had tempered their enthusiasm for the research. Repeated attendance at team meetings was required to remind and encourage care managers and it was difficult for the researcher to demonstrate whether there simply were no more potential interviewees who met the criteria at that time, or care managers were not examining their caseloads for consideration. A pragmatic decision had to be made, combined with a perceived point of some degree of saturation, in order to maintain existing working relationships and adhere to realistic research timescales. Responses were gradually elicited and this allowed interviews to be conducted with the following timescale:

August 2008 - Ethical approval secured.

August 2008 - Attendance at team meetings.

September 2008 to November 2008 - Interviews conducted, transcribed and reflected upon.

December 2008 - Attendance at team meetings

January 2009 to March 2009 - Interviews conducted, transcribed and reflected upon.

April 2009 to June 2009 - Preliminary organisation of data.

July 2009 to October 2009 - Detailed analysis and theory development.

Interviews and transcribing

Interviews, when carried out appropriately can be regarded as a useful method of generating narratives and disclosing the meaning of lived experience (Holsein and Gubrium, 1995; Lindseth and Norberg, 2004); in order to explain and justify the quality of the information produced it is important to describe how the interview material was generated and treated prior to any analysis.

Interviewer

Kvale (1996) describes interviewing as a 'craft', in which the outcome depends on the knowledge, sensitivity and empathy of the interviewer. As a practising occupational therapist with experience of working with older people, the researcher has sensitivity and an emotional understanding of the client group of the study; facilitating the "empathy, close listening and attentiveness" which are essential for a meaningful qualitative interview (Wengraff, 2004, p. 28). It is also important for the interviewer to be aware of the cultural background within which interviews are embedded (Holstein and Gubrium, 1995) and the researcher has several years of experience in working with older people in a rural area, within their own homes. As part of the professional doctorate programme, the research has been preceded by two years of education and self reflection in research philosophy, methodology and professional development. Planning for the interviews has also involved acquiring an in depth knowledge of the subject matter to successfully secure University, Care Trust and Regional Ethics approval.

Interview

Prior to commencing interviews the researcher answered any questions from the information sheet and discussed issues of confidentiality and anonymity. The written consent form was then explained and signed and it was emphasized to participants that they could withdraw consent at any time. Although the interview is an interpersonal and fluid situation, narrative interviews must set parameters to guide and constrain the interview and thus address the research agenda (Holstein and Gubrium, 1995), therefore an interview guide was used in this project (Appendix 1). It is important to bear in mind that such interview guides are not scripts; the guide includes broad pre-formulated questions to focus the interview, as well as a range of prompts to encourage further narration (Lindseth and Norberg, 2004).

It became apparent during the course of the project that some interviewees did wish to have a carer present. This is potentially a topic of debate in itself concerning harmony and conflict of carer and service user wishes and interests, but for the purposes of this research both parties are users of social care services who live in a rural area. Holstein and Gubrium (1995, p.70) have recognised the positive role that the presence of a carer can have in this type of interview when, "the narrative force of significant others

helps shape the stock of knowledge accessed by interview participants”. In this project, the presence of a carer in the interview situation is in keeping with the philosophy and methodology of the research which rest on the tenet that social interaction constructs and conveys meaning.

Interviews were planned to last approximately 1 hour, plus 30 minutes would be allocated at the beginning and end of the interview to allow for discussion regarding consent and any questions. The approximate timescales allowed for the interviews were accurate; a further 1- 2 hrs travelling time was also required for each interview. Northumberland Care Trust lone working policy was adhered to as the researcher was working in remote locations unaccompanied.

Transcribing

With the participants’ permission, all interviews were tape recorded; this allows the interviewer to concentrate on the dynamics and content of the interview (Kvale, 1996) as well as providing an accurate text for detailed analysis. All interviews were transcribed as soon as practically possible (always within 5 days) so that the context of the interview remained current. The interviews were transcribed by the interviewer and this helped in familiarization and immersion in the raw data, which is regarded as crucial in the sequential process of qualitative analysis (Burnard, 1991; Pope, Ziebland and Mays, 2000). Transcribing each interview took approximately 6 hours and self transcribing by the interviewer meant that each interview could be reflected upon and notes made regarding content and sequence. This process of ongoing immersion in each interview allowed the researcher to determine when saturation was reached within the practical limitations of selecting the sample.

Anonymity of person and place

As interviews were transcribed, all people’s names used within the narratives were changed to rule out any possibility of identification i.e., when carers, care managers, neighbours or family members were referred to. When main towns in west Northumberland were referred to, for example, Hexham, this was not changed as it would not in itself jeopardise confidentiality. However, reference to main population centres along with other geographical features or small place names could potentially

identify participants, therefore the names of small villages, hamlets or specific geographical features were changed to assure confidentiality.

Analysis and theory development

Narrative analysis is a complex process of continual interpretation and reflexivity, in this study the process can be described in three stages.

Stage one – developing a thematic framework

Interview transcripts were first read and re-read as openly as possible to understand the narrator's interpretation of sequence of events (Muller, 1999) and define major content categories that emerge from reading (Leiblich, Tuval-Mashiach and Zilber, 1998). At this stage notes were made on general themes and patterns that emerged through repeated reading of the texts. Geanellos (2000) points out that repeated engagement with a text is necessary to avoid premature, interpretive closure. It was very useful at this stage to draw on the work of Dey (1993) who emphasizes that the original research questions provide a vital starting point in categorizing data; this is a useful reminder when immersed in large quantities of qualitative data. Dey (1993) also points to the importance of rooting categories in relevant empirical material and part of the analytical process involved referring back to the literature so that findings are theoretically grounded. Eventually it was possible to draw up a table of categories (Table 2) which comprised three overarching key themes and concepts which fell into each of these themes.

Table 2 – Thematic framework

Sense of place	Meaning of choice	Social care experience
Familiarity – neighbours and family	Allowing people in, permission	Carers bring the outside world in – information and ‘gossip’
Isolation and being alone but not lonely		Carers as friends
Continuity – a sense of history	Choosing to live here	Continuity of carers and care manager is important
	Being at home	
Access – external/transport		Rurality no perceived impact on service
Access - internal	Alterations and equipment to help me stay here	Realistic
Flexible local resources		Mutual flexibility
	Need not want	Need not want
	Wanting to stay at home i.e., not go to day care etc	Lack of resources
		Battle/struggle
	Constructive dependency	Grateful/Satisfied
		Self-effacing
Need to be organised		Need to be organised
		Aware of policy/changes
		Triggered by crisis (hospital)
Perceived better quality of life	Un-materialistic values	Perceived better in rural area - relationships
	Don’t have the information or expertise to choose services	Trust in experts
Technology to keep in touch		
		Not listened to

Stage two - coding data

This involved applying the thematic framework systematically to all of the data (Pope, Ziebland and Mays, 2000). The transcripts were tabulated, with text in the left column and assigned code in the right column; the letters A, B and C were used to indicate which overarching theme the code fell into. In some cases a meaningful unit of text would have a number of codes assigned to it, see for example Table 3.

Table 3: Sample text

I find it very pleasant, and my brother lives up on the top. So he does my shopping and err, I'm handy, well I got the 'phone in just about a year ago. So if I have to go to hospital or anything like that I just get in touch, get an ambulance car, no bother. But it's quiet you know it's very pleasant. And I'm used to being on my own. I know a lot of people don't like to be on their own but I'm quite happy and I mean if anything befalls you, well, it's got to happen sooner or later, so I am quite content.	<p>A familiarity – family nearby</p> <p>A technology to keep in touch</p> <p>A good quality of life – quiet</p> <p>A isolated but not lonely</p>
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Stage three - constructing common narratives and theory development

The next stage of the analysis involved collecting together transcript extracts within each main theme and developing theory about the construction of narratives and the factors that appear to influence the construction (Muller, 1999; Edwards and Titchen, 2003; Holloway and Freshwater, 2007). In keeping with the phenomenological philosophy of Schutz (1970) and hermeneutic theory of Gadamer (1976) this process of interpretation and theory development is back and forth rather than linear; as common narratives and ideas about theory construction are constantly referred back to the original text.

This stage of the analysis can be seen as the development from descriptive to a much more conceptual level of categorization (Bryman and Burgess, 1994). Although Janesick (1998) has described traditional ways of thinking about generalisability as inadequate, she asserts that it is through the development of theory at a conceptual level that the research gains general implications and relevance. Similarly Conrad (1990) suggests that the generalisability of qualitative research is acquired through the applicability of theory and concepts developed to other settings.

This stage of the research involved relating the findings from this study to the work of other researchers and established theory; in this way the theoretical findings from the present study can be verified and existing theory can be built upon. Morse (1994, p.34) describes the successful implementation of this process as the “theoretical elegance” which demonstrates the applicability and implications of the research findings.

To ensure rigor and trustworthiness in this process of analysis the following were adhered to:

1. Comprehensive data treatment; working with a small sample allows repeated and comprehensive analysis which avoids anecdotalism (Mehan, 1979; Silverman, 2004). All of the data generated in the study was used in analysis and the process involved constantly referring back to original transcripts.
2. Coherence; this refers to the way different aspects of interpretation fit together to create a meaningful picture (Leiblich, Tuval-Masiack and Zilber, 1998). This was ensured both internally i.e., concepts and themes within and between transcripts, and externally i.e., against existing theories and previous research.
3. Adequacy and appropriateness of data; this ensures methodological rigour in qualitative research (Morse, 1998). This was secured through purposeful sampling and through continuing with data collection until saturation had been reached.
4. Audit trail; documentation of the project’s development allows scrutiny of procedural and conceptual development (Holloway and Feshwater, 2007). This was ensured through the professional doctorate process incorporating critical milestones and academic supervision as well as in the written thesis itself.

Ethical considerations

The Research has been approved by National Research Ethics Service and this required detailed consideration of all ethical issues. Although securing ethical approval is a lengthy and time consuming process, it helped to ensure not only that all ethical issues had been carefully considered, but as methodologically flawed research can itself be regarded as unethical, that the theory and methods of the research were carefully researched before the interviews commenced. The two main ethical issues in this study are informed consent and confidentiality.

Informed consent

The potentially vulnerable nature of the participants meant that detailed steps needed to be taken to ensure that consent was given in a fully informed manner, and that consent was freely given i.e., participants did not feel obliged to consent. As a piece of insider practitioner research there is a heightened risk that participants could feel obligated to consent, therefore steps had to be taken to reassure participants that the research was unconnected to current service delivery. The following steps were taken to ensure consent was informed and freely given:

1. Only older people who were in 'long-term' teams would be considered for invitation; this would rule out the possibility of approaching anyone who was in a crisis situation in the midst of having care arranged, as would be the case in the 'intake' team.
2. Only older people with named care managers would be considered for invitation; this meant that if any new needs arose within the course of the interview, they could be referred directly back to the care manager.
3. Any older people known to the researcher in her capacity as an occupational therapist and care manager would not be considered for invitation; this would reduce the risk of potential participants feeling obliged to consent.
4. Care managers acted as gate keepers, only selecting people for invitation who they regarded as having capacity to understand the information given and on this basis, to choose whether or not to participate. Potential participants were also assessed by the care manager as being mentally and physically well

enough to consent and participate in the research. The ethical requirement to protect the potentially vulnerable group of people that form the population under investigation outweighs any other methodological concerns; this view is supported by other research with older people who require social care (McCann, Ryan and McKenna, 2005; Hardy, Young and Wistow, 1999).

5. Potential participants were provided with clear information sheets prior to invitation and were given at least a week to consider this information and discuss with friends/carers. When clients were contacted by telephone they were assured that agreeing to meet with the researcher did not equate with consent, they were agreeing to discuss further. This information sheet was discussed along with consent and confidentiality when potential participants were visited to ensure they fully understood the process. It was emphasized that they could withdraw consent at any time.

Confidentiality

Confidentiality is an important consideration in any research involving people; rural areas have been associated with specific challenges concerning confidentiality because of gossip networks and the visibility that characterizes social life in remote areas (Parr and Philo, 2003). The following steps were therefore taken to maintain and ensure confidentiality in this research:

1. The researcher and any care managers involved in the research are bound by strict professional and employment codes concerning confidentiality of personal client information. Participants were assured of this and it was made clear to participants that although care managers select clients for invitation, they would not be informed of who agreed to participate.
2. Any contact between the researcher and participants or potential participants was neither recorded on the Care Trust computerized information system nor discussed with colleagues. The issue of new needs arising during the course of the interview would have necessitated re-referral to participants' named care managers.
3. Preliminary analysis of data took place on Northumberland Care Trust premises where identifiable client information was removed. Data for analysis

including tapes, transcripts and notes all carried coded and not identifiable information.

4. Any identifiable information was stored on NHS premises in a locked filing cabinet. Any electronic information was stored in a password protected computer.
5. Any identifiable information in the transcripts, such as names of specific places or people, was changed so that extracts can be used and published.

Practitioner research

As part of the professional doctorate programme, the research was carried out by an occupational therapist employed as a practitioner within the area of study, Northumberland Care Trust, it can therefore be described as ‘insider practitioner research’ (Fish, 1998). A crucial part of the narrative methodology used in this study is the researcher’s own interpretation and development of the participants’ self-narratives; therefore for any reader to critically examine the research they need to understand the motivations and potential pitfalls that lie behind a practitioner researching their own area of practice. This section therefore begins with a personal statement which by its very nature must be written in the first person. The features that distinguish practitioner research from other research are then discussed under the realms of the organisation, the professional role and professional development.

Personal statement

From this thesis it is evident that I recognise the importance of one’s personal narrative in defining who we are and how we interpret events; as the person who co-constructs the interviews and interprets the findings it is important for me to recount those aspects of my narrative which have shaped this research. As a piece of practitioner research this project unites what I have perceived until now as parallel paths of professional practice and academic study.

I qualified as an occupational therapist in 1988 and the values and beliefs which guided that career choice can still be seen in choices made relating to this research. As one of six children I grew up to value my own personal space and independence, but at the same time I also appreciated the importance of a network of love and support. My early environment and education instilled in me a strong work ethic and a firm belief in social justice with a consequent vocational leaning towards the public sector. These combined values of occupation, interdependence and equality of opportunity led me to the profession of occupational therapy. After qualifying, I spent a few years trying some different fields of practice open to occupational therapists but soon discovered that I felt most at home working in social care. I enjoyed the privilege of working with people in their own homes and recognised that this setting gave a true

picture of people's aspirations and values. I also felt that the daily pressures and challenges of working in social care facilitated close multi-disciplinary team working which I enjoyed; this area also allowed me to network with a diverse skill mix of people in matters relating to health, housing, equipment and construction.

As the community care changes of the 1990's began to take effect, different local authorities reacted in different ways; the city in which I worked chose to break up the multi-disciplinary teams and the occupational therapists were accommodated as a separate specialist resource. I consequently re-located to Northumberland County Council which had reacted very differently to the reforms, strengthening multi-disciplinary teams to include community nurses as well as social care staff and all practitioners were given a role as care manager where appropriate. For occupational therapists this meant they would care manage cases with ongoing complex physical disability issues, for me this not only offered a genuinely holistic way of working with people but also the challenge of applying core skills in broader and more complex ways. At a service delivery level this flexibility of professional roles seemed to be an efficient use of resources for a vast county like Northumberland, but I felt it also facilitated therapeutic relationships and continuity of care. Since I started working for Northumberland there have been a number of organisational re-structures but the core service delivery model of care management has been relatively unchanged until now; the current Government's commitment to increase the number and scope of personal budgets in social care is going to have a significant impact upon the way all social care staff are required to practice. My desire to understand the ideology behind such policy imperatives and to evaluate their impact upon services users motivates my research 'career'.

My research 'career' began three years after qualifying when I embarked on the part-time BSc in Therapeutic Studies at Northumbria University. It is quite difficult to pin down what motivates that strange compulsion known as part-time study; there is the intellectual desire for personal and professional development and the emotional satisfaction of meeting a specific personal challenge. Soon after completing the degree, I started the part-time MA in Health and Community Care at Durham University and three years later successfully achieved distinction; this led my project supervisor to suggest I should proceed to doctorate. This created a dilemma; I had

indeed thoroughly enjoyed the Masters and would have relished the challenge of a PhD at that time, however I was firmly committed to my professional career as an occupational therapist and faced with the choice between that and academia I chose occupational therapy.

Whilst practising, I undertook training courses and maintained my professional development portfolio, however, I felt ill-equipped to carry out real world research into my practice and the policy drivers that lay behind it. Eventually the professional doctorate in occupational therapy became available at Northumbria University and I saw this as an ideal opportunity to bring together my academic and professional ‘careers’. As I had been away from formal study for a number of years I felt the taught element would bring me back up to date in research skills as well as relating my writing specifically to professional practice. The taught element did indeed enable me to proceed through the required milestones with realistic targets and timescales, whilst I continued to work full-time. The prospect of the research phase was daunting, but I set off on the journey with no expectation of completion; I undertook it for the sake of the journey, to hopefully expand and deepen my knowledge whilst at the same time contributing to improved professional practice.

Research organisation

The researcher conducting insider practitioner research can be described as an ‘insider’ for two reasons; firstly, they work within the organisation under study and secondly, they are professionals within the realm of policy or practice under scrutiny. From within the organisation, practitioner researchers are already embedded within the culture they approach in a way academic researchers are not; this can be advantageous in qualitative interpersonal research, when it is important for the interviewers to be aware of the cultural background within which interviews are embedded (Holstein and Gubrium, 1995). However, practitioner researchers also have a history, a current status and a future within that organisation that includes allegiances, friendships and commitments that may be influenced by the research process; this highlights the degree of determination and acuity required by this type of researcher (Reed and Proctor, 1995). Any researcher has to negotiate access into an organisation and the position of the practitioner researcher means that if they can

successfully negotiate the aforementioned relationships, they begin that process extremely well informed (Reed and Proctor, 1995).

A number of sources have recognised the importance of having an organisational culture that supports questioning and values self-development, in order for insider practitioner research to take place (Clark and Wilcockson, 2000; Knowles, Holton and Swanson, 2005; Clark and Wilcockson, 2002). Northumberland Care Trust is an NHS organisation and the Department of Health does have an explicit commitment to promote research through its research and development arm. However, NHS organisations tend to be hierarchical and bureaucratic; such organisations do not generally value the risk taking and challenging thinking which promote practitioner research (Argyris and Schon, 1978; Clarke and Wilcockson, 2002). Although Northumberland Care Trust did agree to act as sponsor as set out in The Research Governance Framework and did agree to the researcher taking a short unpaid sabbatical, this particular research undoubtedly could not have taken place without the support of Northumbria University. Reed and Proctor (1995) have suggested that, to critically examine practice as an insider, requires a supportive environment in which critical comment is valued rather than feared; the academic community of Northumbria University provided that environment for this research. This research supports the view that academic institutions have an important role to play in supporting practitioners to conduct insider practitioner research (Clarke and Wilcockson, 2002; Titchen, Butler and Kay, 2001).

