Combining qualitative and geo-spatial approaches to explore older adults' lived experiences of ageing – *as well as they can* – in place

Presented by

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Abstract

This thesis explores the lived experience of older people within the Greater Dublin Area of Ireland, to determine how they define and enact ageing well in place. It combines qualitative and spatial methods, including preliminary focus groups (Stage 1), as well as in-depth interviews, mapping exercises, and go-along interviews with older people in two contrasting Study Areas (Stage 2). Results provide participant accounts of the importance of getting out and about, showing how this varies between participants and how it fluctuates over time. Findings reveal why getting out and about is valued by participants, focusing on the importance of connecting with others, and presents both positive and negative experiences of social interaction. Results demonstrate the places or phases where these interactions occur or do not occur, the nature of these interactions and relationships, as well as how older adults develop schedules and routines to maximise opportunities to interact with others. Drawing in depth on four individual lifeworlds with health and mobility challenges, geo-narratives and annotated maps are presented to highlight how getting out and about is navigated and negotiated, based on dynamic personal and environmental contexts, as well as what matters most to that individual for a good quality of life. By integrating and empirically grounding ageing in place and ageing well, this thesis produces a lay and relational conceptual framework of ageing – *as well as you can* – in place, which emphasises the need for pragmatic and subjective definitions of ageing well and recognises the importance of engaging beyond the home to feel and be 'in place' to connect with others. Finally, some recommendations are offered to policymakers, which could support older people not just to age in place, but to age as well as they might want.

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This thesis is dedicated to my late grandma Esme

– it was with you in mind that I wrote this.

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Chapter 1. Introduction

1.1 Thesis Overview

Despite policy initiatives in Ireland emphasising the importance of 'ageing in place', the variation in the everyday realities of older people and the influence this has on their *quality* of experience, has received far less attention. This thesis critically examines the concept of ageing in place, by bringing to it a health geographical understanding of environment, health, and wellbeing. Alongside this, I have incorporated an understanding of 'ageing well' that is subjective and informed by Sen's (1993) Capability Approach, where quality of life is determined by the extent to which individuals can pursue valued 'functionings'.

Informed by existing literature and theories from Health Geography, Healthy Urban Planning, Geographical Gerontology and Environmental Gerontology, I argue that an important indicator of how well someone may be ageing in place, is the ease with which they are able to engage and participate with their broader neighbourhood environment. However, it is also recognised that this is easier for some than others, depending on an individuals' personal and environmental 'fit' or congruence (Lawton and Nahemow, 1976). Where individuals find it more challenging to get out and about, their ability to engage in meaningful interactions and activities may be diminished and their valued routines may have to be curtailed, which can impact their health and wellbeing.

Increasingly, academic literature is recognising the value of 'lay' perspectives and the need to learn from and understand older peoples' everyday experiences of ageing. Within this thesis, I am interested in what matters to older people who live at home, and how they define a good quality of life based on what is of most importance to them. Informed by existing research that highlights the wellbeing benefits that can arise from being outdoors and mobile, I am interested in the importance of 'getting out and about' to older people, which incorporates leaving the home, travelling, attending destinations, as well as the activities and interactions carried out along the way. I am interested in individuals' most valued places, routines, and activities, as well as how easy it is for them to engage with these. This will provide insight into how ageing well in place is both defined and enacted by

older people themselves. These findings will be of use to both policymakers and planners, to design places and service provisions that support older people not just to age in place, but to age *well* in place.

1.1.1 Thesis Aim and Research Questions

The overall aim of this thesis is:

> to explore older adults' everyday lived experiences to determine how they define and enact ageing well in place.

This thesis has three broad research questions:

1. What is of most importance to older people for a good quality of life and to age well in place?
2. What places, routes, routines, and interactions outside of the home are most valued by participants?
3. What personal and environmental factors influence the ease with which participants can 'get out and about' to engage in meaningful activities and interactions?

To answer these research questions and to explore the subjective and lay understandings of ageing in place and ageing well, I carried out multi-staged and multi-method empirical research in the Greater Dublin Area (see Figure 1.1) that combined qualitative and spatial approaches. Stage 1 included four exploratory focus groups, carried out with thirty-one participants in June 2017 to familiarise myself to the ageing in place experience in Ireland. Stage 2 then focused on individual experiences and involved interviews, 'go-along' interviews and mapping exercises with thirty-four older people between December 2017 and August 2018 in two contrasting Study Areas. Informed by environmental, health and ageing demographic patterns within Ireland (discussed further in Section 1.2), this research was carried out in a suburban and inner-suburban setting. The next section (Section 1.2) of this chapter provides a brief overview of the ageing policy context of Ireland to situate this thesis, before highlighting some of the relevant urban processes, demographic trends and health contexts that were examined for this research. In Section 1.3, I summarise the key findings and identify the empirical, methodological and

theoretical contributions of this thesis. I conclude this chapter in Section 1.4 by outlining the structure of the remainder of this thesis.

Figure 1.1 Map of Greater Dublin Area

1.2 Ireland: A great country (for some) in which to grow old?

The Republic of Ireland is a relatively 'young' country by EU standards, with one of the lowest proportions of people aged 65 years across the EU (Department of Health, 2013). However, Ireland's ageing population is growing. According to the latest population figures from April 2021, of a total population of 5,011,500, there were 742,300 people aged 65 and over, an increase of 112,500 (17.9%) since 2016 (CSO, 2021). By 2051, the number of people aged 65 and over is predicted to increase to between 1.53 million and 1.6 million (depending on different migration scenarios) (CSO, 2018). The number of those aged 65 as a proportion of the total population will increase from 1 in 7 to 1 in 4 (Institute of Public Health, 2020). Furthermore, it is predicted that the population aged over 80 will increase substantially, from 147,800 in 2016 to between 535,900 and 549,000 by 2051 (CSO, 2018).

1.2.1 An Overview of Ageing Policy in Ireland

Within this section, I focus on three key topic areas within ageing policy, which are of relevance for this thesis: ageing in place, ageing well, and age friendly environments. I explore two policy agendas in particular: the National Positive Ageing Strategy (NPAS) and Age Friendly Ireland.

National Positive Ageing Strategy

In 2013 a *National Positive Ageing Strategy* (NPAS) was developed by the Department of Health, setting out the vision for ageing and older people in Ireland. The overall Vision Statement for the strategy is that:

> Ireland will be a society for all ages that celebrates and prepares properly for individual and population ageing. It will enable and support all ages and older people to enjoy physical and mental health and wellbeing to their full potential. It will promote and respect older people's engagement in economic, social, cultural, community and family life, and foster better solidarity between generations. It will be a society in which the equality, independence, participation, care, self-fulfilment and dignity of older people are pursued at all times (Department of Health, 2013, p.3).

The strategy emphasised that later life could provide many opportunities and be a positive time for older people:

> later life can and should be a time for active citizenship, for continued contribution and participation in local community affairs, for engaging in the kinds of activities that enhance physical and mental health, and a time for involvement with family, friends, neighbours and the wider community (Department of Health, 2013, p.5).

The strategy promoted a "positive societal approach to population ageing", based on the concept of "intergenerational solidarity" (p.6) and recognised that wider determinants can influence the ability of older people to age well and adopted a life course perspective to examine this. Throughout the strategy there are references to a variety of types or forms of optimal ageing. However, it recognised that whilst there are many different types of ageing well, such as healthy, active, positive, productive and successful, what was common across these concepts is the idea that older people are:

> capable of living a self-reliant life, successfully compensating for losses, contributing to the public good, helping themselves and others, as well as striving for positive fulfilment through meaningful engagement (p.6).

The NPAS was underpinned by both the World Health Organization's (2002) *Active Ageing: A Policy Framework* from 2002, which has three key pillars of participation, health and security, as well as the United Nation's (1991) *Principles for Older Persons*, which emphasises the importance of independence, participation, care, self-fulfilment, and dignity. The NPAS identified four national goals which were aligned directly with the *Active Ageing Framework* (p.19):

- National Goal 1: Remove barriers to participation and provide more opportunities for the continued involvement of people as they age in all aspects of cultural, economic and social life in their communities according to their needs, preferences and capacities.