Professional role

The professional role of the research practitioner influences the chosen topic under investigation, as well how the research is carried out (Skeil, 1995). In health and social care, a primary motivation for practitioners undertaking research is often an awareness of lack of fit between services provided and needs of clients (Clarke and Wilcockson, 2002); this research is indeed driven by an apparent discrepancy between the Government's vision for social care and day to day professional practice. When conducting this type of research the practitioner will obviously occupy two roles simultaneously (Reed and Proctor, 1995), but this need not cause conflict. Beresford and Croft (2004) have suggested that for health and social care practitioners,

managing possible contradictions in their role, e.g., gate keeper, public servant, professional practitioner and compassionate human being, is an inherent part of the therapeutic process. There is some consensus that, provided ethical considerations are strictly adhered to, practitioner skills and experience can make a valuable contribution to research (Reed and Proctor, 1995; Fuller and Petch, 1995).

In practitioner research it is particularly crucial to ensure consent is fully informed and entirely voluntary as potential participants could feel obliged or fear reprisal if they decline. Because of the potential power relationship between practitioner and client, within this study the researcher is not the first person to approach potential participants. The researcher's first telephone contact invites only for more discussion and not participation and clients on the researcher's current caseload are not considered for invitation. All of these issues are addressed in the submission for NHS ethics approval and allow consideration to be given to the positive contribution of the professional role to the research process. The knowledge and experience that practitioners have can give insight into the problems faced by participants and how these problems may influence their responses (Fuller and Petch, 1995; Skeil, 1995). The professional therapeutic relationship has been described as "a trusting connection and rapport established between therapist and client through collaboration, communication and mutual understanding and respect" (Cole and McLean, 2003, p.44); the skills developed in building and maintaining such relationships can be valuable in facilitating a meaningful qualitative interview.

Professional development

Much of the professional knowledge and experience that is indeed so applicable to research can be described as implicit; Hardy et al (2009) refer to the hidden nature of professional artistry. Being able to articulate this expertise and understand the processes that create professional knowledge is crucial to support client-centred care and expand the health and social care discourse beyond that of quantitative performance indicators. Insider practitioner research can encourage practitioners to make explicit what Paterson, Higgs and Wilcox (2005) refer to as 'professional practice judgement artistry', a blend of doing, knowing, being and becoming. Phenomenological, interpretive techniques such as those used in this research project

can help make visible, not only therapeutic processes and professional knowledge, but also aspects of human experience which would otherwise remain invisible. Within this research, the dissemination plan (Appendix 4) articulates the findings and research process at a local and national level. Professional health and social care practitioners have access to, and knowledge about, specific groups of people whose opinions and experiences may remain invisible without the interpretation of insider practitioner researchers (Reed and Proctor, 1995).

As well as helping to expose and articulate implicit aspects of professional practice, the very process of acquiring research skills can contribute to professional development at an individual and organisational level. Reflexivity is regarded as a crucial aspect of professional judgement and expertise (Paterson, Higgs and Wilcox, 2005) and engaging in practitioner research can provide an opportunity for practitioners to develop reflexivity, through exploring, explaining and justifying each stage of the research process (Hardy, 2009). Acquiring research skills also equips practitioners with a more critical approach to the social and political structures which underlie professional practice (Fuller and Petch, 1995; Reed and Proctor, 1995). This critical approach in turn makes research practitioners better able to expose and challenge organisational constraints and contribute to more creative and flexible care delivery (Clarke and Wilcockson, 2002; Lamb and Simpson, 2003).

Introduction to findings

Presentation of the findings of the research is guided by the methodology. Purposive sample selection combined with the use of an interview guide keeps the narratives focused on the aims of the research; this means that full transcripts can be used throughout the analysis process to retain richness and depth in the data. It is important in presenting the findings to maintain this vivid intensity in order to convey the ‘life world’ of the participants. The findings are therefore presented with frequent reference to quotations from the transcripts; the text is as accurate as possible to the original interview within the constraints of anonymity and confidentiality.

This research is guided by a constructivist and hermeneutic philosophy, with a goal not simply to hold up a mirror to participants’ narratives but to interpret meaning and situate this within a social and political context. This approach is reflected in the presentation of the findings; participants’ responses are interpreted through common narratives and themes that emerge from the data itself but also by drawing relationships with existing theoretical and research-based evidence. This inevitably leads to instances where conclusions are drawn and theories suggested which can be further developed and consolidated in the implications section of the thesis.

The main body of the findings is presented in three sections, social care experience, sense of place and the meaning of choice. This categorisation of the findings reflects the original thematic framework that was drawn up in the analysis and allows detailed consideration to be given to the aims of the research; to explore the meaning and experience of rural older people who require social care support. These dimensions of participants’ lives are discussed in separate sections to allow clarity and depth of discussion, however there are some empirical or theoretical aspects of the findings that recur throughout and these are brought into focus in the final section of the findings chapter.

Findings: Social Care Experience

Introduction

Participants' social care experiences began when the care was first arranged and the findings recount how this journey was instigated and the crucial role that family members play within this process. Securing social care in rural areas has been well documented as problematic; therefore it is important to understand the service users' own perception of the impact their rural location has upon securing this care. The findings discuss this perception and suggest experiences which influence how it is formed.

Participants' awareness of the 'bigger picture' of social care in terms of resource implications and re-organisations, influences their perception and judgements of the social care journey and this is reflected within the findings before moving on to discuss relationships with carers. The ongoing relationship with formal carers is an integral part of the social care experience and this is relayed in some depth within the findings; participants' recounted experiences are related to existing gerontological research and theory to formulate a coherent interpretation of their personal narratives.

Arranging the care

For all but one of the participants in this study, the journey as a social care service user began with a crisis involving a hospital admission; this is a finding supported by other studies, for example Janlov, Hallberg and Petersson (2006); Hardy, Young and Wistow (1999). At one level this can be regarded as a success of existing hospital discharge policy; in 2003 the Government implemented the Community Care (Delayed Discharges) Act (DoH, 2003c), exerting financial leverage on local authorities to ensure they set up appropriate social care support in a timely fashion for those people who needed it. This policy has not been completely lost on participants themselves as the following two excerpts illustrate:

Client G: "And every now and again it comes under Hexham Hospital, you know they get this err, Hexham maybe tell them they've got to clear patients out, the ones that can go for new ones coming in."

Client K: “I was in hospital for 6 weeks and that’s when I got all the help. Yeah. Apparently at the time they said this was the one way you’d get help, once you go into hospital and you see an occupational therapist, it worked.”

These comments are indicative of a recurrent theme that participants had some awareness of both national and local social care policy, but their knowledge is very limited and seems to be based on snippets of information.

Armed with their fragmented and limited information of policy, in the midst of a personal crisis and deterioration in their health, how then do services users arrange their social care package to support them when they come home? It is clear from the interviews that the majority of people in this study had close family or a close friend to support them in this process. Of the ten people whose care was set up on discharge from hospital, three had a family member living with them who was able to support them and advocate on their behalf, five people had family living nearby who could do the same, two people had a good friend who was a strong advocate for them. Only one person (client M) seemed not to have, and not to require, a personal advocate in the setting up of social care support; however she had built up a very good relationship with her husband’s care manager over several years and this care manager automatically took on the role of supporting client M when the crisis arose. This client spoke highly of her care manager:

“She’s such a nice person. Some people I talk to don’t even know if they’ve got a care manager, I don’t understand how that works? I think perhaps some people have family managing their affairs and they don’t know themselves who their care manager is. I think I’m very fortunate.”

It is also important to point out that client M had quite an unusual personal history, one of adventure and courage which may have contributed to her confidence in managing her own affairs; not only taking an active role in managing her care, but also an interest in where services came from and how they were organised. The presumption of specific life experiences contributing to later coping strategies is supported by gerontological theorists Carstenson, Hanson, and Freund (1995) and

Danneffer and Uhlenberg (1999); they assert that the range of personal resources available to older people in dealing with challenges of later life is related to previous life experiences. Although client M was unusual in this study group, she is certainly not unique amongst older service users and in the context of setting up a social care service her narrative reveals two crucial indicators: Firstly, that practitioners cannot assume that service users need or want an advocate in arranging their care and secondly, that older service users have a long and varied personal history which can influence how they approach social care.

Role of family support

The role of family in helping to arrange the social care service is a recurrent theme in the narratives, given by service users themselves and their carers but it is a complex issue requiring detailed and systematic consideration. Service users themselves acknowledged the role of close family members in helping to arrange social care and providing ongoing support, illustrated by client L:

Interviewer: "So who arranged the care, can you remember?"

Client L: "Err, Oh my sisters-in-law, they saw to it."

Interviewer: "Did you have much choice over what the care was, much control over what time they would come, what they would do, things like that?"

Client L: "No, well, Margaret (*sister-in-law*) arranged it all."

Interviewer: "And did you agree with that?"

Client L: "Yes (*emphatic*)"

Client G (*referring to a home visit from hospital*):

"A couple of physiotherapists brought me out, a couple of weeks before I was due to come out and I remember it was the middle of winter. Luckily my brother and his daughter and son-in-law were coming down to put the heaters on night and day to stop any freeze ups".

Service users' attitudes to this family support seems to be very different to their approach to the formal support they receive. Whilst they express emphatic gratitude, with repeated reference to how marvellous various professionals and carers are, the

absence of any such expressions in relation to family indicates an implicit assumption that family are expected to provide care. Indeed there is evidence that participants tried to play down the impact they were having on their informal carers:

Client F (*with reference to her son who living with her*): “Luckily I’m a good sleeper so we have good nights as a rule don’t we. And we have arranged it so that I can get out onto my commode by myself. So nights are quite good, which is a good job because he’s on duty all day.”

Client G (*referring to brother doing his shopping*): “It’s quite good of him really, but he is doing his own at the same time.”

This attitude is a natural extension of older people wishing to see themselves as ‘independent’ as discussed elsewhere; however it can also be seen as playing a significant role in situations reaching crisis point before care is put in place. The informal carers who participated in this study were also close family members and they themselves acknowledged that they had struggled on in their caring role until the situation reached crisis point:

Client F’s son and carer: “For the first five years we’d not tapped into social services or anything at all and I just, twenty-four, seven looked after mum and everywhere she went I went and that was that.....I think when the social worker first got involved actually it was a crisis.”

Client C’s wife and carer: “He was in hospital six weeks and I did not realise when he went into hospital, I did not realise how low and tired I was. Cos I mean I had had no help at all before then.....Because it had to be done you just got on and did it.”

This would imply the expectation of family support is an entirely mutual understanding which has a major impact on the way in which social care services are delivered. Heenan (2006) and Hanlon et al (2007) emphasise the rural dimension to this mutual expectation of family support. Other evidence suggests this bond is both strong and universal (Wiles, 2003; Wiles, 2005b; Janlov, Hallberg and Petersson, 2006). When combined with the evidence from the chapter ‘A sense of place’, this

research seems to support the view of Parr and Philo (2003) and Innes et al (2005), who suggest that this familial informal care phenomenon is not specific to rural areas, however the situation may be intensified in rural areas. The important role that family support plays for this group of participants is also perhaps a reflection of their high level of need; Wenger (1990) in a longitudinal study of older people in rural Wales, found that their network of support became more family-focused as people aged and their needs increased. This feature will of course be impacted by the fact that older people are living longer; the family members providing the care are often themselves quite elderly, this is summed up by one participant's daughter:

Client N's daughter and carer (*referring to care line system*): "My brother lives in the village so they are on the system. The only thing that I find now with that system, see mam is getting older, obviously all the people that we know are getting older as well. My brother and his wife, well I got wrong for saying this last time, she is seventy-six and he is seventy-five, although they are quite fit they are in their middle seventies and he has had an operation on his knee so he can't run."

Securing the care

Problems accessing social care services in rural areas have been identified in the literature and it is an issue the researcher recognises as a practitioner covering a rural area. However the only person in the study to recognise that their rural location could have a negative influence on the service they received was Mrs F's son and full-time carer:

"I think living out here we are limited in the services that they can provide because there are so few people living out here it makes it financially not viable."

He had to drive his mum to the day centre every week because the transport did not come out to their rural location, so he was obviously acutely aware of the problems delivering services in rural areas. However, he did not feel that securing the social care support had been a struggle or a difficult process because of the support he had from their social worker/care manager.

None of the other participants in the study perceived their rural location as having a negative influence on the process of securing the care or the service itself once in place; of course if they have not received a service anywhere other than their present location they cannot reasonably be expected to make a comparison. The only participant who could make a comparison because she had received services in the city from which she re-located, was quite certain that the service she received in her current location was vastly better than the one she had received in the town.

Client K: “Well quite honestly compared to what I got in Sunderland this is one hundred per cent better. I know it sounds strange because you’d expect it the other way around but, yes definitely.”

Although client K is the only participant who can make a direct rural/urban comparison, how the other participants **perceive** the impact of their location on securing social care vis-à-vis other factors is an important consideration, particularly in relation to their expectations. When related to the findings from ‘A sense of place’, it is clear that participants have a close attachment to, and a high regard for, their rural location and this may influence their judgement of how that location influences delivery of social care services. Three participants did describe the process of securing care as a struggle or a battle though none of them perceived this as being related to their rural location; when asked if they thought where they lived influenced the type of service they received they responded:

Client A: “Wherever, it might be the same. Yes I think so....It doesn’t matter where you are, if you wanted something you would have to push for it.”

Client C’s wife and carer: “No, I think when you get the service it’s very good, when you get it. No complaints at all.”

Client J: “No, I think there is just a shortage (*of carers*) anyway.”

Of these three participants, two were the only people in the study to be very critical of their care manager; effectively ‘blaming’ them for the problem they had gaining the appropriate care:

Client C's wife and carer: "No, I don't mean to be derogatory about Shirley (*care manager*) but she never gave me any thoughts about what we could have to help... .. No. And anything I've wanted I've had to battle for."

Client A (*referring to setting up care*): "But it took a lot of digging and organising."

Interviewer: "When you say it took a lot of digging and organising who was doing the digging, was it you or.....?"

Client A (*interrupts*): "Yes! It was us that was having to push hard, the care manager wasn't pushing hard enough."

Interviewer: "Did you feel supported when you were having this battle?"

Client A: "No, there was very negative answers for a long time. We had to push hard. I had the same care manager when I came here and I'm afraid to say I was quite pleased when they moved on."

The third participant who recounted a struggle to secure care was very complementary about the care manager, but he was the only participant arranging his care through a direct payment so the responsibility fell on his shoulders to find appropriate carers. Although he felt the direct payment scheme gave him more choice and control, he and his main carer/friend describe a struggle to secure care:

Client J's formal carer and friend: "They couldn't get any carers to get him home, how long did we spend trying to get you out of that home (*to client J*)? Even in the first six months when we tried to get somebody so I could have a day off how many people did we interview, was it four or five?"

Client J: "Yes."

Carer: "Eventually we got a company from London. It was very expensive. They were, were they Polish?"

Client J: "Yes, there were different ones. There was a Polish guy and one from South Africa."

In the end, client J secured the care he required with the support of his friend/main carer and through the use of a direct payment:

Client J: “I don’t know how I would have managed without the direct payment scheme.”

None of the other participants recognised any sort of problem securing their care despite their rural location and it is proposed that this is due to their care manager acting as a ‘buffer’; someone who does the searching and negotiating on their behalf. Although this study has not involved the views of care managers, other research has evidenced that rural care managers spend a large part of their time trying to find appropriate and timely care packages (McCann, Ryan and McKenna, 2005). The important finding from this study is the service users’ understanding of the situation; and in most cases the role of the care manager certainly seems to protect them from the stress of securing care when this role is carried out effectively. This finding echoes previous research which found that the overwhelming majority of older people requiring social care relied on care managers’ advice when they entered the system because they felt they knew too little about the various services to make an informed choice (Hardy, Young and Wistow, 1999).

The role of the care manager seems to be particularly highly valued by service users and carers when they have been involved for a number of years allowing a relationship of trust to build up:

Interviewer (*addressing carer*): “Do you tend to deal with Maureen (*care manager*)?”
Client N’s daughter and carer: “Yes, it’s usually me. Just this past few weeks, things have been..... But I know if I want Maureen she’s there. She would come about once a year or she would come if you wanted her to come. She’s been coming for seven years..... If I ring her I just have to say it’s Anne and she’ll know who it is.”

Client F’s son and carer: “I also really value the fact that I can ring Claire (*care manager*) if I have a problem. That to me is very important. I think it’s important that it’s somebody who knows mum, knows the circumstances.”

Client M (*referring to her husband, now deceased*): “He was a smashing bloke he never complained. However the care manager was simply wonderful, June Smith,

she's still care manager. She was so good she got him everything possible to make him comfortable and I have some things for me because of my fall in '98".

This finding reinforces the Government's own consultation exercise (DoH, 2006b) which revealed that older people place a high priority on continuity of professional, believing that this is safer and more effective because the person knows them and their care needs better. In addition to this finding, there is some evidence from this study that not only is the relationship with the care manager important in itself, but the nature of this relationship translates to participants' general attitude to the social care service. For most participants who have had a relationship of trust with their care manager, they articulate a sense of faith and trust in the service in general; most specifically in relation to their belief that more care would be forthcoming if they needed it:

Interviewer: "If you needed more help do you think you would have any problem getting it?"

Client G: "I don't think so, it would be there, even if the nurse called. And I suppose if I fell and broke an arm or something I would get home helps as well."

Interviewer: "So if you needed a bit more help do you think that would be ok?"

Client E: "Oh I think they (*the carers*) go, well I know nearly all the people they go to."

Interviewer: "So you don't think it would be a problem?"

Client E: "No I don't think so."

Interviewer: "If you needed a little bit more help, maybe at night or something, how would you arrange that?"

Client L: "Well, I would just ask my carer to come at night, you know, I could have some extra time."

Interviewer: "You don't think that would be a problem?"

Client L: "No, because Julie Smith (*care manager*) keeps asking if I can manage you know."

Unfortunately, when the relationship with the care manager has not been good, the belief in being able to secure more care is very different:

Client C's wife and carer: "I don't think I'd have a hope of getting any more."

The relationship between service users and social care practitioners has been recognised as fundamental to the assessment process (Foster et al 2006), and qualities of mutual understanding, trust and honesty are regarded as crucial to the concept of client-centred practice (Cole and McLean, 2003; Palmadottir, 2006). This finding not only supports this view, but demonstrates the wider impact this relationship can have on service users' faith in the whole social care service.

Impact of resources and re-organisations

Although most of the participants did not find securing care a struggle, they are aware of the resource implications and limitations of social care in a 'public' sense, and this is reflected in an understanding that although they would sometimes prefer more help, they express the view that this is not realistic:

Client E: "Well, I suppose I could say it would be nice if someone would pick you up and we could go out for coffee. Yes like that. But I'm not fussy like. They'll not always want to be looking after us old things!"

Client J (*referring to his direct payment, which he 'tops up by £4 per hour'*): "Well, I suppose there's no way round it. Obviously I would prefer it if they paid the whole lot but they have their regulations."

Client G: "Well, actually the way costs are you don't want to have anything unnecessarily."

Not only do participants have an understanding of the financial limitations of social care services, but in describing their experience of social care over a period of time they also articulate the view that resources seem to them to be diminishing. This view is related either generally, or in reference to specific aspects of the social care service:

Client D: “Mind you, Marjorie’s (*carers*) time has diminished... She spends at least five minutes filling the damn book in there and I have to sign two bits of paper.”

Client F’s son and carer: “I would have no qualms in going and asking (*for more help*). I’m sure the care manager would do what she could but it would all depend on whether the resources were there and I really don’t know because the amount of resources seems to be diminishing all of the time.”

Interviewer: “Do you feel you had a lot of say in the care that was set up?”