- National Goal 2: Support people as they age to maintain, improve or manage their physical and mental health and wellbeing.

- National Goal 3: Enable people to age with confidence, security and dignity in their own homes and communities for as long as possible.

A fourth national goal, recognised the need for more research about people as they age, to better inform policy (p.19):

> - National Goal 4: Support and use research about people as they age to better inform policy responses to population ageing in Ireland.

Within each national goal, several objectives were identified. Many of these related to the broader local environment, recognising that the built environment can be a key determinant of health and wellbeing. Four objectives had strong place-based components, which this thesis speaks to. The first two objectives were linked to National Goal 1, whilst the third and fourth objectives were linked to National Goal 3 (pp.20–21):

> - Promote the development of opportunities for engagement and participation of people of all ages in a range of arts, cultural, spiritual, leisure, learning and physical activities in their local communities.
>
> - Enable people as they age 'to get out and about' through the provision of accessible, affordable, and flexible transport systems in both rural and urban areas.
>
> - Support the design and development of age friendly public spaces, transport and buildings.
>
> - Continue to implement An Garda Síochána Older People Strategy and empower people as they age to live free from fear in their own homes, to feel safe and confident outside in their own communities, and support an environment where this sense of security is enhanced.

An Garda Síochána (2010)'s *Older People Strategy* featured prominently in the NPAS, which was developed in response to concerns about the fear of crime amongst older people in Ireland. This recognised the impact perceived fear can have on older people's quality of life by reducing mobility and activity within their communities, leading to the potential isolation and social exclusion of older people. The strategy provided a commitment to older people to support them through four objectives (p.10):

> - Develop and maintain effective communication links between Gardaí and older people

- Deliver a timely and effective response by An Garda Síochána for older people
- Increase trust and confidence by lessening the fear of crime amongst older people
- Determine and respond to the needs and expectations of older people on an ongoing basis

A strength of the NPAS was the awareness that ageing in place is more than just being in one's own home but that it includes engaging meaningfully with the broader community and neighbourhood as part of this. It recognises that environmental disparities can impact the experience of ageing in place and prevent older people from being able to engage and participate beyond the home, with subsequent implications for their health and quality of life.

Age Friendly Cities and Communities Programme

Alongside the NPAS, a key international policy initiative which has focused on the community setting in which older people live, is the World Health Organization's (2007a) Age Friendly Environment movement. The Age Friendly Cities and Communities Programme was developed in 2007 and its key strategy and vision was to make the world more age friendly. The programme produced *Global Age-Friendly Cities: A Guide*, which was informed by older people and identified eight domains and created a series of accompanying checklists that could provide more age friendly environments (World Health Organization, 2007b). The eight domains comprised of: 1. Outdoor Spaces and Buildings; 2. Transportation; 3. Housing; 4. Social Participation; 5. Respect and Social Inclusion; 6. Civic Participation and Employment; 7. Communication and Information; 8. Community Support and Health Services (World Health Oganization 2007a) (see Figure 1.1 below).

Figure 1.2 The Eight Domains of an Age Friendly Community (Source: Age Friendly Ireland, 2021a)

Age Friendly Ireland

Countries have since adopted this international programme and there is now a global network of Age Friendly Cities and Communities. In many ways, Ireland is leading the way in terms of age friendly policy. In 2014, the *Age Friendly Ireland Programme* was set up. Its overall vision was to "make Ireland a great country in which to grow old", by guiding and supporting communities at various spatial scales and developing age friendly strategies, which would be informed by older people and "enhance their quality of life and participation in Irish life" (Age Friendly Ireland, 2021b). This "commitment to action" was in response to concerns about the need to prepare for the ageing of Ireland's population, recognising the implications of this for public policy, as well as the impact of "environmental, economic and social factors that can play an important role in the overall health and wellbeing of older people" (Age Friendly Ireland, 2021a; 2021b). Louth was the first county and local authority to sign up to the Age Friendly County Programme, and by November 2014, all 31 local authorities had signed up to the *Dublin Declaration on Age Friendly Cities and Communities in Europe*, which committed to "creating an

inclusive, equitable society in which older people can live full, active, valued and healthy lives" (Age Friendly Ireland, 2021c). Ireland was the first country in the world to be fully affiliated with the World Health Organization's *Global Network of Age Friendly Cities and Communities* in 2019 (Age Friendly Ireland, 2020).

In addition to ageing policy, there are some notable urban and demographic trends which are likely to influence the ageing experience of older people, and two trends that are of relevance for the Irish context are now considered. The first is the expansion and development of low-density housing in the peripheral areas of Dublin and the surrounding counties that has occurred since the second half of the twentieth century and which continues to this day. The result of this is that increasing numbers of older people will be living in suburban settings now and in the future. The second trend is the health context of older people in Ireland. Whilst many older people may have good health and mobility and are living longer, there are also many older people with multi-morbidities and health challenges. Research from the UK has shown that disparities in health can follow along health and social gradients, where those with the greatest health challenges have the fewest resources to overcome these challenges (see Hart, 1971; Marmot, 2018; Marmot, 2015). The combination of these demographic and environmental characteristics is likely to have significant implications on the ageing experience for older people in Ireland and as a result this needs to be recognised by and prepared for by policymakers.

1.2.2 Geographic and Demographic Trends of Older People in Ireland

Nearly two-thirds of the Irish population live in urban areas (62.7%) compared to rural areas (37.3%). Much of Irelands' population is concentrated in the east of the country, with approximately 1.9 million people or 40% of the population living within the Greater Dublin Area as of 2016 (CSO, 2017). The Greater Dublin Area is defined as Dublin City and its suburban counties (Fingal, South Dublin and Dún Laoghaire-Rathdown), as well as the surrounding counties of Kildare, Meath and Wicklow which are a mix of both urban and rural areas (see Figure 1.2). Nearly 35% of the over 65 population live within the Greater Dublin Area as of 2016 (see Table 1.1). Furthermore, those counties in Ireland with the fastest growing older adult populations between 2011 to 2016 Census were located in the more suburban or

peripheral counties within the GDA to the east of the country. As shown in Table 1.1, the greatest percentage change of the over 65 population between 2011 and 2016 occurred in Fingal (36.1%), South Dublin (34.1%), Kildare (32.2%), and Meath (27.4%) (CSO, 2017). Dublin City Council, located in the centre of the GDA, experienced the smallest increases in older people aged 65 (8.8%). Owing to the nature of development and demographic patterns within Ireland, this trend is set to continue (CSO, 2017). This means that increasing numbers of older people will be living and ageing within their communities in Ireland in the future and that these communities are likely to be urban rather than rural. In addition, the built form of these areas is increasingly suburban.

Suburbanisation and Urban Sprawl in Ireland

The built form of the Greater Dublin Area is predominantly suburban with a "low density urban form", which is "dispersed and dependent on car-based transport" (Nedovic-Budic et al., 2016, p.159). Ireland has experienced one of the highest rates of urban expansion in Europe, producing urban sprawl (Ahrens and Lyons, 2019). It is estimated that the Dublin area covers twice the land of cities with a similar population, such as Prague, Cologne or Copenhagen (Williams and Shiels, 2002). Several trends have led to the population moving to more suburban peripheral areas, but a significant factor has been the re-housing of inner-city residents during the 1970s in particular to local authority housing in "new towns" (McManus, 2019), as well as high costs of housing in Dublin (Oana et al., 2011; Winston, 2007).