Client K: “Yes, yes. Not so much now mind. They must’ve had more time available or something. Well, I certainly got my housework done then, which I don’t now, that came off. But I can’t really complain because a lot of people have less time than I have. I have been on it a long time I don’t know if that has anything to do with it.”

In re-counting their social care journey clients clearly have an acute awareness of resource implications and in some cases concern that these resources are diminishing. This highlights the impact of national policy to tighten eligibility criteria for social care, upon older people’s personal experience as a social care service user.

Local social care policy in the form of changes to service delivery models can also be seen to have a significant impact on older people’s experience of social care; the following two examples illustrate how such changes can cause fear and anxiety:

Client A (*referring to a forthcoming re-organisation where in-house home care providers will be office based; she refers to this proposal three times throughout the narrative, which suggests it is a major concern on her mind*): “But what are we going to do in August, when it all goes into the office..... I mean what happens if a girl is sick and rings in at 6 O clock in the morning, you can do that with the co-ordinator when they are here, you can’t do it in the office, I mean who is going to be in at 6 o clock!?”

Client D (*referring to a new case management system where people with 'low' needs do not have a named care manager but are dealt with on a duty basis*): "I've never had a problem, except with that lot at Hexham. I have found out since that there is a different duty officer every day, well who's my duty officer if it's a different one every day! A today and B tomorrow, B doesn't know what A did and it could be C on Wednesday. I don't like that and that's why I complained. What frightened me, I thought there's me I've got nobody to turn to." (*The outcome of the complaint was that she reverted to having her named care manager back.*)

It is important to recognise that, although social care practitioners may feel in the front line of constant reform and re-organisation, limited knowledge about such planned or present reforms can have a significant impact upon service users' experience of social care.

Relationships with carers

The crucial role of family in helping to arrange social care support is evidenced from this study and supported by other research; this begs the question of what happens to those older people who do not have family to assist. As already pointed out, of the ten people who needed support to set up care on discharge from hospital, two people had good friends to assist and advocate on their behalf, rather than family and it is very pertinent that these people form part of a sub-group of four participants who moved out to a rural area for a better quality of life. Of these four people, one of them moved along with her son who was her carer and the other three had no family nearby. If future predictions are to be believed (Andrews and Phillips, 2000; Northumberland Strategic Partnership, 2008) then such people are likely to become more prevalent in rural areas as retirement migration to desirable areas increases; it is therefore important to understand how this group of participants secure and maintain social care support.

Of the three participants who had no family support nearby, two relied greatly on formal carers who had undoubtedly become close personal friends:

Client K (*referring to her private domestic help*): “I’m fine now because I’ve got Anne who’s become a good friend, I mean I pay her on top of what I pay already but she’s an angel” and referring to her main formal carer via Northumberland Care Trust; “I have got one permanent carer, Sue who is wonderful..... ..we have become friends.... ..I mean, Sue will try to come with me if it’s a hospital appointment, but that’s in her own time.”

Client J relied heavily on his formal carer to facilitate his discharge from hospital and arrange appropriate social care; this carer’s description of events seems to reveal her own feelings of affection for him:

“Of course when he was in there they wouldn’t do his washing so I was going backwards and forwards to the hospital just seeing him deteriorate basically wasn’t it, you were just getting more and more depressed.... .. He was a totally different man then, bent double and just letting them get on, it was horrible to see.”

This type of close personal relationship with formal carers is a finding that has been repeated in other studies exploring rural social care, e.g., Wenger (2001); Parr and Philo (2003) and Innes et al (2005). Indeed, McCann, Ryan and McKenna (2005) in their study of Community Care in rural Ireland found that care assistants of people who had no family living nearby became particularly close and a crucial source of support. The third participant in this study to have no close family support, client D, seemed to rely on the presence of her care manager to provide emotional support and re-assurance:

“I’ve always felt Social Services was there. I wouldn’t waste your time, I wouldn’t be a nuisance but I always felt if push came to shove I could ring Peggie (*current care manager*).”

The three above clients seemed to have care packages that were, in quantitative terms, commensurate with their level of disability when compared to the other participants in this study. However the above evidence points to a qualitatively different experience of social care in terms of the *emotional* support required, for people who have no

family support; this can be contrasted with the crucial *social* support that the social care experience affords to the other participants.

Although it is termed *social* care, a large part of the social care service is actually implemented to meet older people's basic daily living needs, in accordance with Fair Access to Care (DoH, 2002). Even when formal carers are coming in to provide such essential tasks, the evidence from this research is that they are undoubtedly providing social support to varying degrees and the findings suggest this can be described at three levels which are not necessarily mutually exclusive; carers as a presence, carers as friends and carers bringing the outside world in.

Carers as a presence

'Carers as a presence' refers to the finding that people benefit simply from having a fellow, friendly human being coming into the house:

Client E: "I think it's nice that there is somebody coming in the house."

Client C's wife and carer: "They're all cheery, you know which is great. Because I think we could get a bit fed up of our own company if we didn't have folks coming in."

From the informal carers point of view it can be peace of mind for them to know that a carer is present to keep an eye on their loved one:

Client N's daughter, when asked which aspect of the service she values most asserts: "The four (*visits per day*) have just started coming in this year since mam was in hospital and really it's to have somebody coming **in**."

Client F's son describes the importance of having a carer present: "She needs somebody here, not because you are doing something for her necessarily, but because if she wants something done for her you've got to be here to do it. The carer might actually only **do** anything for 10 minutes in the two hours she's here but somebody's got to be here."

The value that clients and informal carers place on the presence of carers simply to ‘be there’ is a particularly ironic finding when social care services are currently so **task** orientated; it can be regarded as the tip of the iceberg in terms of the social support that formal carers provide.

Carers as friends

‘Carers as friends’ has already been outlined as particularly important for older people in rural areas who do not have family nearby; for the respondents in this study who do have good family support, the relationship with formal carers does not seem to be as intense but still retains qualities of reciprocity and emotional attachment that could be termed ‘friendship’. This relationship with formal carers does seem to be a crucial factor in how the older people experience the social care journey and all respondents report this aspect as positive because of three interrelated features; continuity, familiarity and mutual flexibility.

Continuity of staff is a feature that has been reported elsewhere as highly valued by older people who use social care (DoH, 2006b; Wiles, 2005b) and also specifically by older people in rural areas (McCann, Ryan and McKenna, 2005.) This study reveals that not only is it a quality that people value, but it is an aspect of service that seems to have been successfully delivered in rural Northumberland. People report having the same formal carers for a number of years:

Interviewer: “Some people say living in a rural area it’s harder to get carers or things like that, have you not found that?”

Client L: “No, no (*emphatic*) I’ve had the same ones since it started (*3 years*).”

Interviewer: “How long has Marjorie (*carer*) been coming in?”

Client D: “Nine years.”

Interviewer: “And how long has she (*carer*) been coming in?”

Client E: “Ee, pet, how could I tell you, I think since I came out of hospital you know (*2 years*).”

This continuity leads to a sense of familiarity summed up by one client:

Client N: “And I’ve got to know them and they know me. So it’s not like strangers.”

This familiarity is articulated by another client, when she recounts her routine with her formal carers:

Client L: “Well, I have Joan, she comes today until Friday, then I have Tracey on a Saturday, she comes every Saturday unless she’s on holiday, and I have May once a fortnight and in between I have Trudy or Pauline. Pauline comes, say if Joan’s off a few days, I know them all.”

Client L later goes on to recount where all of her formal carers live but it is pertinent to note that when asked which agency her carers worked for she had no idea; they are clearly familiar to her as individual people rather than as employees of an identifiable organisation.

There is some evidence that this familiarity is reciprocated by formal carers, for example:

Client C’s wife and carer: “The carers are so pleasant, they are all pleasant which makes a terrific difference, you know. One of them even has breakfast, because she starts early so she has her slice of toast and a cup of tea with us.”

Client J’s formal carer and friend: “I don’t feel as though it’s a job now, he’s just part of the family.”

This reciprocal nature of the formal care relationships in rural areas has been evidenced elsewhere (Wenger, 2001; Parr and Philo, 2003) and two of the respondents in this study did express the view that these relationships are qualitatively better in rural areas when compared to urban:

Client N’s daughter and carer: “I think it’s good here because you are getting the same ones (*carers*) all of the time, whereas in towns it’s not the same ones all of the

time. Plus the ones that come here are, err, people that live in the country and people that live in the town are different people and its country people that come.”

Interviewer: “In what way (*is the service better here than in Sunderland*)?”

Client K: “I think the whole thing, the doctors and everything, I don’t know whether they’ve all changed in their attitude but there is a different relationship. More friendly, easy to talk to. I think generally everyone is.”

Mutual flexibility with the carers is a quality re-counted by most of the respondents as positive in the social care experience:

Client J: “With Jan (*formal carer*) having this thing on tonight, normally she gives me my tea or supper, whatever you want to call it at about half-past five or so but she can’t do that today so I said just leave me something to have at tea-time.”

Interviewer: “And then she’ll be back at bed-time?”

Client J: “Yes.”

Client J’s formal care and friend (*Jan*): “We are very flexible that way, if he wants to watch a football match or something I’ll come in at ten instead of eight and things like that.”

Client M: “Once a fortnight she changes my bed because I can’t cope with the duvet and things. Now she’s on holiday this week and they rang up to say the girl who’s replacing her can only come tomorrow, is that alright? Well, I would just fit in straight away because you can’t just have everything you want, can you. I mean when they offer a service like that you’ve got to fit in.”

Interviewer: “Does that work both ways?”

Client M: “Oh yes, well I did get it changed because it was always inconvenient with the foot man.”

It seems to be important for the clients to express that this flexibility is **mutual**, emphasising their active contribution to the relationship which then becomes one of reciprocity that can equate to ‘friendship’.

Carers bringing the outside world in

Formal carers coming into one's home could be seen as an intrusion of personal space; as Aronson (2002) suggests, even carers' very presence signals an intrusion of public into private. None of the respondents in this study described their social care service as any kind of invasion or imposition in their given narratives; on the contrary they seemed to perceive their carers as contributing to their social space in a way which has been termed 'bringing the outside world in'. In some cases this was articulated in the way that carers provided information about services and help available:

Client C's wife and carer: "I mean nobody ever told us what actual help we could have, anything we've got I had to find out for myself."

Interviewer: "How have you found out?"

Client C's wife and carer: "Well, mostly from the care girls, you know what gadgets I could have and things."

Client F's son and carer: "But I understand it's gone the other way now and they have less work than they can cope with. From something somebody said the other week. Was it something someone said to you mam?"

Client F: "Yes, one of the carers, she said oh you know we are looking for work."

At a more personal level, clients reported knowing about their carers' lives and about carers keeping them in touch with the local community:

Client G: "But they are all really good, well I've known some of them in the village you know, I've known their parents and maybe their grandparents as well. There's one I didn't know she came from the outskirts of town, her hubbie died and she just started on the home helps... .. You know when you live in a village it's just like a big family, you know everybody."

Interviewer: "Do you like that?"

Client G: "Oh I like it."

Client E (*referring to her formal carers*): "They are pretty good unless there is somebody who is not so well and they go to them first. You see I know such a lot of

people they go to, all the people in the village and I ask how they are, or she'll say eee, such and such was asking after you."

Interviewer: "So you keep in touch with what's happening?"

Client E: "Yes. But oh the carers are all very nice. One of them lives down by the church, you know, she has a son at University, then another lives at x (*nearby village*)."

Client L (*referring to her formal carers*): "No, everybody is that good with me. I'm quite happy, they tell me about their families and that."

For all of the participants, the majority of their time is spent within the home and most of them never go outside at all; this can be seen as a reflection of incremental rationing of social care services which has focused services on those with greater levels of disability. But, although at a superficial level their physical world would appear to have shrunk, this engagement they have with formal carers portrays them remaining connected to people and places which are now beyond the bounds of current physical limitations; this can be described as maintaining what Wiles et al (2009) refer to as social space.

Other research into older people's evaluations of social care has suggested that the social contact with the carer is more important than the task being carried out (Netton et al, 2005; Clark and Spafford, 2001; Vernon and Quereshi, 2000), however, for most participants in this study this is not necessarily the case. For example, when asked which aspects of the service they valued most, responses included:

Client F: "I think the respite is a good thing because it means David can go away."

Client L: "Well I would say getting my bed made, and putting my tights on, that's important."

Client C's wife and carer: "I should think the general help really, because I mean I just couldn't do it and if I couldn't do it C would have to go into a home."

Interviewer: "You mean the physical practical aspect."

Client C's wife and carer: "Yes, entirely."

Such responses could be an indication of the good existing social support that most of this client group have from family and neighbours, or it could reflect how desperate they were for the practical support when it arrived and that the service is indeed meeting “critical need”, in accordance with Northumberland’s fair access to care criteria.

Summary

Almost without exception, for participants in this study the social care journey began with a crisis; this can in part be seen to arise from a mutual expectation of family support which buttresses older people’s view of themselves as self-sufficient and ‘independent’. The delay in timely intervention may also be due to participants’ fragmented information about services combined with their acute awareness of their resource implications.

Contrary to existing research evidence, most participants do not perceive their rural location as hampering access to services; this seems to be due to the protective role played by their care manager and highlights the significance of the nature of this relationship. Relationships established with care managers are particularly crucial when services are established or changed, but those formed with formal carers play a fundamental and ongoing role in the social care experience. Such relationships constitute an emotional dimension to the social care service and can be recognised as forming a vital connection to people and places now physically out of reach to participants.

Findings: A sense of place

Introduction

Participants' narratives about where they live reveal a strong attachment and the findings explore the intrinsic qualities of this sense of place. This attachment is neither uniform nor intransigent and differences in experiences within the group are detailed and explained; as are instances of personal adaptability. The specific qualities of rural living which participants value are discussed in relation to existing rural literature, revealing common ground as well as some contradictions which are tentatively accounted for.

Familiarity and continuity

For participants who had lived in their current neighbourhood all or most of their lives, their sense of place strongly demonstrates how the meaning of place represents a meeting of geography and temporality. Their narratives about where they live recount detailed familiarity with local landmarks and villages and this is clearly interwoven with a sense of history. Client G gave a detailed example of this, recounting how he would have a walk while waiting for the bus, when he was mobile (approximately two years ago):

Client G: "We used to live up, you'll not have heard of it C (*hamlet*), up by Smith's farm. It was a shepherd's cottage. Well, there is a road goes down onto the Main Road, these houses are down on that road that we used to live there. So I, the blue heaps, you know the blue heaps? Blue waste from the iron ore. I used to have a walk up there and it was great, going back to my childhood seeing things I had long forgotten..... I used to walk down past the blue heaps on the Main Road and past a couple of gates and I daren't go any further in case I missed the bus."

In other cases, the familiarity with places was not given in such detail but references to it were woven throughout the whole transcript:

Client L: “I was born in T (*small town*), just down the road, and then we got married and we lived up beside Jones’s farm there, we bought a little farm at S (*village nearby*), then we bought this house.”

(*Later*) “Oh I love it here because I know everyone, I went to the village school.”

(*Later*) “The church is just up the road. John (*husband*) used to sometimes take me to that church. This church is just on two days a month and I never missed going. But now the vicar comes to me.”

Although these participants no longer visited these places or physically travelled the routes their narratives demonstrate a kind of ‘mental map’ of where they live with personal meaning attached to places they recall. Rowles, (1983) and O’Bryant (1983) use the term “physical insideness” to describe the way that we, as humans, become accustomed to familiar routes that we walk and routines that we use. This study demonstrates the way that this “physical insideness” becomes an integral part of the meaning we attach to places, even when we no longer traverse the familiar routes.

In recounting this familiarity and sense of history, participants asserted their link with where they lived and most specifically a feeling of continuity with where they lived. In some cases participants used this sense of continuity as a reason to wish to remain living in their current location:

Client A: “Well, yes I couldn’t live in a town, neither of us could. Because we never have, I was brought up on a farm.”

Client C’s wife and carer: “My husband was born here, so he has been here all of his days..... I would hate to live in a town. Oh I would loathe it. I have lived in the country all of my life so.....”

Although this strong familiarity and historical attachment to an environment which participants can no longer get to seems almost paradoxical; it re-affirms geographical gerontological theories which assert that older people maintain their sense of self in times of change through assigning personal meaning and continuity to their physical environment (Rubenstein, 1989; Altman and Lowe, 1992). The focus of this study is older people’s rural location and their accounts do suggest that they gain a sense of

continuity and purpose from this environment through recollection of places, feelings and relationships. Rowles (1978) referred to this form of geographical experience as 'geographical fantasy' but within the context of this research, the separating of fantasy from reality is too dualistic to explain the way that participants narrate their sense of place. Participants' accounts of where they live in terms of history, familiarity and relationships with places as well as local people seem more to reflect Michael Cutchin's explanation of place as a dynamic process; always linking the past and the present as well as people and their environment (Cutchin, 2008).

Participants who had always lived in their current location, undoubtedly demonstrated a sense of history about where they lived and they recounted stories about how they came to live in their current home; for example marriage, work, illness, but so too did the participants who moved from an urban area for a better quality of life:

Client K: "Oh well, I'll tell you the tale. I lived in Sunderland until I was fifty-four, I lived with my dad. Somebody said to me what will you do when he goes? I said oh I would go and live in the country and they were absolutely staggered when I did."

Tells history of her own working life and what happened to her father and concludes with: "So really it was a combination of seeing what a lovely place it was up here and deciding if I didn't make the break I would be staying in the same place all my life doing the same things."

Client D: "Well, I lived at Newcastle and I'll be perfectly honest with you, we'd lived there twenty years, about that and my husband just dropped down dead you know, the day after boxing day. And I just couldn't cope with it, it probably seems ridiculous to you I know but I felt I just couldn't settle in the house."

These examples illustrate that there can still be an emotional narrative linking the persons past with their present home even if they do not have an enduring sense of history attached to where they live. This finding supports the work of Manzo (1994) who documents how places become meaningful as transitional markers or symbols of significant life events. For the participants in this study who re-located to start a new life, their move can be seen as having an element of risk attached to it which magnifies the emotional investment they have deposited in their current home. For

both groups of people then, their current rural environment is a central part of their life story and therefore personal identity.

Access

While in the context of our everyday lives our sense of place is so familiar that we essentially relate to it in an unconscious way (Manzo, 2003), participants in this study described episodes in their lives which brought their thoughts and feelings about place to a much more conscious level. The stories told of why they came to live in their present home illustrates this, both by people who re-located as above, but also by people who moved within their neighbourhood:

Interviewer: "You have lived here all that time?"

Client E: "Not in this house darlin', I was in the house down at the bottom, the second one. I lived in there and then when Peterson's (*neighbour*) died, I had trouble with my back, you know when I had my son. Cannot manage stairs very much you know. So I said to the landlord when Peterson's died I fancied coming up here."

Client G: "Well, I worked in the forestry for forty two years. I had an invalid mother then and we lived off the main road, in fact off any road at all. And, err, my mother was beginning to ail, and the farmer who owned this err, I approached him about buying it and he said he had a few after it but you're the one in greatest need so he sold it to me."

Interviewer: "It was a better location for you?"

Client G: "Oh it was, well the road, you know it was no distance away and if an ambulance had to get in there was a road just there."