Table 1.1 Older Adult Population Change in the Greater Dublin Area 2011-2016 (Source: CSO, 2017)

County	Population (2011)	Population (2016)	Population Aged 65+ (2011)	Percentage of Population Aged 65+ (2011)	Population Aged 65+ (2016)	Percentage of Population Aged 65+ (2016)	Percentage Change of Population Aged 65+ (2011-2016)
Dublin City	527,612	554,554	66,490	12.60%	72,355	13.05%	8.8%
Fingal	273,991	296,020	19,861	7.25%	27,035	9.13%	36.1%
South Dublin	265,205	278,767	23,053	8.69%	30,925	11.09%	34.1%
Dún Laoghaire-Rathdown	206,261	218,018	29,872	14.48%	34,669	15.90%	16.1%
Kildare	210,312	222,504	16,656	7.92%	22,014	9.89%	32.2%
Meath	184,135	195,044	16,322	8.86%	20,788	10.66%	27.4%
Wicklow	136,640	142,425	15,001	10.98%	18,576	13.04%	23.8%
GDA Total	1,804,156	1,907,332	187,255	10.34%	226,362	11.87%	20.9%
Ireland	4,588,252	4,761,865	535,393	11.67%	637,567	13.39%	19.1%

In addition to low density built form, this region is characterised by less well-developed transport networks and faces significant challenges related to historically poor planning and lack of strategic and sustainable planning policies. This is recognised in the *Transport Strategy for the Greater Dublin Area 2016-2035*:

> Over the next 20 years, transport infrastructure and services must deal with a historical legacy which saw significant levels of growth and migration of land uses to suburban and peri-urban fringe locations, typically at lower densities and unconnected to existing and planned public transport services and facilities (National Transport Authority, 2015 p.27).

The relationship between urban sprawl and health is complex. For some, moving to suburban neighbourhoods may lead to improvements in health and wellbeing, through gaining more space, greenery and perhaps a garden. However, at a population level, there can be "unintended consequences" associated with urban sprawl (Frumkin et al., 2004, p.221). For example, car dependency can increase traffic congestion, air pollution, which can influence respiratory health and risk of injuries. For the populations that live in these areas without access to a car, there is likely to be greater challenges with travelling. Lower rates of walking and cycling and engaging in more sedentary behaviours can contribute to a variety of poor health outcomes (Ewing et al., 2003). The mental health impacts of urban sprawl can be significant and can influence the ability to develop social capital (see Leyden et al., 2003; Melis et al., 2015), particularly if these environments are stressful and lacking in aesthetically pleasing design. Finally, the consequences of these health impacts may not be felt equally across the population, with certain population groups more vulnerable to the negative effects (Frumkin et al., 2004). Of those, older people, as well as those living in more disadvantaged communities are notable, because they may be less able to compensate for poor urban design, as they may be less mobile and therefore more dependent on their immediate local environments (Buffel et al., 2012; Milton et al., 2015; Yen et al., 2009).

For this reason, low density suburban environments, particularly those characterised by urban sprawl are considered less 'healthy' or 'restorative', owing to a lack of amenities, car dependency, less walkable neighbourhoods, and limited public transport and infrastructure (Frumkin et al., 2004; Roe and McCay, 2021). Fong et

al. (2020) have conducted research exploring the lived experiences of older people in suburban communities in Australia and have raised concerns as to whether such environments can meet the needs of the older adult population and argue that it is a "question that policymakers must address urgently" (p.2). As a result, there is a need to consider the impact of suburbanisation and urban sprawl on the ageing population and to learn more about lived experiences and the contextual challenges that older people within these locations may face. In the next section I consider some of the health characteristics of the older adult population and how this varies in Ireland.

1.2.3 Health Characteristics of the Older Adult Population

This thesis is underpinned by several key principles within Health Geography, Urban Planning and Environmental Gerontology. One of the most important theoretical underpinnings is that an individuals' health and wellbeing experience, is in part determined by the broader physical and social environment in which they live. Both the built and natural environment are recognised as determinants of health. In turn, health is likewise a determinant of ageing well. Figure 1.3 presents a socio-ecological understanding of the determinants of health and highlights the complex ways that an individual and their built environment interact to influence their behaviour and health (Barton and Grant, 2006). This includes the natural and built environment, as well as the types of activities carried out within a particular neighbourhood. The local economy and community can play an important role in health and wellbeing, particularly the social capital and social networks that an individual has. Lifestyle and personal factors can influence the nature of engagement with local environments. Age, gender, and genes also contribute and influence the health and well-being an individual can attain, along with wider structural forces that influence policies, societal and cultural norms, and expectations.

Figure 1.3 Environmental Determinants of Health and Wellbeing (Source: Barton and Grant, 2006, p.2)

Determinants of health can arise over a lifetime and result in extreme variations in health and ageing experiences:

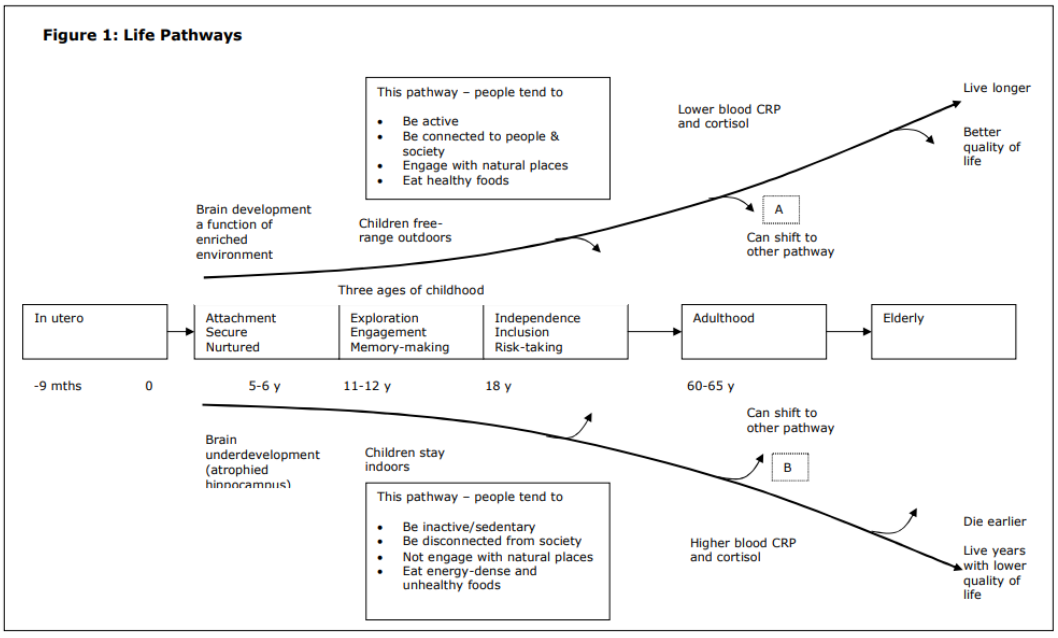
> the way we experience and react to places is shaped by the layered accumulation of life experiences in environments over our life span (Rowles, 2018, p.204).

Old age is typically perceived as the latter part of an expected or normal life span. The most used definition is based on chronological age, and is when people would have traditionally retired, at age 65 (Fahey et al., 2007). This is a common threshold for an older person and used within the Census in Ireland. However, The Irish Longitudinal Study on Ageing (TILDA) collects data from people aged 50 and over, showing that there is not always agreement on how to define an older person. Within this thesis I use the term older person or older people, as this has been established and preferred by older people themselves (Age UK, 2019), as opposed to terms such

as ‘elderly’, which can denote images of dependency and vulnerability and negative stereotyping.

Figure 1.4 demonstrates how access or a lack of access to natural environments from a young age can result in different life pathways. These diverging pathways can result in disparities in behaviours and health outcomes, which can widen over a life course. By the time a person reaches 65, they will have different life expectancies and possibilities for a good quality of life. With people living longer, some with and others without chronic conditions, the experience of older adults and their lived realities is becoming increasingly diverse. As a result, it is becoming increasingly difficult to define an older person. For some older people, what can be physically expected from an individual at a certain age is being redefined, but it is important to remember that not everyone is able to attain such optimal levels of health and engage with valued functionings that may be of importance to them. Some older people experience a variety of health challenges and age-related conditions, which may be present before what might be considered a chronologically old age. As a result, sharing the same year of birth does not mean an individual will experience the same abilities, health, outlook, wishes, and desires.