It is apparent from participants' narratives that they had all thought consciously about 'access' regarding their present home either internally, as illustrated by client E, or externally as illustrated by client G. Most of the literature regarding rural areas describes access as a problem, but many of the participants in this study were actually very positive about access in relation to where they lived. For participants who had lived in a rural area all of their lives most regarded simply living anywhere near a main road as 'good' in terms of access:

Client C's wife and carer (*they lived 2 miles along a rough track in what would be considered a remote location*): "I don't think there are any disadvantages to living here at all. Well, we are 20 minutes from Newcastle and we might be 200 miles from Newcastle."

Client A: "Where we live now it's far easier to get to Hexham than it was before. It was 40 minutes before but now it only takes us quarter of an hour."

Some participants like client G moved from more remote locations specifically to be nearer a main road. Unsurprisingly perhaps, the only participants who referred to their present geographical location as problematic in terms of access are those who had re-located from an urban area, for example:

Client D: "I only sold my car last year. In fact, I have been wondering whether to buy another one. I sometimes think to myself I'm a bit inhibited here.... Basically I don't feel in charge of myself. This year I've only been to the dentist or doctors and if I had a car I could say to myself I'll go down to the woods this afternoon."

Client J: "I suppose in a way it would be more convenient for me if I was nearer a town or something, because I don't get out, very rarely get out. My carer sort of walked along the lane with me and back and that's as much as I've seen. Except on two or three occasions we got a wheelchair taxi to take me out."

This could be seen to support the work of Bailey (2004) who asserts that older rural residents rely on access to a car to maintain their quality of life. However, some of the long-term rural residents rarely had access to a car and they did not report this as a significant problem in their life; they seemed to take a more philosophical or accepting view of the situation:

Client L: "The last time I was out was October about my eyes and I don't need to go back until March."

Interviewer: "And someone takes you in the car?"

Client L: “Yes, Jim at the top there. They want me to go to the new Marks and Spencers in Hexham, but.... .”

Interviewer: “Are you not one for shopping?”

Client L: “Oh I loved shopping, I loved it *laughs*, but that’s all gone now.”

This finding may be due to the long-term rural residents having an embedded social network which comes to them, reducing their need for personal mobility. But the geographical access concerns of the participants who moved out does seem to reinforce the view of Stockdale (2006), who reports that pre-elderly migrants are part of a wider mobility culture that favours high levels of personal mobility as part of an individualised society. As the pre-elderly migrants become older and experience greater levels of disability it would be expected that they would feel the loss of this personal mobility more keenly.

For participants who have moved to be nearer a main road, who rely on friends and family to drive them places or who are severely restricted because they cannot use a car, the issue of external access is intimately bound up with their own health problems and disability. The topic of internal access is even more closely related to participants’ health problems. Although the focus of this study is the rural dimension to place, participants did spontaneously raise the issue of internal access within their home. This is unsurprising when mobility problems have meant that they have had to make or accept changes to their home environment in order to remain living in their location of choice. In some cases this meant moving to a more suitable property within the same neighbourhood, like client E, in other cases it has meant having alterations carried out:

Client K: “I got a lift put in, it goes up and down there, because my stairs are like that and they couldn’t get a stairlift in or I would’ve had my legs around my head, *laughs*. And just a couple of years ago they did my bathroom so I’ve got the shower unit in. They widened my path because I kept going off the side with my wheelchair.”

It is apparent that client K believed having these alterations done will enable her to remain living in her present home longer:

Interviewer: “Do you envisage yourself staying here the rest of your days?”

Client K: “Yes, I’m not going into a home, definitely not unless I’m crackers and I don’t know the difference. They have fixed it so I can live here, you know I can get up and down to bed, it’s all geared up.”

For one participant the changed living arrangement (having the bed brought downstairs) seems to have been a decision that was out of her hands:

Interviewer: “So how did you feel about having the bed brought downstairs?”

Client N: “Well, I didn’t want it, no, but it was all done.”

However she came to accept it because it meant she can remain living in her own home:

Interviewer: “On reflection, do you think it was a good idea, if you are frightened of steps?” (*Participant had earlier said she was frightened of steps.*)

Client N: “I think it was, there is a toilet downstairs.”

Client N (*later in the interview*): “I am quite happy to stay here.”

The fact that participants had narratives to tell about access within their home highlights that this has been an issue they have had to deal with in order to continue living in their desired location; they are prepared to accept changes to their immediate environment i.e., the home, in order to achieve constancy in their wider environment.

Participants’ narratives about internal and external access provide evidence that they have had to make choices and sometimes take risks to live in a location that sits comfortably with their self-identity. Ruston (2009) asserts that anticipating the consequences of alternative possibilities, evaluating their desirability and choosing the most desirable option lies at the core of human agency. But for participants in this study the issue is not just one of making positive choices, it is interconnected with adapting to changes in their personal health and mobility; agency is thus closely linked to what Crossley (2003) terms ‘narrative reconfiguration’, when personal stories help us to make sense of illness and insecurity.

Quality of life

When participants talk about the positive aspects of living in their current location, most of them corroborate findings from other research exploring older people's perceptions of rural living (Manthorpe, Malin and Stubbs, 2004; Manthorpe et al, 2008); describing peace and quiet and attractive countryside features as being important positive qualities. Irrespective of whether participants have always lived in their current location or migrated from a town, there is a common appreciation of the sight of natural or rural scenes:

Client D: "Everybody thinks it's wonderful (*living here*). Beautiful views. The other week I had an engineer here fixing the cooker, he said come and look at this. There was a cow calving in the field!"

Client G: "Oh it's nice (*living here*). I mean in the Spring you get the birds coming in, the curlews and the oyster catchers. You know they more or less tell you when it's Spring. Oh it's just like Spring watch on the telly but just to look at!"

All of the participants in this study were now, for the vast majority of their time, confined to their home and previous research has found that the aesthetics of the natural environment can provide an 'uplifting experience' and combat depression for people who spend most of their time indoors (Day, 2008). This may go some way towards explaining why, despite their severe physical health problems, none of the participants in this study recounted narratives of dissatisfaction or unhappiness; on the contrary most of them explicitly said they were 'content'.

Peace and quiet is another recurrent feature which participants describe as making their place of residence appealing, but a number of participants take this feature further to emphasise that it is actually being away from people that adds to their quality of life:

Client C's wife and carer (*regarding living here*): "You know it's.... And we don't, we aren't bothered by anything really.....You know too many people erm, I like my space."

Client A (*regarding living here*): "It's on its own and it's quiet.... I was brought up on a farm, sort of away from everybody else and quiet.... And away from everybody... you just don't think of being among folk."

Client D: "I have a friend who lives in one of those housing complexes and they have a bus that takes them out, but that wouldn't suit me. I say to her I couldn't live the way you live. I think now I'm of an age where at five o'clock, once I draw my curtains I'm not bothered by anything or anyone. I'm a bit too much that way inclined."

This desire to be away from people seems to contradict with the next section which refers to the 'community spirit' and 'neighbourliness' of rural areas, but perhaps the very paucity of people in rural areas heightens the quality and intensity of the relationships.

Flexible local resources and community support

All of the participants in this study referred to their neighbours in the context of recounting their narrative about where they live. Neighbours clearly provided a crucial source of social and in some cases practical support for this group of people:

Client E: "Now Teresa (*neighbour*) is very good..... She is a very good friend, and some nights when I'm by myself the 'phone will ring if she's at home, she 'phones, eee come on I've put the kettle on."

Client L: "Well, Jean, my neighbour she comes in, say if I wanted a tin opened or, well every day there's a little bit of something she does for me."

Interviewer, "Is there, right?"

Client L: "Aha, because like today, well she comes in every day. She'd been in an hour. She's company for me and I'm company for her, because she's on her own."

The above two examples typify the way that neighbours provide well-established social support for participants who have lived in their community for many years, and there does seem to be a reciprocal nature to this support. This finding supports the view of Wenger (2001) who asserts that older people in rural communities do have more contact with their neighbours than in many urban areas. For participants who moved out to their current location later in life, the relationship with neighbours is not recounted as one of close friendship or reciprocity but neighbours do still play an important role. For this group of participants neighbours seem to have offered practical or social support on an 'as required' basis:

Client K (*referring to when she first moved into the neighbourhood*): "Neighbours roundabout started coming and doing bits of hoovering and what not, they were wonderful."

Client D: "Susan, my neighbour, she's a nice girl but I'm too old for her. She likes to take over, she said I'll take care of you. To tell you the truth Susan helped me into the shower and get clean clothes on, and she checked me every hour." (*This assistance was provided following a fall.*)

Client J: "I see my neighbours, not very often but they are very good. They occasionally send me a meal in."

This finding seems to support the view of other authors that there is some credence to the notion of 'community spirit' in rural areas (Scharf and Bartlam, 2006; Hanlon et al, 2007). There is evidence from this study that this community spirit in some cases extends from the specific to the general:

Client M: "Then there's a lady, a neighbour who delivers the newspapers all along this row."

This example forms a link between 'good neighbourliness' and flexibility of local resource provision. It can be problematic delivering and securing resources in rural areas and there is evidence from participants' stories that people who are tasked with

delivering services or goods are prepared to be flexible in order to do so. A number of participants recounted that local shops (which can be several miles away) would assist in arranging delivery of basic household shopping along with the newspapers, either from within their own resources or via local people prepared to assist. Crucially, medication was also delivered from the nearest pharmacies. One shop owner seemed to be particularly accommodating:

Client G (*referring to the owners of the nearest shop, approximately seven miles away*): “He fetches the newspapers and milk as well, anything people want, he is good. He looks at the fire and if the fire’s low he’ll say you could do with a bit of coal on there and he’ll go and get it”. (*Later in the interview*) “One day I was on about my hair. It was just about onto my shoulders and he said we used to cut one another’s hairs in the forces, I’ll cut it if you like. Well I said certainly, I’m not bothered how it’s cut and he made a right good job of it. He didn’t want to be paid but I gave him something for his kids.”

Wenger (2001) has suggested that older people in rural communities are more likely to belong to and attend a church; evidence from participants in this study indicates that ‘the church’ in rural communities is taking a flexible approach in helping older people maintain that sense of belonging to their church. In some cases this involved a member of the church coming to collect someone:

Client M: “I go to chapel, someone comes to fetch me from the chapel but I can only go once a month.”

In other cases a minister from the church would come to visit the older person at home on a regular basis and for one participant, the church would hold a meeting at their home:

Client K: “And then there’s a house group comes here tonight, we have a guide book to go through and we have a laugh. They make the tea when they come in so I have nothing to do.”

If, as Krause (1998) suggests, religion functions as a coping resource for older people with a beneficial effect on health, then this flexible approach of rural churches is one to be encouraged and supported by social care services.

Although participants' accounts give evidence of local resources taking a flexible approach to endeavour to continue providing a service, there is also another narrative suggesting that local resources are diminishing. This can be seen in people's accounts of shops, post offices and banks closing down:

Client N: "The only disadvantage (*of living here*) is if you want some extra shopping you've got to go to Hexham..... We used to have a big grocer shop. And we had a drapers, used to sell wool and clothes. I used to buy all my wool there you know."

Client L, "I used to get my pension there, it used to be a post office but it's not now. Now I get it from T (*next village*) and they are closing from January so I am just having it paid into the bank and Nancy will get cash from Hexham."

This declining availability of shops in rural Britain has been evidenced elsewhere (Phillip, 1999), but participants in this study also reported small community resources folding due a diminishing membership:

Client E: "I used to go to the tea club but it finished you know. Oh it will be just about a month ago, I got the shock of my life, we were out on the Thursday and the next thing we were told it was finished. At the finish there was just three of us."

Interviewer: "Do you think the coffee morning might start up again?"

Client E: "No because there's not many of us."

Client K (*referring to a local craft group*): "It is three or four years now since ours packed in, couldn't get the numbers. We started with fourteen people and it went down and down because people died off and moved and nobody moved in. It was very good I enjoyed it."

This reported feature of dwindling membership seems to contradict quantitative evidence of an ageing population and in particular a growth in the rural older

population (Department for Work and Pensions, 2005). It may be that younger older people or people who have recently migrated from urban areas have different expectations and do not wish to participate in such distinctive support groups. One participant in this study, who moved out from the city on retiring, is noticeable as an exception in the way he used information technology as a means of entertainment, social support and community membership:

Client J (*referring to the fact that he never gets out to the theatre etc these days*):

“I’ve got practically all the entertainment I need here. I’ve got television with DVD player and tape player, plus I’ve got sky-plus so I can record my own films and programmes when I want”. (*Later in the conversation*) “At the moment I’m spending quite a lot of time looking at the blogs of my local football team as they come in... .. I also use skype and have a web cam to keep in touch with family.”

Some authors have suggested that the increasing use of information technologies is diminishing the importance of local social ties (Wellman, 1979; Surratt, 2001) and perhaps client J is a sign of the future. In keeping with other research, (Izarry, West and Downing, 2001) most of the participants in this study do use the telephone to keep in touch with friends and family:

Client L: “With my eldest sister being dead, her eldest daughter rings me every Sunday morning. Then my young sister, well she’s eighty-five, she’s just lost her husband so we talk every weekend on the ‘phone.”

Client A: “And you just ring up friends to talk to them, you don’t actually see long-term friends regularly, you know because either they are getting too old or they cannot drive.”

But this use of technology does not seem to have impacted on their local community networks which, according to participants’ own narratives remain strong. It may be more apt to suggest that the use of new technology complements, rather than replaces other modes of communication and social support (Stern, 2008).

Summary

It is apparent that all participants have an emotional investment in where they live which is integral to their personal identity and helps motivate their desire to remain in their current location. Despite this common ground, there is evidence of subtle differences in how a sense of place is experienced by long-term dwellers or in-migrants. Long-term residents have images and meanings of past and present geographical landmarks woven into their personal narratives; while for in-migrants their present home represents a significant life-changing decision. Long-term residents are less inclined than in-migrants to perceive access to their rural location as problematic; they are however, all prepared to undergo internal access alterations in order to remain in a geographic location which they value for its natural beauty and tranquillity.

For long-term residents, neighbours are more likely to be a source of well-established social relationships as well as practical assistance; while for in-migrants, neighbours tend to be a source of help as and when required. There is a commonly represented view by both groups of participants that such neighbours and the wider rural community provide flexible and resourceful assistance to meet their needs. This includes those tasked with delivering services, whether they are voluntary, private or public, being willing to be flexible and accommodating in order to meet the challenges of population sparsity. Despite this reported adaptability, narratives also recount evidence of local community resources diminishing. Such a finding has been evidenced elsewhere and may be due in part to changes in expectations of rural communities.

Findings: The meaning of choice

Introduction

The findings relating to choice epitomize the importance of situating participants' responses within the context of the whole transcript in order to elicit meaning. A term which can, in an isolated response be swept aside as irrelevant to social care, is revealed to be a complex and meaningful dimension to social care when analysed in depth within participants' narratives. In keeping with the philosophy of this study, the meaning of choice for participants is discussed from a phenomenological and non-rationalist perspective revealing personal and cultural influences on the choice process, as well as contradictions which can be inherent within that process.

Expectations

An intention of this research was to explore the meaning of choice for older people who use social care; this was specifically because 'choice' is so high on the current political agenda for both health and social care. In seeking to interpret participants' narratives around choice, it is apparent that the concept can be related to their experience of social care and their desire to remain living at home, but both arenas are underpinned by participants' sense of agency and personal identity.

When directly asked about choice in relation to their social care experience most participants struggled to respond; this was also a finding of Clark, Smith and Vidler (2006) who describe people as being alarmingly unable to specify what choice means to them in relation to public services. Significantly, the only participant for whom choice was an explicitly meaningful concept in relation to social care was the sole recipient of a direct payment; he was quite clear that before receiving the direct payment he did not have any choice, for him this meant the choice to return home:

Client J: "Well, I realised that I didn't have any choice, I would have preferred to come back home but I didn't get that option."

He later reported that his current service gave him a lot of choice:

Client J: “I would say I have a lot of choice. Jan (*formal carer*) is very willing, she will do all sorts of things she’s not required to. Even to the extent of putting weed killer down.”

For all of the remaining participants, at a superficial level there was an understanding that social care services are more about need than choice:

Client A: “Well, it’s not a case of choice it’s a case of what you **need**.”

Interviewer: “When the care was set up do you think you had choice or control over what was happening?”

Client D: “No, no, I got what I wanted, well I got what I **needed**.”

However this response is of course intimately bound up with people’s expectations. For this group of participants their expectations seem to be fuelled by the prevailing rural culture of self-effacement and stoicism recognised by Heenan (2006), as well as an embedded ideology of self-reliance and ‘keeping going’ that has been found to be of value to older people (Secker et al, 2003; Tanner, 2001; Tanner, 2003). For participants in this study this view they have of themselves as ‘independent’ or ‘self-sufficient’ can be seen as a natural self-image from their past, in which material hardship was a fact of life that had to be dealt with. One participant recounted a typical rural life in the 1940’s and ‘50’s:

Client M: “We lived just around the corner from here because my husband was born here. So, we had no electricity, no water, I had to go to a tap to get buckets of water. We got water in 1952 and electricity in 1953. Some folks say how did you live without electricity, well I say you just did. You got use to oil lamps, no street lights nothing. Of course people were used to it. However we got over it.” (*Later in the interview*) “In the winter you had to buy food to last 3 months. I made bread and that sort of thing.”

Although their material circumstances have changed beyond recognition, participants clearly maintain a sense of continuity in their self-identity through a connection to the past. Conway (2000) suggests that such a connection with the past can create a mental

and moral resource and for these participants it does seem to sustain their sense of fortitude and independence, even when they need care and support. Often for participants these attributes of stoicism and self-sufficiency were woven throughout the whole transcript in words and phrases such as “independent”, “keep going”, “I’m no bother”, “I’ll push on”; but the following examples can illustrate the impact of such an attitude in relation to the social care service:

Interviewer: “You don’t go to any groups or anything, do you?”

Client G, “No, well actually our family we’ve never really needed that kind of thing. When I grew up there was nothing like that anyway. I mean you just had to get on with it.”

Client E: “I had a very big operation you know, mind I was troubled with my back before that. But I always keep going I never give up.”

Interviewer: “If you needed a bit more help do you think you would have any problem?”

Client E: “Oh, I think I would manage unless there was something desperately wrong with me.”

Interviewer: “Did the carers come more frequently in the beginning or just in the morning.”

Client L: “No, just in the morning.”

Interviewer: “So how did you manage the rest of the time?”

Client L: “I just managed. I’m very independent, *laughs* I don’t know how they put up with me.”

For participants in this study their sense of fortitude and independence translates into attitudes of gratitude and satisfaction for the social care service they receive:

Client M: “I’m very fortunate.... I can’t complain what so ever, it’s a jolly good system”.

Client G (*about the service*): “Oh it would all just be glowing praise. I cannot think of anything that could be put right, there’s nothing to be put right. They all do their best and you can’t want better than that.”

Even the few participants who reported having a ‘battle’ to get the care in the first place were still full of praise for the service as it now stood. This recurrent sense of gratitude and satisfaction from participants may be a reflection of the lower expectations that rural dwellers have been found to have (Asthana and Halliday, 2004; Innes et al, 2005). A previous study of urban older people requiring social care found similar comments regarding self-reliance and keeping going, yet this was allied with some negative attitudes about the care service they received in terms of inflexibility and disparity between their felt need and professionals’ assessed need (Tanner, 2001). There were no such negative attitudes evidenced from this study.