Figure 1.4 Dichotomous Life Pathways (Source: Pretty et al., 2009, p.24)



As a result, there are challenges with defining a population group based on chronological age alone. Usually populations are grouped into chronological sub-divisions that have a shared experience or needs, making it either meaningful or useful to do so. However, the older adult sub-group is arguably the most diverse of all age brackets, because of the diversity of experiences that have accumulated over a life time. Many researchers have raised the need to consider the heterogeneity, or diversity of older adults within research (Burns et al., 2012; Cotterell et al., 2018), with Beard and Montawi (2015) arguing that heterogeneity is "one of the hallmarks of ageing" (p.5). Whilst this diagram shows two extreme scenarios and this is just in relation to engagement with green space, it is helpful to demonstrate why older people are so heterogeneous, with many potential life pathways between these two extreme pathways (Pretty et al., 2009). The heterogeneity of older people is therefore partially explained by the "cumulative impact of multiple inequities across life" (Beard and Montawi, 2015, p.6).

Many older people in Ireland can expect to live longer and in better health than previous generations. However, there is also a sizeable and increasing proportion of the older adult population living and ageing with health and mobility challenges, which may impact negatively on their ability to achieve a good quality of life in later years (Department of Health, 2015). Existing data has identified socio-economic health gradients amongst older people in Ireland and research has shown that older people in lower socio-economic groups are at increased risks of chronic conditions and associated disability (Eurostat, 2017; Fahey, 2007; Savva et al., 2011; Sheehan and O'Sullivan, 2020). The culmination of this, is that the experience of being an older adult in Ireland is extremely diverse.

1.2.4 Summary

Both the National Positive Ageing Strategy and Age Friendly Ireland are aspirational policies, setting out visions of what they hope Ireland will become with regards to ageing. A problem with this, however, is that greater attention is placed on ideals and less on the everyday realities of the current older adult population and how this may vary along social and health gradients, as well as influenced by urban development processes such as urban sprawl. Buffel et al. (2012) question the appropriateness of

an objective checklist of age friendliness, as it focuses on an "ideal" age friendly city, instead asking "what are the actual opportunities and constraints in cities for maintaining quality of life as people age?" (p.601). To improve the experiences of older people ageing in place, which both the NPAS and Age Friendly Ireland ultimately intend to do, there is a need to understand the full range of experiences of being an older person, recognising the heterogeneity of this population group.

The establishment of an Age Friendly Cities and Counties Network in Ireland and the subsequent evidence base that arose from this project, was an important step in recognising that where an individual lives influences how they live. It recognises that an individual's environment can serve as a barrier or an enabler within everyday lives and that certain characteristics of the built and social environment are more age friendly than others. However, as I will discuss further in Chapter 2, the World Health Organization (2007a) Age Friendly Environment checklists are built on quite limited and more objective constructs of place, focusing on more tangible components of place and the built environment, rather than the intangible and subjective components, which are often more important to older people themselves (van Hees et al., 2017). As a result, more subjective and heterogenous insight about the older adult experience is missing. This includes a lack of consideration about what is of most importance to older people themselves to age in place and how may they define this. The importance of more subjective experiences of ageing in place and subjective interpretations of age friendly environments is increasingly being recognised within academic literature (Golant, 2015; Lager and van Hoven, 2019; van Hees et al., 2017). The need for this to transfer into policy is likewise acknowledged. Existing research from the UK that has interviewed planning practitioners about *Planning for an Ageing Society* has found that planners are aware of the need for further knowledge about "the composition, aspirations, experiences and requirements of this population, now and into the future" (Hockey et al., 2013, p.538).

A combination of demographic, urban and health trends mean that increasing numbers of older people with a variety of health and mobility needs will be ageing in place with predominantly suburban and car dependent neighbourhoods within Ireland. This could have significant implications for how well older people are able

to realise the policy priority of ageing in place, and yet this has been under-explored within social and planning policy. As Golant (2018) notes:

> it is more enjoyable, easier and less costly to grow old in some places than in others (p.190).