Non-rationalist agency

There seems to be a paradoxical quality to the way that participants are stoical and ‘independent’ and yet at the same time, openly complementary of a service which to outside eyes could be perceived as rendering them ‘dependent’. This apparent conflict does not appear to cause participants discord or distress, indeed they often describe themselves as ‘content’ which implies they do not secure a sense of self from a rationalist model of agency which assumes the subject is either responsible or not responsible; dependent or independent. Rather, their narratives are indicative of non-rationalist (Hogget, 2001) or postmodern (Wray, 2003) form of agency which can incorporate within it paradox and contradiction. This is most evident from participants’ choices to allow other people to act on their behalf in relation to social care; a phenomenon termed ‘constructive dependency’ to encapsulate the way that they are making a positive choice for someone else to take control:

Interviewer: “Do you feel you have control over the service coming in?”

Client K: “I’m not one for having control, just somebody else to sort it out.”

Interviewer: “Do they (*nieces*) manage quite a lot of your affairs?”

Client L: “They manage everything.”

Interviewer: "Are you happy for them to do that?"

Client L: "Oh yes."

Interviewer: "When the care was increased last time how did that come about?"

Client N: "I don't know."

Interviewer: "Did you feel it was out of your hands, did it just happen?"

Client N: "It was out of my hands."

Interviewer: "Does that bother you?"

Client N: "No. I've got to know the carers and they know me so it's not like strangers."

The term *constructive* dependency is used because participants are delegating control of one aspect of their life but still retain agency through their continuing desire to engage with the social world (Wray, 2003). This engagement with the social world is reflected in the reciprocal relationship they have with carers; although many of the participants have explicitly stated that they value the personal space which living in a rural area brings, they actively build relationships with carers to help sustain a coherent sense of self.

Not everyone is positive about choices that are made on their behalf. The two participants who were negative about their care manager, explicitly described feelings of not being listened to or having a tokenistic type of choice offered to them:

Interviewer: "Do you feel you had choices in the process of setting the care up?"

Client C's wife and carer: "No! Because I didn't know what there was..... Complete lack of communication."

Interviewer (*later in the interview*): "Were you being asked or were you being told?"

Client C's wife and carer: "I think I was being told it was good for me."

Interviewer: "Are there things that you think could improve things, make things better?"

Client A: "I think they could do with listening to people."

Interviewer: "Who needs to listen?"

Client A: “Whoever you are contacting, they say they are giving you a choice but they have already made their mind up, they are not interested really.”

These two participants highlight the interpersonal context of choice in relation to social care. Tanner (2003) suggests that assessment of social care services is contingent upon a relationship of openness and trust to ensure that the intervention meets service users’ personal goals. These two participants clearly stated they did not have this sort of relationship with the care manager and this has affected their interpretation of ‘choice’. However, both participants were happy with the service once it had been established, largely because of the good relationship they had with the carers; once the service was in place to their satisfaction, ‘choice’ became no longer an issue. This finding supports previous research which has indicated that if services are provided to a good standard, choice is not an issue; it becomes more important to service users if they experience service failure (Hardy, Young and Wistow, 1999; Clark, Smith and Vidler, 2006).

For all of the participants who were themselves older people, the social care service they received enabled them to fulfil their choice to remain at home; this seemed to be the main priority for them and this may well have influenced their sense of gratitude and satisfaction with the service. However this overriding choice does not negate other implicit choices that participants made on a daily basis; supporting the view of Glendinning (2008) who has suggested that older people who use social care services may experience choice as an ongoing, negotiated and re-negotiated process as circumstances and priorities change. This is most apparent in the way that participants chose to engage with carers on a daily basis with varying degrees of reciprocity, friendship and mutual flexibility; but other instances of choice or ‘agency’ can be seen throughout the narratives of the participants:

Client G chooses not to have a wheelchair but rather to persevere with his walking aids at the moment: “Oh, I wouldn’t have a wheelchair. I would persevere with the crutch or zimmer, and it’s all free from the hospital you know.”

Client K chooses to continue to go to a GP practice that is further away despite transport problems because she knows it offers acupuncture: “But that’s the biggest

problem getting to the doctors. But you see people would say why don't you go to T (*town that is actually nearer than her own GP*). But I would walk the earth to get to my own GP."

Client L chooses not to go to day care: "Well, when I was in Dene Park (*respite and day care centre for west Northumberland*) they said would I like to come because my neighbour comes every Thursday. But you see I would rather be here when Sue and May (*domestic help*) are here because we have a good chat."

Client F would also rather stay at home than go to any form of day care: "Oh yes, I read a lot and do a lot of puzzles. I'm not bothered about a lot of company. I'm not that sort of person."

However client F did agree to go to a day centre once a week to give her son and carer a break and he acknowledges this fact: "She only goes to day care really to give me a break." In this way client F was negotiating her personal wishes with her understanding that her son needs a break. Client F's son was a relatively young full-time carer and he was the only participant in this study to describe the social care service as actually limiting personal choice from his point of view:

"We try not to ask for too much help, because if you know that someone is coming at eight o'clock it means you've got to get up at that time, and likewise going to bed. To a great extent the more you get help the more constrained you are to do what other people want rather than live your own life. So therefore we try to do what we can so we can do what we want."

Although the older people in this study did not articulate this point of view, perhaps because they prefer to express their gratitude, this factor of social care services limiting personal freedom could be influential in people struggling on without care until the situations reach crisis point.

Home

In keeping with previous research (Langan, Means and Rolfe, 1996; Mowl, Pain and Talbot, 2000), there is a recurrent theme from participants of an expressed choice to live in their current home for the remainder of their life. In some cases this was an explicitly expressed wish:

Client G: “And choice, well, I’ve got my choice hopefully till I die.”

Interviewer: “To say living here?”

Client G: “To stay living here and have the conditions that exist at present.”

For some of the widows who participated in the study, this choice to remain at home was influenced by a desire to continue with the wishes of their late husband:

Client E: “Well, I always say my husband was carried out of here, not in this house mind, at the bottom house. I said I will be carried out of the village as well. I only hope, I shouldn’t say it because they are well looked after in the homes, bless their hearts.”

Client N: “My husband bought this house for us both you know.”

Client L: “We bought a little house at Bardon Mill, then we bought this house here.....And err, I was married fifty-two years and John’s been dead ten year, that’s him there with his horse (*points to photograph*) he liked his horses.”

This finding suggests that choices in the present can be influenced by a sense of love and responsibility towards people who are no longer here. Coleman, Ivani-Chalian and Robinson (1998), in their longitudinal study of older people, also found respondents expressed a wish to live according to the wishes of deceased partners and the authors attributed this to a strategy of family continuation to preserve a coherent self-identity.

For some participants, their choice to remain at home was expressed in the form of a thread running throughout the transcript that re-iterates their belief that they can and should remain at home. This repetition portrays a sense that they are saying, ‘I know what you might think but this is my point of view’; very much the storyteller of the narrative ‘holding their own’ (Frank, 2009), which would imply that they are aware of the challenges facing older people who wish to remain in their own home. For client N, the following comments are dispersed throughout her narrative:

“I’m quite happy living here.”

“Well, I’m used to being on my own.”

“I’m happy to stay at home.”

“I’m not frightened of being on my own.”

“Well, I’m quite happy where I am.”

Similarly for client L:

“Oh I love it here because I know everyone.”

“Oh, I’m well looked after.”

“I am content, I think, I have a lovely life. I know I’m on my own but I enjoy reading and television and people coming in.”

“I just managed, I’m very independent.”

“My mother was ninety-five when she died, never been in hospital, just like me she was well looked after.”

These findings support the view that given the choice, participants would prefer to remain living at home; this is unsurprising given the sense of continuity and emotional attachment their home has as outlined in ‘A sense of place’. However some participants also express a philosophical attitude to the future and they are not completely resistant to moving, as illustrated by Client L:

“I’m quite prepared to go into a nursing home if I had to.”

Her philosophical attitude is expressed in other comments:

“Sometimes you wish you could go (*to the shops*), but it doesn’t bother me.”

“It’s hard on her, it is sad but it’s life (*referring to sister-in-law whose family all live in Australia*).”

Similarly Client G expressed an almost acquiescent attitude:

“I mean if anything befalls you, well it’s got to happen sooner or later.”

“It’s a bit sad but it happens.”

“I think it’s just your attitude. Some people say they could never live in this or never live in that, but it’s just their own attitude, they could if they had to do it.”

This type of response was also a finding of Wiles et al (2009) who described the way that some of their participants gave an accepting response which they described as both/and – acknowledging sadness or loss plus a comment about coping with it. Wiles et al (2009) questioned what gives people the personal resources to have such an attitude. Although participants in this study who exhibited such an attitude greatly valued their home and wished to remain there, they seem to demonstrate a confidence in their sense of self from other avenues to know that it could survive a relocation. Client G had strong narratives to tell about his love of the natural environment, his working life and his inherent belief in the goodness of people; Client L had a very strong narrative about her past and present family network. How people respond to the requirement to demonstrate ‘agency’ and make choices depends on the personal resources they draw on at that particular time; where agency and identity are seen not as discrete entities but rather practices of lifelong activity (Ermarth, 2001).

Summary

Although at a superficial level most participants do not relate the concept of choice to social care, detailed theoretical analysis of narratives reveals that choice is related to social care, not as a rationalist one off event but as an ongoing negotiated process. Participants’ choices in relation to social care are bound up with individual and cultural expectations as well as the interpersonal context in which they are framed. The specifically rural qualities of stoicism and self-sufficiency undoubtedly influence social care choices for participants in this study, but these qualities can comfortably co-exist with apparent passivity or resignation; indicative of the non-rationalist or postmodern understanding of agency which is evidenced in this study.

For most participants, remaining in their own home against the odds is the very embodiment of choice, because it provides an element of continuity in their personal identity. However, even with this expressed wish, some participants have a philosophical attitude which leaves them open to the possibility of moving; this seems to be subject to other personal resources which participants can draw upon to enhance and maintain their personal identity in the face of change.

Findings: Recurring theoretical influences

Whilst in this type of research it is crucial to retain the detail presented in the findings, synthesis of key elements is a helpful pre-cursor to the development of research implications. From the findings there are three key theoretical concepts or factors that recur throughout all sections and play a significant role in the way participants experience and interpret their lives; they are narrative identity, relationships and personal resources.

Narrative identity

It is apparent from the findings that participants have a personal identity formed from their life history and still under ongoing formulation. Like many of our current generation of older people, participants have experienced hardship throughout their lives and this has contributed to a personal identity including elements of stoicism and 'independence'. This identity influences their attitude and expectations relating to social care and the choices made therein. Participants' rural location also forms a constituent part of this identity; this can either be through an accumulated time-depth of where they live, or through the narrative of a life-changing move. Either route closely links personal identity with an attachment to place. This narrative identity is not however simply a linear biography, it is an active process of re-configuration and re-telling in which the older person strives to maintain coherence and continuity in the face of life's challenges. At any given time this personal identity that is articulated by participants, may hold within it apparently contradictory qualities or paradox, reflecting the postmodern or non-rationalist conceptualisation that is evidenced in this study.

Relationships

Foremost among strategies which can not only sustain, but enhance personal identity, are the relationships formed within a network of care and responsibility. These relationships form the second influential feature that occurs throughout the findings. Relationships that participants have with family in particular, but also to some extent neighbours seem to be founded upon a mutual expectation of care and support. This aspect of the relationship can bolster personal narratives of independence for all

concerned and delay requests for formal social care assistance. This inherent nature of the relationships with friends and neighbours can also however be seen as the bedrock of the rural community spirit that is evidenced in the findings.

Participants' narratives suggest that the nature of their social care experience is to a significant degree contingent upon the relationship they have with their care manager. When this relationship is founded upon honesty and trust, service users and their carers are less likely to perceive securing care as a struggle and more likely to have faith in the service as a whole. The inherent qualities of relationships established with formal carers can be seen to influence, not only participants' social care experience, but also their personal identity. When relationships with carers have elements of mutual commitment and reciprocity, the participants' active role helps enhance authenticity and agency in their personal narratives. The familiarity and continuity of these relationships maintains participants' crucial sense of place, through the ongoing connection they allow with people and places now physically out of reach.

Personal resources

The personal resources that participants have are those aspects of their life which they can draw upon to sustain and enhance a coherent sense of identity and subsequent positive wellbeing. Relationships with family, friends and professionals as discussed above form one crucial element of those resources. Findings suggest that these relationships can influence the way that participants respond to the challenges associated with ageing and are a significant resource in enabling people to remain in their own home with a sense of autonomy and agency.

The other significant personal resource from this study is the close attachment and high regard that participants have for their rural location. Specific qualities of that location may have varying degrees of significance as a personal resource for individual participants. For some, the aesthetics of the natural environment is a crucial part of their rural identity, while for others the peace and quiet strengthens their attachment. For long-term rural dwellers their attachment to place is reflected in a profound sense of history and familiarity with their environment; this gives their personal narratives continuity in the face of change and constitutes meaning to their

present sense of place. For those participants who have re-located, the risks and challenges that this move entailed mean that process itself forms a personal resource which strengthens their attachment to their present location.

Practical features of the rural community highlighted in the findings, such as the church, the voluntary sector and good neighbours, form important personal as well material resources for participants as they are concerned with emotional, spiritual and moral dimensions of existence. The term 'social space' however is a personal resource by its very nature beyond the bounds of physicality; it refers to the way that participants evidently remain connected to people and places beyond the bounds of practical and temporal limitations. Although social space is a personal and psychological resource, the findings reveal that it relies on engagement with others to be nurtured and enhanced.

Introduction to implications

The findings have articulated and interpreted the narratives of a group of rural older people who use social care. In keeping with the aims of the research, participants' understanding of rural living, social care and choice have been explored in depth; this has revealed the complex way in which these three dimensions of life are not only interconnected but are profoundly influential upon their personal sense of well-being. In order for these findings to have credence it is important to discuss their potential significance within the fields of social care and gerontology. For the purposes of clarity and consistency with the aims of the research this chapter discusses the implications of the research in three specific sections relating to practice, policy and theory. However, it is important to recognise that the three sections are intimately connected and all are underscored by the recurring theoretical influences identified in the findings. Throughout the research the meaning and experience of rural older people is central and the implications chapter is no exception; the aspiration is to utilise the findings to guide practitioners, policy makers and academics to better understand and consequently improve the social care experience.

In discussing the practice implications of the findings it is important to move beyond the practical problems of delivering services in rural areas and explore the personal impact of the social care service. For practitioners, recognising the complex and contradictory nature of personal identity is paramount in order that planned interventions maintain and enhance coherence and continuity in this dimension of self. This section therefore identifies specific personal and interpersonal resources of rural older people which bolster identity in the face of challenges associated with the need for social care.

From a policy perspective, the discussion can be seen as a mutual exchange of implications. On the one hand specific aspects of the findings are drawn upon to highlight the impact of existing social care policy upon rural older people, on the other hand, the findings are developed and discussed to suggest how policy might better accommodate the particularity of rural ageing. This section maintains the themes that were identified as important for practitioners and advocates policy

strategies that can work with and not against the personal narratives of rural older people, their carers and their community.

The aims of the research set out to explore the meaning and experiences of rural older people who use social care, with specific reference to choice and the final section of the implications chapter brings the key conceptual frames of reference together into a theoretical framework. The findings have revealed that identity is at the core of older people's interpretation of events and experiences and the theoretical implications section builds upon this supposition. The non-rationalist, postmodern understanding of identity that is exposed is related to a lived and unbounded sense of place that refutes any assumptions of geographical uniformity. Such an understanding of identity is in stark contrast to the unencumbered self at the heart of current social care policy; this postmodern view of identity facilitates the development of a non-rationalist theoretical model of choice in social care which is more pertinent to the lives of rural older people.

Practice implications

For practitioners working in social care the findings from this research can be seen to have implications in three main areas; the attachment to place that rural older people have and how this impacts on their response to social care intervention, the importance of recognising the personal resources of this group of people and the role of the professional/service user relationship in the social care experience.

Attachment to place

All of the participants recounted a strong attachment to their current location; either because of the enduring sense of history they have or the emotional investment established through relocation. The implications of this for practitioners can be perceived at the level of service delivery and at that of therapeutic intervention. From the perspective of social care service delivery, it is clear from this and other similar studies that many rural older people will endure hardship and neglect with an attitude of fortitude and stoicism because of their attachment to their geographical location. There is evidence that this translates, not only into lower expectations from social care services than their urban counterparts, but also an expression of gratitude and satisfaction regarding any services offered. From the literature which outlines the acute problems of delivering social care services in rural areas, it is open to question whether such service users are actually being realistic rather than self-effacing, but the crucial implication for practitioners is to be aware of this attitude when assessing for and arranging social care services. It is important to recognise the low threshold which may lie beneath expressions of gratitude or coping and explore in detail with rural older people and their carers the potential opportunities for support. In doing so however, there is a delicate balance to be struck between practical service delivery and therapeutic intervention.

The evidence is clear that rural older people maintain their sense of identity through the meaning they assign to their immediate and wider environment and this must be worked with, not against, in negotiating the path to support services. The meaning assigned to the immediate environment i.e., the home, is particularly important for occupational therapists to consider when proposing changes to the home through equipment or alterations. Participants in this study described episodes in their lives

which brought their thoughts and feelings about 'place' to a much more conscious level than the usual everyday familiarity; this process is closely linked to changes in one's personal identity (Manzo, 1994; Manzo, 2003) and for these participants this was often linked to changes in health and mobility. Changes to the home environment therefore are not simply practical solutions, but can involve a process of re-configuring one's personal identity. It is apparent from participants in this study that rural older people are able to accommodate quite significant changes to their home and even relocate in order to continue living in a location that sits comfortably with their personal identity. Practitioners need to recognise the meaning that older people attach to their immediate environment in maintaining their identity, but also the way that their wider environment can be an important resource to help them maintain continuity in their identity in the face of changes. The degree of importance given to either environment in the face of challenges associated with the need for social care support will depend upon the other personal resources that the older person is able to draw on at that time.

Personal resources

Listening to the stories or narratives of older people can give practitioners insight into the personal resources which they possess; such an understanding will ensure that any intervention helps to maintain their coherent sense of identity. From analysis of the narratives in this study it is possible to suggest three key resources, other than their attachment to place, which help older people maintain a sense of continuity in their personal identity. For participants in this study, their appreciation of the natural environment can be regarded as part of their attachment to their rural location. However, when viewed in conjunction with other research and literature, this connection with the natural environment should be seen as potentially a personal resource that can give confidence and resilience to some people's identity. Although all of the participants in this study were largely confined to the home, many of them articulated the value they secured from views of wildlife and countryside; other research suggests that this is not a purely rural phenomenon and the aesthetics of the natural environment can have potentially therapeutic effects for people confined indoors. This clearly has implications for practitioners such as occupational therapists who have a significant role to play in the configuration of older people's immediate environment; but all social care practitioners need to recognise that for some older

people this connection with nature is a personal resource that can help them maintain their identity through periods of change.

For rural older people, still having the sight and sound of the natural environment can be regarded as them remaining connected to a place which they value, but are no longer able to physically access, reflecting the 'elastic' nature of what Wiles et al (2009) refer to as 'social space'. Practitioners need to acknowledge the fluid nature of older people's personal resource of social space, in particular the manner in which it can expand through recollection or imagination, even when their material and social world would appear to be diminishing. Evidence from this study suggests that one way in which older people play an active role in maintaining or expanding their social space is through the interactions they have with carers in their home; this not only enables them to remain connected with familiar people and places, but also introduces them to a new social dimension concerning the lives of the carers. Practitioners need to recognise that when social care services are required some older people maintain coherence and continuity in their personal identity through assimilating the service into their social space. This implies firstly, that a task-orientated approach to assessment and provision is too narrow and secondly, that local service changes and restructuring can have major implications for the well-being of older service users. Some participants in this study recount a detailed recollection of geographical locations and the meaning attached to them to maintain their social space. Practitioners need to consider the implication from this that older people must be given the opportunity to articulate this narrative if they are to maintain their sense of connection to their wider environment.

An older person's previous life experience forms the third aspect of personal resources implicated by this study into social care practice. Although the methodology of this study was not designed to reveal detailed life histories of the participants, they do recount episodes in their lives when they have taken significant risks, successfully overcome challenges and dealt with material hardship. Such experiences can be seen to contribute towards an expressed self-identity that contains elements of fortitude and independence; articulated in such phrases as 'keep going', 'push on', 'I've always been independent'. For one participant in particular who had an unusual and adventurous life history, her connection with the past seems to give her confidence in managing

her own affairs in relation to social care. Many of the other older people in this study are comfortable to hand over control of some aspects of their lives i.e., relating to the practical management of social care, but they maintain coherence in their identity and their sense of ‘independence’ through their connection with the past. For some participants, this link between the past and the present is reflected in their wish to live their lives in accordance with the wishes of deceased loved ones. These findings are consistent with other research which confirms that an older person’s connection with the past can create a personal resource to help them deal with challenges in later life (Carstenson, Hanson and Freund, 1995; Danneffer and Uhlenberg, 1999; Conway, 2000). Practitioners need to be aware of the complex and potentially contradictory nature of identity if they are to support older people to maintain coherence and continuity to this vital element of well-being. Practitioners must also consistently keep in mind that older people have a long and varied personal history which can influence the way in which they deal with challenges and changes associated with the need for social care; the level of support and type of professional relationship they require must be tailored accordingly.

Professional relationship and role

Although the amount of emotional and practical support that older people require will vary according to their own personal resources, this research highlights aspects of the professional relationship and role which are crucial in the effective assessment and delivery of the social care service. For most of the participants it is clear that the care manager plays an important role in protecting the service user from the time consuming and stressful task of arranging social care in rural areas; this is particularly pertinent when looked at alongside the finding that the need for social care is always triggered by a crisis. The implication of this may be unsettling for some, but it is that despite the current social care drive to give individual choice and responsibility to all service users, social care practitioners have a professional duty to carry some of that burden and act as a buffer between the service user and the social care market. This requires professional judgement and a delicate balance, as the assertion is certainly not that service users and/or carers should be ill-informed, indeed information and honesty are revealed by this study as key aspects of a successful care management relationship.

Perhaps the most disappointing finding from this study is the poor experience that two participants recounted of individual care managers, but lessons can be learned from this about how the care manager should relate to service users to meet desired goals. The problems recounted by the people who were not happy with specific care managers related to unresponsiveness, poor communication and a lack of appropriate information; this can be contrasted with most of the respondents and their carers who had a relationship of honesty and trust with their care managers. This finding supports other evidence which has outlined the importance of mutual understanding, trust and honesty in the social care assessment, to ensure that the intervention is in keeping with the service users own goals (Cole and McLean, 2003; Foster et al, 2006; Palmadottir, 2006). This research suggests that the implication of the relationship with the care manager stretches beyond the specific assessment under consideration. Participants who had experienced a poor relationship with their care manager also expressed a general lack of faith in the social care service to meet future needs; while those who had a positive relationship were all optimistic that future needs would readily be met. This implication may be particularly acutely felt in rural areas where people already have low expectations and under-utilisation of social care services, such a bad experience could readily deter them from seeking more help when it is required.

For some participants building up a relationship of trust with the care manager is facilitated by the length of time they have been involved; continuity of professional has been recognised elsewhere as important to older people (DoH, 2005) and such a view is supported by this research. Recent changes to local services delivery models in social care make it very difficult to maintain continuity of professional for service users; however this study demonstrates that Northumberland has successfully achieved this goal for older people in rural areas and it would be reprehensible to discard this aspect in favour of ideologically driven re-organisations. The impact of local re-organisations can be seen from this study to cause fear and anxiety for some service users and this highlights the important role that practitioners have in giving information and reassurance about proposed changes; this is not an easy responsibility to fulfil when practitioners themselves may face uncertainty and anxiety. Like the service users they work with, social care practitioners value continuity and security in their day-to-day role, these qualities are not readily forthcoming in the context of the

constant change that is modern health and social care. If they are to provide the support, re-assurance, information and honesty that constitutes competence in their relationship with older people, social care practitioners have a professional responsibility to seek out their own support and continuity through peer support and professional development.

Policy implications

There are three aspects of the findings which have a direct bearing on social care policy for older people. The first is the inevitable crisis situation which seems to trigger the social care journey; evidence from this study is used to suggest approaches to policy which could lead to a less traumatic introduction to social care. The second aspect is the specifically rural dimension to growing older; the way the inherent qualities of this impact upon relevant policy is discussed. Finally, the findings from this study relating to choice and control in social care are applied to that corresponding policy area; the implications of a gerontological and rural focus on this key Government platform are discussed.

How to avoid crisis intervention

One of the most striking and surprising findings of this research was the impact of the Hospital Discharges Act (DoH, 2003c) on older people's social care experience; this serves to highlight the power of a statutory obligation to do something and how this can have wider implications than its original remit. This piece of legislation was intended to prevent 'bed blocking', through the introduction of financial penalties on local authorities who failed to facilitate appropriate and timely discharge. It seems to have become a crucial mechanism in the setting up of appropriate social care support for older people and their carers, because of the resultant joint framework that had to be created between hospitals and social care departments. The power of legislation can be starkly contrasted with any number of older people's strategies and guidance documents concerning older people's rights to respect and dignity which have had, in some cases, no effect whatsoever on the standard of care they receive. It also highlights the difference between a duty to act, with financial penalties incurred through non-compliance, and a duty to assess, when it is compared with another piece of legislation which impacts on the findings in this study. Carers legislative recognition and entitlement is underpinned by The Carers Act (DoH, 1995), this places no statutory obligation on local authorities to provide services to carers, merely to assess the need when requested to do so; this may go some way towards explaining why the carers in this study struggled in their role sometimes for many years without formal support. Informal carers in this study typically struggled on in their role until a

crisis was reached resulting in a hospital admission and then ironically, the Hospital Discharges Act came to the fore. This is not to assert a raft of legislation relating to social care for older people, but to point out that legislation does have far more power to change behaviour than policy guidance and strategy documents; this power can also sometimes stretch beyond the specific remit of the Act concerned.

The Hospital Discharges Act was clearly crucial for the participants in this study because their social care journey always began with a crisis; this finding is not uncommon and typifies the reactive rather than pro-active nature of social care for older people. Such a feature has not been lost on policy makers and a number of initiatives have been founded with the specific aim of preventing such crises occurring, for example housing-based solutions such as Home Improvement Agencies, intermediate care and rehabilitation programmes such as Falls Prevention Teams and the Supporting People Initiative. The evidence from this study raises the question of the efficacy of such programmes when older people seem to have an almost an unshakable self-belief and inherent desire to ‘struggle on’ in the face of adversity. Detailed analysis of the findings reveals two crucial factors which lead to the crisis situation for people in this study and which need to be considered in social care policy; firstly, the personal narrative or identity of the service users and their carers and secondly, the rural location in which they are situated.

All of the participants in this study and most of the carers were over the age of sixty-five, the majority were considerably older than this and they all form part a generation who have witnessed vast changes in material comforts over their lifetime. As articulately expressed by one participant (client M), these changes have been more pronounced for people living in remote, rural areas and the experiences they have had form a constituent part of their current identity. It is therefore unsurprising that they retain an attitude of ‘making do’ and a mutual expectation of family support; there is an inherent awareness of resource implications and not wanting anything ‘unnecessarily’. Despite this, the evidence suggests that people can successfully reconfigure their personal narratives to incorporate receiving help, either as a service user or carer, once they have been through the crisis which triggers social care services. The question for policy makers is how to work with existing personal narratives to provide support in a timely fashion, before the crisis which can be very

distressing for all concerned. One way to do this is to allay people's fears through appropriate information given in a useful format for potential users of social care. There is evidence from this study of narrators 'holding their own', with regards to staying in their own home and this articulates a fear of, or resistance against, going into a care home. Although it may seem absurd to policy makers and practitioners alike, older people do still make a connection between social care and going into 'a home' and policy makers seem to have leapfrogged over that issue in the race to provide personal choice.

A second way to work with existing personal narratives is through addressing local need. Evidence from this study indicates that the rural location may contribute to the development of a crisis in relation to social care, but the process is not a straightforward causal link with the much talked about 'lack of resources in rural areas'. This study is consistent with other research in suggesting that the expectation of informal familial care may be intensified in rural areas and this would inevitably lead to service users and carers delaying any request for formal assistance. It is open to debate how far this culture is due to a pre-existing lack of resources, but the findings from this study present a conflicting picture in relation to resource provision. There is evidence that respondents are aware of dwindling local resources, which reflects the national picture of closure of shops, post offices etc., but they also talk of the flexibility and creativity of some rural providers to endeavour to provide a service. When this service level creativity is combined with support provided from neighbours, it is perhaps understandable that people feel no need to turn to formal support services until a crisis occurs. The challenge of social care policy is to utilise, but not exploit, existing care networks, so that formal support can be gradually introduced in a manner consistent with the personal narratives of service users and carers. The only way to expressly focus social care policy on local needs in this way is to articulate what is meant by the rural dimension of older people's needs.

Rural dimension to ageing

There are two critical aspects of rural ageing revealed by this study which impact on social care policy; the out-migration of people from urban to rural areas and the qualitative attachment that people have to their rural location. A sub-group of participants in this study had moved out to a rural area on retirement for a better

quality of life and evidence suggests such people will become more prevalent in the future. This form of migration will therefore increasingly impact upon social care service delivery and the findings suggest there are subtle changes in the needs and expectations of this group of older people. Having already highlighted the important role of family in rural care provision, the most crucial difference of this group is that they tend not to have close family nearby and this factor impacts on the type of social care support they require. Although the evidence does not suggest they receive quantitatively more care than long-term rural dwellers, this perhaps being a reflection of the increasingly tightened and standardised eligibility criteria in social care, they do appear to have qualitatively different needs. These participants tended to rely greatly on either a formal carer or their care manager for emotional support, in addition to the practical and social support that one would expect. This questions the relevance of a social care policy which is founded upon principles of market economics; accommodation needs to be made within the policy for the emotional dimension of social care support. Such accommodation would include a move away from the prevailing focus on self-sufficiency in social care policy, with an expressly articulated recognition that social care is underpinned by human relationships.

The expectations of the older people who have moved out to rural areas are complex and in many ways actually serve to reinforce the particularity of rural social care. It has been suggested that retirement migrants are part of a wider mobility culture that value a high level of personal mobility (Stockdale, 2006). Such participants in this study were indeed more acutely aware of access and transport problems relating to their rural location, when compared to the long-term rural residents. However, surprisingly they did not necessarily relate these access problems to any difficulties they may have had securing or maintaining social care; the huge emotional investment they have made in moving to a rural area seems to diminish any possible negative attributes of their location. In this way although out-migrants do have some qualitatively different needs, they appear to have practical expectations which are very similar to long-term rural dwellers, raising doubts about the value of a social care policy predicated on geographical uniformity.

The theoretical implications of the strong attachment that all participants have to their rural location are examined in the appropriate section; there are a number of features

inherent in these attachments which have specific relevance to social care policy. Participants in this and other similar rural studies present with an attitude of self-sufficiency, stoicism and low expectations, which would appear to sit comfortably with the current social policy drive towards 'independence' for older people. However, close examination reveals that the self-sufficiency of rural older people is at the level of the community, not the individual, and is underpinned by a web of social and practical support. Family provide intense emotional support for long-term rural dwellers, but evidence suggests that neighbours, as well as private, statutory and voluntary organisations, all contribute towards enabling rural older people to continue living at home. Delivering social care services in rural areas is undoubtedly problematic, and trying to implement a policy based around the individual as consumer in these locations could be regarded as absurd. Without wishing to undermine the importance of person-centred care at a practitioner level, it is apparent that social care policy could pay greater attention to the wider network of support which enables rural older people to 'age-in-place'. This could involve greater statutory support for informal carers, whether they are family, friends or neighbours, and recognition in policy that rural service providers from all sectors can play a vital role in contributing to social care for older people.

Formal carers play an important role in maintaining the strong attachment to their rural location which participants in this study expressed; understanding the way that rural carers perform this role may lead to lessons being learned for wider social care policy. Within this study, formal carers are a vital source of information about familiar people and places, which helps to keep the participants connected with their local environment and social network. This process is facilitated by the carers themselves becoming part of the participants' social networks, through the relationships developing into genuine friendships founded on mutual care and concern. This reciprocal nature of formal care relationships in rural areas has been evidenced elsewhere and may explain why some participants expressed the view that such relationships are qualitatively better in rural areas when compared to urban. A key contributory factor in this success seems to be the continuity and longevity of care staff which leads to familiarity and security for service users. It is possible to speculate why rural areas are able to retain social care staff, for example, limited other employment opportunities, smaller caseloads and social care staff wishing to continue

living and working in ‘desirable’ locations, but specific research into this phenomenon is needed so that social care policy can implement strategies to support the retention of social care staff in all locations.

Participants’ attachments to their rural location undoubtedly stretches beyond the boundaries of their home environment, to include familiar geographical landmarks, the aesthetics and peace and quiet of the countryside; indeed it is apparent that they are often prepared to accommodate significant changes to their home and even a local relocation in order to remain in their desired location. Such an attachment has major implications when rural older people require residential or nursing care; within the policy of ‘free choice’ for those who have the resources to pay, no allowance is made for geographical attachment. Rural land is at a premium and rural care homes are therefore not only rare, but also more likely to be expensive i.e., above the contracted local authority rate. Rural older people without the resources to self-fund or family to pay a top-up would therefore be required to re-locate to a care home which could be many miles from their established home. Social care policy therefore needs to make allowances for this specifically rural phenomenon, to enable rural older people to maintain their place attachment when they are required to ‘choose’ a care home.

Choice and control

The concepts of choice and control are at the heart of current social care policy and the ideology underpinning this has been critiqued in detail. Exploring these concepts in this research leads to policy recommendations in the areas of policy rhetoric and performance indicators. It is apparent from this research that the choices older people make in relation to social care are not one-off events but they are complex negotiations between needs, expectations and responsibilities of care and concern for others; the requirement to make such choices is also intensified at times of acute personal crisis. It is therefore unsurprising that older people often feel most comfortable having practical and emotional support to help them make the choices required and they do not always wish to retain complete control in this area of their lives. This would suggest that in many cases older people require more than simply a ‘broker’ to negotiate the complexities of the social care market; they may require continuous professional support from someone who understands their needs and expectations. This appears to be particularly important in rural areas where it is

recognised that older people have low expectations which translate into under-utilisation of social care services. There consequently needs to be a move away from the idea in social care policy that choice and control are qualities which service users either possess or they do not, with the subsequent drive through the use of legislation and performance indicators to ensure that they are qualities which are indeed possessed by all. An explicit acknowledgement is required of the varying degrees of choice and control which people may wish to have at different times along the social care journey and the commensurate level of support they may require.

Direct payments can be seen as the forerunner to individual budgets and the legal materialisation of ‘choice and control’, it is therefore important to discuss any implications of this research on this specific policy area. The fact that only one participant in this study was in receipt of a direct payment can be seen to reflect the general picture that older people who use social care have a low uptake of direct payments. This low uptake has led the Government to introduce increasingly ambitious performance indicators for local authorities to persuade older people to have more choice and control; the findings from this research highlight the futility of imposing inappropriate performance targets. Even the one participant who did use a direct payment to arrange his care had major problems securing the care he needed, reflecting the general fallacy that market choice can be a reality for service users in rural areas. It would appear from this study that lessons in arranging social care can be learned from those who provide existing services in rural areas, whether they are voluntary, private or spiritual; where there are no economies of scale the emphasis is on flexibility and a personal approach.

Not only do rural market conditions render the choice envisaged in cash alternatives to care elusive, but the majority of participants in this study deem the application of such a purchasing-based model to social care erroneous. It is pertinent that the only participant to utilise a direct payment was quite certain that it gave him the level of choice and control he desired. This is in keeping with evaluative studies of direct payment use, and reinforces the position that services users need, and want, different degrees of choice and control in relation to social care. The apparent success therefore, of cash in lieu of services, should not lead to a blanket approach in social care policy, which in effect enforces a high degree of choice and control upon people

who may not be in a position to utilise it. Social care policy should place less trust in performance indicators, and more faith in social care staff working in partnership with service users, to recognise the degree of choice and control that is appropriate for each individual.

Theoretical implications

From a gerontological perspective, the findings from this research suggest that rural older people who use social care are actually coming to terms with the ‘postmodern condition’ better than most of us. The main basis to this assertion is that for this group of people, far from being a tool of the modern consumer, ‘choice’ is actually an ongoing and negotiated process, which takes place within the context of narrative re-configuration of one’s identity. Success in re-creating one’s identity is contingent upon utilising powerful personal resources, prime amongst which for rural older people is their attachment to place. This assertion brings together the three key theoretical concepts of place, identity and choice; this connection will become more apparent as the way in which the findings impact upon the theoretical understanding of each concept is discussed in turn.

Place

Regardless of whether rural older people have lived in their current location all of their lives or whether they relocated around the time of retirement, the attachment they have to their geographic location is underpinned by a strong emotional investment. In this way, they are all choosing to live in a place that is congruent with their self-identity, but this is based on an understanding of place which can be described as postmodern, in theoretical terms, because it is not defined by traditional boundaries and holds inherently paradoxical qualities. The meaning of place for this group of people gives a steadfast thread of continuity and familiarity to their lives, but it is also imbued with fluid and dynamic qualities because their sense of place is situated within a kaleidoscope of social relationships.

It is quite clear from some of the narratives recounted in this study, that the continuity and familiarity place offers, comes from a depth of meaning that only time can create, reflecting Rowles’ (1993, p.67) description of “time depth” to articulate the temporal dimension of ageing-in-place. But this is certainly not a passive process; while participants may indeed have a ‘mental map’ of familiar landmarks and a detailed knowledge of childhood friends, they have assigned meaning and emotional attachment to these features in order to reinforce their current rural identity. This is in

keeping with theoretical understandings of place which emphasise the dynamic way that the past informs the present (Massey, 1992; Cutchin, 2008). Participants who have relocated exhibit a similar connection with the past in the context of their present location; their current home is perceived as a transitional marker in that life-changing decision and forms part of the emotional narrative that connects them to their rural location.

The strategy of reinforcing an attachment to a desired place through memories of people and places can be regarded as maintaining what Wiles et al (2009) refer to as 'social space', to denote the flexible connection to people and places which stretches beyond the bounds of physical and practical limitations. Their use of this term, 'social space', echoes that of the philosopher Henri Lefebvre who recognised that social spaces are "not things, which have mutually limiting boundaries" but they "attain a real existence by virtue of networks and pathways, by virtue of bunches or clusters of relationships" (Lefebvre, 1991, p.86). In his seminal work, 'The Production of Space', Lefebvre (1991) set out to criticise the binary notions of spatiality and introduce an understanding of place that is lived, practiced and inhabited. The narratives recounted by participants in this study do imply such a dynamic and social interpretation of place which can be reinforced by their social care experience; formal carers maintain and sometimes expand connections to people and places which are beyond the bounds of practical expectations. This theoretical notion of place has methodological implications for geographical gerontological research; Lefebvre (1991) suggests that we should be concerned with a 'sense' of place, a directly lived movement and "nothing that even remotely resembles a system" (p.423). It follows that the meaning of place for older people can only be understood by listening to their narratives and situating their experiences within their past and present relationships; it also follows that the strength of attachment to place may vary according to circumstances and social networks. Older people's understanding of place is a dynamic and interactive concept, and their attachment to place is an important personal resource, which they draw upon to maintain coherence and continuity in their personal identity. Other personal resources such as memories, family relationships, aesthetics of nature, peace and quiet, may indeed strengthen an older person's attachment to place at any given time, but the relationship is not necessarily contingent, and examining the constituent

qualities of someone's attachment to place could help predict the impact of a potential relocation on their core identity.

The theoretical link between place and identity is brought to the fore most keenly by two aspects of the findings; firstly, through the narratives around 'access' and secondly, in the apparently rural culture of stoicism and self-sufficiency so frequently articulated by participants. Participants' narratives that fall within the theme of 'access' recount episodes in their lives when their understanding of place has been brought to a conscious level; this may be when they have re-located to be nearer facilities, moved to a more suitable property or had alterations to or a reconfiguration of their existing home. These changes are undoubtedly connected to health-related challenges and reflect a time of life when personal identity needs to be reconfigured; this process of constructing and re-constructing identity seems to be effected to some degree through the relationship that participants have with place. This finding is in keeping with a theoretical understanding of our relationship to place which asserts that in the context of our daily lives, we usually relate to it in an unconscious way, indeed, the role of familiarity and habit are crucial elements in what we perceive as our 'sense of place' (Rowles, 1993; Manzo, 2003). However, it is recognised that at times in life when we grapple with our identity or experience significant changes, our feelings about places can come to the forefront of consciousness (Manzo, 2003).

This theoretical interpretation is particularly pertinent to gerontology; it is understood that older people are likely to experience a range of health-related challenges, which increase with age (Pawelec, 2006), and result in their local and immediate environment playing a more significant role than other age groups (Kellaheer, Peace and Holland, 2004; Philips et al, 2005). This suggests that the process of thinking about place consciously in relation to one's personal identity will be more frequent and more intense for older people, than it is for the rest of the population. The findings from this study suggest that the participants have successfully negotiated this process because of the social and emotional support that they have had and because of their strong emotional bond with their geographic locality. However, it is important to consider that the specific selection criteria of this sample would rule out the inclusion of any service users who were either, at the point of crisis when social care is first set up, or psychologically not well enough to participate. The theoretical development

beyond this specific project, of the link between an older person's sense of place and re-configuration of their identity, allows consideration to be given to the level of support which may be required at such potentially psychologically stressful times, when significant changes in health and social care needs arise. Indeed, it also allows for the possibility that for a minority of people, their attachment to place may be such a crucial resource in helping them cope with challenges of ageing, that successful narrative reconfiguration of their identity in the face of relocation may be impossible.

If the above discussion outlines the theoretical relationship between place and identity with a focus on change and redefinition, the expressed rural culture of self-sufficiency and stoicism focuses on recourse to familiarity and continuity, even in the face of practical challenges. Participants in this study exhibited typically rural qualities of self-reliance and low expectations, which are reflected in their expressed gratitude and satisfaction of the social care service, as well as in the service being a strategy of last resort. This aspect of their identity is closely connected with their attachment to their rural location, a bond formed on a foundation of hardship, 'making do' and good neighbourliness. This bond formed with their rural location and rural culture forms such a strong aspect of their identity, that many of the participants need to retain and recount this, even when their material circumstances have altered dramatically and they require care and support with practical daily living tasks. This finding confirms a theoretical link between place and identity, emphasising that older people themselves construct a narrative identity through maintaining major themes in their lives (Coleman, Ivani-Chalian and Robinson, 1998; Philipson and Biggs, 1998; Tanner, 2001). In addition to this, the strong connection to the rural location and rural culture reflects a theoretical understanding that attachments to place can, not only stretch beyond the bounds of the dwelling (Manzo, 2003), but also that such attachments are constructed within a context of wider prevailing discourses (Agnew, 1993; Nikander, 2009; Gregory, 2000).

Identity

The preceding discussion outlining the link between identity and sense of place implies a theoretical understanding of identity that is both constant and changing; this is in keeping with postmodern ideas which give credence to the continually changing core of ourselves which forms our identity (Lyotard, 1984; Brah, 1996; Ermarth,

2001). The findings from this research contribute to the legitimacy of this premise specifically in relation to gerontology in two ways; firstly, through the crucial role that social networks play in participants' lives and secondly, the way that participants use narrative to position themselves in the world.

The findings from this study support other research which has suggested that older people and rural older people in particular, have a strong expectation of care and support from family and neighbours; participants' accounts suggest that this expectation is not only fulfilled in reality, but is also a mutual understanding. This immediately situates rural older people in a web of social support, which sits comfortably with Charles Taylor's postmodern view of identity as embedded in "webs of interlocution" (1992, p.35); however, only by exploring the way in which older people relate to this social network can the theoretical implications be developed. Reciprocity forms a key dimension to all of the relationships discussed and participants are keen to reiterate this aspect in their narratives, whether this is in the mutual expectation of family support, the shared good neighbourliness or the friendships formed with formal carers. This active role that they take in the relationships can be seen to reflect a move from merely 'identity' to a positive self-identity; creative engagement with others has been described as a fundamental component of psychological well-being (Giddens, 1991) and an essential precursor to 'successful ageing' (Wray, 2003). Participants in this study generally refer to themselves as content, satisfied and happy and this leads to the assertion that for older people, a postmodern identity per se is an insufficient antecedent for well-being, a feminist postmodern position is required.

Although some postmodernists would refute the notion of any lingering ideologies such as 'feminism', Bauman himself could be referring to the feminist ethic of care in his assertion that 'being for others' is an essential part of the human condition (1993). In keeping with a postmodern approach to identity, advocates of a 'feminist ethic of care' refute the notion of the unencumbered self in favour of a relational ontology; there is an emphasis on interdependence and mutual vulnerability (Daly and Lewis, 2000; Sevenhuijsen, 2000). The relationships that are described in this study are not simply about 'social support'; they involve reciprocity, care, emotion, responsibility and obligation, which suggest that older people construct their identity within an ethic

of care framework to promote a sense of well-being. Such a framework can help retain core themes to one's identity such as 'independence', family and neighbourhood, because there is an implicit awareness of one's own place in the networks of care and responsibility. Such networks exist across time and space, reflected in respondents' sense of duty or care to deceased loved ones, but also in their sense of 'public responsibility' to consider resource implications and not to accept care unnecessarily. These findings imply that one aspect of the identity of today's older people is a sense of responsibility to the rest of the community and to future generations. One would hope this might be reciprocated by the current and forthcoming population, and the feminist ethic of care is one of the few theoretical frameworks to articulate the intergenerational obligation that underpins social care for older people; there is an acknowledgement that people need different degrees of support at different times of their lives and the giving or receiving of care may be in a 'chain of obligation' (Fine and Glendenning, 2005).

The way that participants situate themselves in this network of care and responsibility helps to maintain coherence in their personal identity and consequently a positive sense of well-being. Findings suggest they achieve this through narrative and this narrative is not simply a 'story' of one's life, but it is a way of positioning oneself in the world and a strategy to successfully negotiate changes and challenges.

Participants' narratives of 'staying at home' clearly reflect the way that preserving continuity and coherence can come from a diverse array of sources (Tanner, 2001), as they draw upon their attachment to place, experiences and relationships both past and present, to construct their narrative of remaining in their own home. However, for some participants these narratives also demonstrate positioning themselves in the world, in a way that they perceive as against the grain, almost as a form of resistance; they are obviously aware of a public discourse or expectation that older people at some point go into care, and they are asserting their position through their narrative that they can, and should, remain at home. This is in keeping with a view of narrative as holding one's own (Frank, 2009), or from a more political standpoint, "a space in which previously oppressed voices are able to find expression and claim their due" (Poiana, 1999, p.99). This theoretical understanding of narrative is clearly an argument in favour of narrative research in gerontology, as a tool to give a political voice to people who may not usually participate in the political sphere.

The way that participants use narrative to negotiate changes and challenges is apparent from the stories they tell about moving house or having their current home altered; the subsequent narrative unifies identity by attaching meaning to experiences that help retain major themes in one's life. Such examples encourage consideration of the integrative function that narrative performs, giving coherence and continuity to one's identity (Ricoeur, 1992; Giddens, 1991). The way in which participants in this study construct narratives implies a theoretical understanding of narrative which is complex; the concept does have biographical qualities, but it also sits in the present, and through its telling helps to affirm aspects of one's identity. This theory of narrative as a work in progress constructed at any given point in time echoes postmodern ideas on identity as a moving nexus (Ermarth, 2001), or nodal point of discourses in practice (Lyotard, 1984). Narrative then is not necessarily the story of one's life, but it can be; Ricoeur (1992) has pointed out that the path of life can weave several plots and recount several stories. It is clear that participants in this study have recounted their narratives for the researcher and this highlights the way that narratives are not only assembled at a given moment in time, but also for a specific situation and sometimes for a specific audience; although narratives are a personal way of making sense of one's life, they can also have discursive or dialogical qualities which implies a requirement of generous listening on behalf of that audience (Holstein and Gubrium, 2000; Frank, 2009).

Choice

The findings from this study are in keeping with an existing body of literature which refutes the notion of a market model of choice in relation to social care. Participants struggled to articulate the relevance of 'choice' to health and social care services and they certainly did not fit the mould of the autonomous, self-sufficient consumer. Rather than trying to impose an irrelevant theoretical model of choice upon service users, it is therefore important to try to establish how choice can be conceptually represented for this group of people in relation to social care. Glendinning (2008) has suggested that for older people who use social care, choice is an ongoing process of negotiation and re-negotiation; this research supports this assertion, but also proposes the dimensions which the negotiation is between and the context in which it takes place.

The theoretical model proposed is discussed at length but can be depicted below in figure 1.

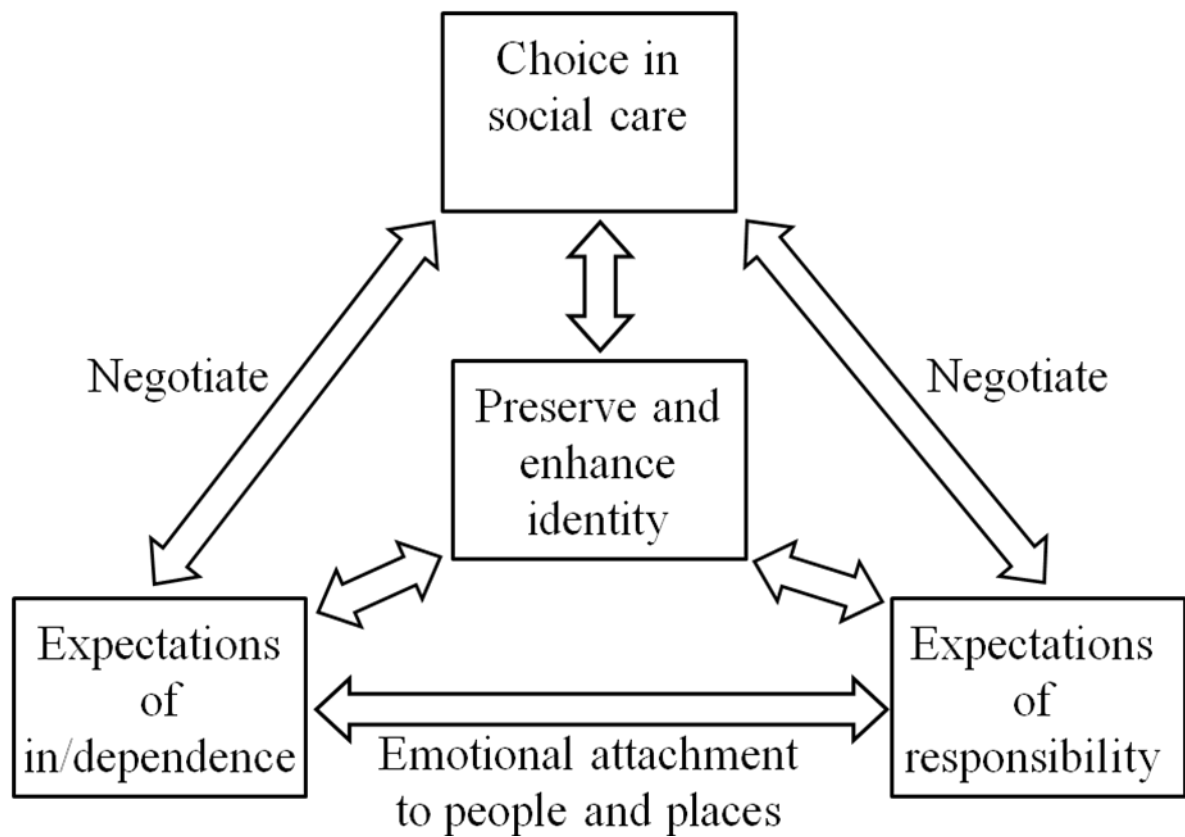


Figure 1 - Choice in social care

Detailed analysis of the findings from this research suggests that older people negotiate and re-negotiate the expectations of themselves and others, when making choices in relation to social care in order to preserve and enhance their identity; the process is not linear but is cyclical and choices made can in turn influence future expectations that they have. This cyclical nature is most starkly illustrated with participants' choice to remain at home; for most of them, this is the only explicit 'choice' they refer to in relation to social care, and as the findings demonstrate, it clearly impacts upon their judgement, expectations and in turn other choices in relation to social care. The home as site of negotiation for older people has been recognised elsewhere; choosing to remain at home can involve negotiating personal expectations about independence in the face of environmental restrictions and personal limitations (Inrie, 2004; Haak et al, 2007). This theoretical model is underpinned by two key categories implied by the findings, they are responsible/not responsible and dependence/independence; although each category is two-sided they are not mutually exclusive. Participants in this study evidently negotiated degrees of responsibility when making choices in relation to social care. This process reflected expectations about their sense of responsibility for themselves, for loved ones both past and present, as well as their public sense of responsibility as members of their community and as citizens.

This idea of choice in social care as a complex negotiation of expectations about responsibilities is supported by Tanner (2001) from a qualitative study of older people requiring social care; they found the acceptability of choices for the older person concerned, relating to social care depended upon expectations of responsibility underpinning existing informal care relationships. Fine and Glendinning (2005), in their sociological analysis of 'care' and 'dependency' refer to delayed or transferred responsibilities to describe the interdependence at the level of community and this is in keeping with the expectations of responsibility that participants' had beyond their immediate and present care network. Hardy et al (1999) in their examination of parameters of choice in social care, illustrate this aspect of the model with the specific example of the transition to residential care. They describe this as usually a fully negotiated choice in their study, where the older person was aware of their main carer's work or family responsibilities, but Hardy et al (1999) report that some service

users felt 'a burden' or a 'nuisance' and this reflects the emotional context of the negotiation they must make as well as the link to their expectations about their own independence or dependence.

Participants' in this study negotiated expectations of their own degree of responsibility with that which they expected from others towards them; for example the phrase "it's not about choice it's about need", reflects an expectation that someone else will take responsibility for certain elements of social care, but it does not mean the participants have relinquished any expectations of their own personal responsibilities. This suggests that older people can have an expectation of themselves as responsible, alongside aspects in which they are not responsible, as they formulate choices in relation to social care.

Participants in this study negotiated their own expectations about degrees of independence versus dependence in relation to the expectations of others, when going through the choice-making process in relation to social care. It is evident that in order to maintain a consistent and coherent personal identity they can make choices which incorporate elements of both; illustrated with the phenomenon aporetically termed 'constructive dependency' in the findings, to encapsulate the way they make a positive choice for someone else to take control of one aspect of their life at any given time. This finding implies that older people can retain an expectation of themselves as 'independent', whilst simultaneously renouncing some aspects of control in their lives which can be equated with 'dependence'.

Secker et al (2003) have also linked choice and independence for older people and they too found that some older people could have a strong reliance on others, whilst possessing a sense of personal independence. Baltes (1996) has argued that for older people, expectations of independence and dependence are not clear cut, but are a negotiation of care giving and receiving; he asserts that perceiving oneself as dependent in one area of life can be an 'optimising strategy' to protect and maximise the use of scarce personal resources in other areas of life that have high personal value. This complex and inherently contradictory explanation of 'choice' does not sit comfortably with the individual agent of modernity that lies at the heart of the Government's vision of choice; the theoretical model of choice outlined is allied with

a non-rationalist and postmodern model of agency that can incorporate paradox and contradiction within it (Hogget, 2001; Ermarth, 2001).

The context in which the negotiations take place gives further credence to the inherently postmodern nature of this theoretical understanding of choice. Negotiation and re-negotiation of expectations when making choices, takes place within a context of emotion; although others have emphasised the interpersonal context of choice in relation to social care e.g., Tanner (2003), findings from this study suggest the context is broader, incorporating an emotional attachment to place as well as relationships with people. The geographical gerontological literature suggests that older people's emotional attachment to their rural location influences when they seek social care support and the subsequent choices they make. Such an attachment can be crucial to preserving a particular aspect of personal identity and can lead to increased personal expectations of independence and self-sufficiency (Heenan, 2006; Parr and Philo, 2003; Innes et al, 2005) but also to heightened expectations of ongoing family responsibility (Shelton and Grundy, 2000; Walters, 2002). A postmodern understanding of choice gives legitimacy to this emotional aspect of choice; agency is perceived as a creative capacity, characterised by irrational and sometimes inexplicable sympathies and loyalties (Bauman, 1993; Wray, 2003).

Limitations of the research

Social care practice takes place within the structural and organisational constraints of financial control, information management, performance targets, standardised documentation and legal parameters. Situated within the NHS, Northumberland Care Trust is also subject to a form of bureaucracy typified by the governing of performance through rules, pre-determined routines and standardised procedures such as clinical pathways and National Service frameworks, (Fish, 1998; Harrison and Smith, 2004; Crinson, 2005). This research was an attempt to explore an area of practice from a radically different paradigm to that which dominates, and its limitations lie within the personal, ambiguous and emotive nature of phenomenological practitioner research.

The nature of practitioner research is that it tends to deal with specific and context dependent problems or situations (Reed and Proctor, 1995). This research set out to explore the meaning and interpretation of a specific group of people to a specific situation and in relation to a specific concept; the findings cannot therefore be generalised to all rural older people or all recipients of social care services. Indeed, because of the specific nature of the group under study, some of the findings may contradict studies with larger and more diverse samples. Phenomenological studies are designed to provide a depth of understanding into personal experience; when combined with other research this can give greater insight into the meaning of the phenomena under investigation (Dahlin-Ivanoff et al, 2007). This study must therefore be recognised as providing in-depth insight into the experiences of rural older people in Northumberland who require social care services, and contributing to the wider body of knowledge relating to rural ageing and social care. Whilst the study is grounded in existing theory and research, the limitations relating to sample size and geographic location must be acknowledged in drawing wider implications.

The sample size and geographic location are limited by the aims of the research and the underpinning philosophy of the research; this guides the use of purposive sampling, the selection criteria and the discursive understanding of terms. The influence of organisational re-structuring and ethical considerations on sample size

and selection has been discussed in the methods section. Through the use of purposive sampling, there is also potential that the sample was selected for other reasons than that laid down in the selection criteria, for example invitees may have held favourable views of care managers, may have been easier to approach, or may have been regarded as particularly responsive or talkative. One would hope that expectations of professional conduct would rule out such diversions from sample selection criteria, but in reality the organisational limitations on the number of potential invitees probably ruled out the possibility of care managers using anything other than the stipulated inclusion criteria.

It is unfortunate that service re-organisations within Northumberland Care Trust limited access to potential research participants within this study, but this limitation serves to highlight that, when carrying out research within the NHS, ethical considerations are paramount and pragmatic considerations are inevitable. As a piece of practitioner research within the NHS this project was subject to rigorous ethical scrutiny and this justifies any limitations that existed for ethical reasons. As part of the professional doctorate programme the research was also subject to close academic supervision which helped to rationalise and justify any pragmatic decisions that had to be made relating to sample size and selection.

As practitioner research, this study is explicitly grounded in professional practice as artistry (Fish and Coles, 1998) which emphasises the moral, creative and uncertain aspects of social care practice. Such an approach can be regarded as inherent to health and social care practitioner research, indeed Reed and Proctor (1995) regard the moral and intrinsically motivated nature of such research as its most important distinguishing feature. The theoretical and methodological underpinnings of this research are also rooted in the interpersonal and dialogical nature of human existence; this limits the research to focus on the older persons' experiences and relationships. While the ideology underpinning the current drive to increase choice in social care has been discussed in depth, the research has not fully addressed the structural and organisational factors that impact upon social care practice and the choices made within that.

As a practitioner, the researcher has, along with her colleagues been professionally and legally obliged to offer choice to service users in day to day practice, for example since 2003 practitioners have been legally obliged to offer direct payments to anyone requiring a social care service; in the prevailing culture of inspection and regulation practitioners are monitored to ensure they fulfil such obligations. This can be seen as an organisational and structural imperative to encourage older people to accept more responsibility for their own care, as the ethos of the direct payment along with the more recent personal budget is that the service user is given cash in lieu of care to arrange their own support. As the organisational division between older people's services and younger people's services was removed in Northumberland, there is clearly an organisational expectation that the degree of personal control and choice is not contingent upon age.

The way in which practitioners interpret such organisational imperatives has not been explored within this research; some would argue that such a perspective could only be fully addressed by research conducted from outside of the organisation, rather than insider practitioner research in which the researcher is subject to pre-existing cultural and organisational practices (Padgett, 1998). It would be futile for an insider practitioner researcher to claim any degree of objectivity, instead such a researcher can only be explicit about the personal and professional goals which motivate the research, as outlined in the section on 'practitioner research', so that a critical eye can evaluate accordingly. Insider practitioner research may struggle to address organisational issues surrounding practice, but its strength lies in its close proximity to the area of practice so that implicit knowledge can be made explicit, invisible stakeholders can be given a voice and a learning culture can be encouraged (Titchen, Butler & Kay, 2001).

Conclusion

The conclusion of the research can be seen as an evaluation or judgement of the project; this not only requires consideration of whether the aims have been met, but also the motivational factors that lay behind those aims. Addressing these motivational factors from a professional, academic and organisational perspective situates the research within its relevant communities giving the reader an opportunity to determine credibility and significance. The implications of the research have been discussed in detail but in the conclusion it is important to give weight to the impact of the project by outlining the possibilities it generates for future research.

Motivational factors behind the research aims

Professional

As a constituent part of the professional doctorate in occupational therapy, the aims of the research were initially motivated by a perceived discrepancy between the Government's vision for social care and day-to-day practice with older people in a rural area. Examination of the literature revealed the importance of situating this apparent conflict within a political and theoretical context. An investigation into the history and ideology of social care, revealed the political liberalism and economic philosophy that underpins the current policy drive to increase choice. This could be starkly contrasted with professional and sociological interpretations of social care, which emphasised the emotional and ethical aspects, paving the way for a more complex understanding of choice. Professional experience had highlighted the challenge of practicing in a rural area and the corresponding literature attributed this challenge essentially to an urban bias of health and social care policy. As a consequence of this critique, locating the findings within social care theory and policy became integral to the aims of the research.

Academic

The academic impetus behind the research must come from gaps in knowledge that have been identified from the relevant literature. Gerontological research and theory situated ageing-in-place within an existential and discursive framework, allied to postmodern understandings of identity. Such postmodern approaches could be seen to

challenge the very structures on which social care policy has been founded, opening up the opportunity to develop theoretical links between ageing-in-place and social care. Although a detailed critique could readily be constructed, from an ideological and sociological perspective, of the Government's interpretation of choice, there was evidently little theoretical analysis of what choice actually means to users of social care. From an empirical perspective, problems associated with providing care in rural areas could be comprehensively identified, however, the personal impact of these problems were not explored. Examples of such research carried out within England were very few, and although other UK and international studies are relevant, differences in policy and legislation heighten the need for studies to be carried out in all areas. Finally, although it was possible in the literature review to highlight the specific features associated with rural ageing, it was not possible from the evidence to explain what underlies the community spirit, stoicism and independence, pointing to the need for a more phenomenological understanding of rural ageing.

Organisational

Northumberland Care Trust was the host organisation for the project and could be seen to drive the recognised need for the research for two reasons. Firstly, the area it covers includes the most sparsely populated region of England, which accentuates the challenges of service delivery in rural areas, and the need to explore what it means to live there. Secondly, Northumberland Care Trust is one of only eight NHS organisations in England to provide social care; it was formed in 2002 to integrate primary health, community health and social care in Northumberland. From an organisational service delivery perspective, this means that social care in Northumberland is subject to, not only local authority scrutiny, but also NHS performance indicators and national imperatives. This intense degree of standardisation and clinical audit leaves little scope for qualitative, let alone phenomenological, research and creates a deficit in avenues of expression for marginalised service users.

Re-visiting the research aims

To explore what it means for older people who use social care to live in a rural area.

Adopting a hermeneutic approach to analysis facilitated detailed interpretation of what it means for the participants to live in a rural area and theoretical contextualisation allowed the findings to be generalised. The findings have revealed that this group of people attach great significance to their rural location. While there are evidently individual differences in which features of rurality are most highly valued, living in a rural area has been shown to be an integral part of personal identity for older people, and a personal resource which they draw upon to deal with the challenges of age and disability. Older people who require social care are potentially vulnerable and isolated; however, detailed analysis of narratives suggests that living in a rural location is perceived by them as being synonymous with a network of care and support.

To explore the concept of ‘choice’ from the point of view of rural older people who use social care.

To access what choice means to this specific group of people the interview guide helped to focus their personal narratives, but conceptual and theoretical analysis of the whole transcripts allowed the meaning of the concept to be explored beyond its immediate term of reference. From the older person’s perspective, it would appear that choice is not a rational, individually executed event, but it is a complex negotiated process situated within relationships both past and present. Narratives relating to the meaning of home and ‘constructive dependency’ in particular, exposed choice as a potent and sophisticated realization of personal agency for this group of people.

To explore the meaning of choice for rural older people who use social care in relation to social care theory and practice.

The meaning of choice for rural older people who use social care was explored in relation to social care theory and practice by situating it in the comprehensive literature review. Participants’ understanding of choice was allied to postmodern understandings of agency, giving credence to emotional and contradictory aspects of

human thought and behaviour; the back and forth analytical process between theory and narrative interpretation led to the development of an original model of choice in relation to social care. Positioning this understanding of choice within social care practice has helped to expose and justify vital qualities of the therapeutic process, such as critical listening, professional judgement and emotional support. The influence of clients' personal resources and identity upon their decision making process in social care was explored in detail in the findings and implications. When related to practice, this highlighted the need for practitioners to recognise and work with these crucial implicit dimensions of choice, so that the degree of professional support in the decision making process can be tailored to enhance, and not undermine, personal identity.

To explore the experience of rural older people who use social care services in relation to national policy.

The chosen methodology encouraged participants to recount their personal experience of the social care journey, this allowed authentic exploration of that experience and development of themes and common narratives which could be compared to relevant policy. It is clear from the findings that the intrinsic qualities of human relationships influence every stage of the social care journey for rural older people; from the mutual expectation of familial support which lead to the inevitable crises, to the ongoing emotional support required by in-migrants who have no family nearby. Such findings seem out of step with the ideology of social care policy that was outlined in the literature review, resting as it does on a model of the unencumbered self. From a wider policy perspective, the research has also highlighted the role of a rural location on the social care experience, and draws attention to problems of national policies being predicated on uniformity of place. Suggestions are therefore made for policy to be given a geographical as well as a gerontological focus.

Possibilities for future research

This research was an unusual synthesis of the academic disciplines of geographical gerontology and social care and through successfully meeting the aims an original perspective has been contributed to each domain. The broad theoretical base and exploratory nature of the research opens up wide-ranging avenues for further

investigation but three legitimate and practicable avenues generated by the research are discussed.

The meaning of rural

This research has identified specific qualities that can be associated with rural living for older people. It is clear that a significant aspect of this rural experience is the interpersonal context in which it is situated; family, carers, neighbours and service providers all contribute to the features that define rural for this group of people. A natural progression from this research would be to seek out the meaning of rural for those people who are part of this network of care and responsibility. This would answer questions concerning staff retention, neighbourliness, familial obligation and flexible service provision, from the perspective of the very people concerned. It is important to understand how and why the qualities that define rural for older people are created for two reasons. Firstly, to ensure that the network of care so highly valued by rural older people does not jeopardise the well-being of another part of the rural community; and secondly, to ensure that those aspects which are mutually beneficial to the rural community are supported and not undermined when services are planned and delivered.

Narrative re-configuration

Narrative re-configuration is a term that has been used elsewhere to explain a psychological coping strategy to illness (Crossley, 2003); however, in this research it refers to the process of creating and recreating one's personal identity. This is acutely touched upon but not explored in depth in the findings relating to 'access'. For older people facing health and mobility problems, access issues come to the forefront of consciousness as part of a complex re-configuration of narrative identity that involves drawing upon existing personal resources. This process warrants exploration in depth, in relation to the practical alterations so often recommended by occupational therapists to facilitate ageing-in-place; there is a need to understand what impact the introduction of physical changes to the home have on personal identity, and what strategies or personal resources people utilise in the associated narrative re-configuration. This would not only help deliver timely and appropriate therapeutic intervention founded on evidence-based practice, but it would also contribute to policy debates concerning ageing-in-place versus specialist housing.

Choice in social care

This research has built on existing understandings of choice in relation to social care and composed a complex theoretical interpretation. This explanation, although grounded in gerontological and social care literature, has been developed from personal narratives of rural older people and it requires critical examination from the perspective of other service users. The concept of choice is such a crucial platform in both health and social care policy that it warrants a specific research focus to allow depth of investigation. This project can be seen as giving a voice to one particular group of service users, and the meaning of choice this revealed was far removed from that found in policy discourse; it is important that the same type of narrative methodology is used to access the personal stories of other service users and make explicit their understandings of choice in social care.

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Appendix 1: Interview guide

Perceptions of rurality

Tell me how you came to be living here?

Tell me what it's like for you living here **now**?

Possible prompts if required:

*What to **you** are the good things about living here?*

*What do **you** see as the disadvantages of living here?*

Can you tell me how it is different from living in a town?

Can you think of anything that would make this a better place to live for **you**?

How do you think where you live might influence the choices that are available to you?

Possible prompt if required:

Some people might think there is limited access to services and facilities, such as shops, doctors, hospitals, leisure centres how do you feel about that?

Some people might think living in a remote area limits their options of, for example what type of house they can live in, what are your thoughts on that?

Can you tell me about the social support that you have, by that I mean the people that you see on a regular basis or perhaps people keeping in touch by 'phone? **LINK TO SOCIAL CARE**

Experience as a service user

Tell me if you can how it came about that you have the carers coming in?

Can you tell me a bit about your thoughts and feelings about the process, when the care was first being set up or when changes have been made?

Possible prompts if required:

What aspects do you think went well?

What aspects do you think did not go well for you?

In what way could things have been better?

Can you tell me about the decisions or choices you have faced throughout the process?

Possible prompts if required:

Can you remember when the care was first set up or changes made what sort of choices you had about what the service was, who came into your home, when they came in, any changes made to your home or equipment supplied, things like that?

Tell me about the help you had in making these decisions?

How do you feel about making (or not making) those choices?

Possible prompts:

*Can you tell me if there were any situations when you did **not** have a choice and you think you should have?*

*Can you tell me if there were any situations when you were **required** to make a choice and you would have preferred not to?*

Thinking about any support that you have **now**, whether that is from carers or other professionals can you say which aspects you value most, *(are most important to you)*?

Thinking about the support you have **now**, can you say if there are any aspects of the service which are not good or get you down?

Thinking about the support you have now, how do you feel about the amount of choice you have?

Possible prompts:

What aspects of the service, if any do you feel you should have more choice over?

Can you tell me about those aspects of the service where you are happy for other people to make the choices?

How do you feel about professionals making choices for you?

How do you feel about carers making choices for you?

How do you feel about family making choices for you?

Thinking about the support you have now, or in the past, can you tell me if there are any ways you think where you live influences the service you get; either in a good way or in a bad way?

If bad:

Can you think of any ways that those things could be improved upon?

Are there any other suggestions you have for improvements to the care you receive?

Is there anything else we haven't covered but you feel is important to include?

Appendix 2: Client information sheet (issued in font 18)

Title: An exploration of 'choice' in relation to social care for older people in a rural area.

First of all let me introduce myself, my name is Audrey Bell and I am an Occupational Therapist with Northumberland Care Trust. I am undertaking some research as part of a Professional Doctorate with Northumbria University. I would like to invite you to take part in this research study. Before you decide it is important that you understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and discuss it with friends or family if you wish. Do not hesitate to contact me if anything is unclear or you would like more information. Please be assured that if you decide to take part, you can withdraw at any time if you change your mind.

What is the purpose of the study?

This study seeks to find out about the thoughts and feelings of older people in rural Northumberland who require care services.

Why am I being invited to take part?

Because you live in a rural area and you have a regular package of care, your thoughts and feelings would make a valuable contribution to this research. You have been invited because I have asked care managers in your area to select older people who live in a rural area, currently have a care package and the support of a care manager. The care managers concerned do not know who eventually decides to take part in the research.

Do I have to take part?

You certainly do not have to take part. It is entirely up to you to decide whether you wish to participate or not. Even if you agree to participate you are free to change your mind at any time and you do not have to give a reason. Your decision to take part does not influence in any way the standard care you receive.

What will happen to me if I take part?

You will be given at least 1 week to read this information and consider the invitation. I will then contact you to see if you wish to meet up to discuss further and possibly participate. If you agree to participate I will remain with you for approximately 1 hr, in which time I will ask just a few questions and allow you to talk freely about the specific issues relating to the research. The interview can take place in your own home, or if you would prefer it to be elsewhere we can discuss alternative arrangements. In order that I can give my full attention to you, I will ask your permission to tape record the interview so that I do not have to take lots of notes.

What do I have to do?

If you take part in the study you will spend approximately 1 hour talking about your thoughts and feelings as someone who requires care and who lives in a rural area.

What are the possible benefits of taking part?

Whilst I cannot promise that this study will directly improve your care, it is hoped that the information gained from this research will be used to improve services for people in rural areas.

What are the possible disadvantages or risks of taking part?

The interview may make you feel upset, uncomfortable or even angry to think about some aspects of the service or where you live that you have not been happy with. I appreciate that the subject matter is sensitive and I understand if you wish to change the subject or take a break. You are free to interrupt or end the interview at any point. Throughout the interview you will have control over how much information you wish to reveal and I will respect your privacy at all times.

What happens after the interview?

Once all of the interviews have been carried out, I will analyse the information and write down my findings. I will share these findings with you, prior to publication if you would like me to do so.

What happens if I do not want to carry on with the study?

You are free to withdraw from the study at any time whilst it is being undertaken.

Will my taking part in the study be kept confidential?

All information which is collected about you during the course of the research will be kept strictly confidential. The tape and transcript of the interview will only be accessed by me and my academic supervisors, all of whom are bound by a professional code of confidentiality. Tapes and transcripts will be coded to preserve anonymity, securely stored and destroyed once the research has been written up. When the research is written up any information that could identify you will be removed to preserve anonymity.

Who is organising and funding the research?

The research is supported by Northumbria University and Northumberland Care Trust. I am carrying out the research in my own time in order that the service I provide as an Occupational Therapist with Northumberland Care Trust is not adversely affected.

Who has reviewed the study?

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee to protect your safety, rights, wellbeing and dignity. This study has been reviewed and given a favourable opinion by The County Durham and Tees Valley Research Ethics Committee. This study has also been approved by Northumbria University Research Ethics Committee and Northumberland Care Trust Research and Development Ethics Board.

Contact for further information

If you have any further questions about taking part in this study do not hesitate to contact me, Audrey Bell on 01661 832758

If you wish to contact another person, you can contact my supervisor from Northumbria University, Professor Jan Reed on 0191 2156142

Appendix 3: Client letter (issued in font 14)

Dear Sir/ Madam,

I would like to invite you to look at the information sheet enclosed regarding research I am undertaking concerning older people in Northumberland.

I am undertaking a project to learn more about how we can improve social care services for people who live in rural areas. The information sheet attached explains what the study is about and why you have been invited to participate.

I would be most grateful if you would take time to read the information, and if you wish discuss it with friends or family who can help you decide if you would like to participate. I will give you at least one week to consider this information and I will then telephone you to ask if you would like to meet up to discuss further, with a view to your possible participation in the study.

Please be assured that this invitation does not mean you are obliged to participate and even if you do agree to my visit, you are free to change your mind at any time.

If you, or someone on your behalf would like further information, do not hesitate to contact me on 01661 832758.

Thank you for your time,

Audrey Bell

Appendix 4: Dissemination plan

Local

The findings of the project and where appropriate, how the study was conducted, will be disseminated at a local level in an appropriate format to the following groups:

1. A written summary of the key points of the study findings will be shared with participants of the study who had expressed a wish on the consent form to receive this.
2. A presentation of the key findings and implications of the study will be given at team meetings in West Northumberland.
3. An outline of the whole project will be presented at Northumberland Care Trust Governance day.
4. An outline of the project, with specific reference to Occupational Therapy will be presented at the North-East Regional College of Occupational Therapists Study day.
5. An outline of the project with key implications will be presented to Northumbria University School of Health, Community and Education Studies research conference.

National

With appropriate academic guidance the findings and implications of the research have potential to be shared at a national level in the following way:

1. Presentation at the annual College of Occupational Therapists Annual Conference and Exhibition.
2. Publication in The British Journal of Occupational Therapy.
3. Publication in Health and Social Care in the Community and Ageing and Society.