Informed by this ageing landscape within Ireland, this thesis addresses several research gaps (Miles, 2017) and, it is hoped, thereby makes several distinct contributions, which are now summarised.

1.3 Thesis Contributions

As mentioned at the beginning of this thesis, there is a policy imperative towards ageing in place and promoting age friendly environments. However, it is acknowledged by the NPAS that we know very little about the everyday lived experiences of older people ageing in place in Ireland. Based on population and environmental trends identified in the previous section, it is reasonable to assume that Ireland is likely to be a great place for some more than others to grow old in and existing research is needed to further explore this. There is a lack of qualitative research that highlights how the interaction of personal and environmental factors can influence the *quality* of this experience. This thesis is therefore responding to these knowledge gaps.

Within this thesis, I focus on older people's experiences of suburban environments, recognising that within Ireland, this is an area where increasing numbers of older people are and will be ageing in place in the future. Informed by existing literature and based on my own experience of working as a Planning Policy Officer in the UK, I am aware that the built forms of suburban environments are likely to provide additional challenges for older people to get out and about and be mobile, especially when they may also experience health and mobility challenges, which increasing numbers of older people within Ireland experience. Exploring this from a Health Geography perspective will allow me to detail the health inequalities and social gradients that influence the ability to age well in place. Again, there is little research within Ireland that has considered how these broader environmental and health contexts may influence the daily lives of older people ageing in place. To address

this knowledge gap, the Study Areas where I conducted my fieldwork were selected with this in mind. For example, Study Area 1 was more suburban in characteristic, with a mix of recently ageing and newly ageing populations with higher level of deprivation and health challenges. Study Area 2 included a mix of inner-suburban and inner-city characteristics and was an area that had a more established older adult population. It was an area that was experiencing urban change, had better transport amenities, more walkable neighbourhoods, and fewer health challenges at a population level.

This thesis examines how ageing well in place is defined by older people themselves and as a result, responds to a practical-knowledge gap, building on existing critiques of ageing in place, age friendly environments and ageing well. This recognises that both professionals and policymakers typically focus on more objective and validated measures of ageing well and age friendly environments characteristics, rather than focusing on the perspective of older people themselves, which may not necessarily align (see Hockey et al., 2013). Lay experiences and forms of knowledge are prioritised within this thesis, as well as the heterogeneity of older adult experience. Consideration has been given to attending to the types of older people and perspectives that may typically be under-represented within age friendly research (Gilroy 2021). To address this population gap, I have tried to capture the perspectives of range of older people who traditionally may be less engaged by researchers, and this is discussed further in Chapter 4.

The overarching theoretical contribution of this thesis is the empirically grounded theoretical model I have developed of 'ageing – *as well as you can* – in place'. This model integrates ideas about ageing well and ageing in place through the Capability Approach lens. A strength of this model is that it recognises the variability of the ageing experience, in terms of changing health, mobility and functioning over time, as well as the subjectivity of what matters most to people as they get out and about. Whilst existing literature has recognised the need for a Capability Approach lens to ageing well (discussed in Chapter 2), my own research grounds these ideas empirically and spatially. This was enabled by the methodological approach taken, by metaphorically and physically meeting older people where they live, using

innovative in-situ methods such as the go-along interview and mapping exercises, and qualitatively mapping their everyday experiences.

Empirically, I have added to existing literature that highlights the importance of getting out and about for wellbeing, showing variations in how this is prioritised and valued by older people and how it changes over time. I have added to the existing literature that highlights the key places of importance for social interaction, including 'third places', responding to Finlay's (2019) call for further research on this. This work confirms much of the existing findings but adds some new ideas about routine and scheduling which may have been overlooked by traditional third place literature, which appear to be of relevance to older people. Finally, this research adds to the literature that has identified the significance of the everyday experiences of older people as they navigate health and mobility challenges. I use annotated maps and 'geo-narratives' to showcase what is of most important to older people and how this is navigated. This empirical research adds to our understanding of the quotidian experience of ageing in place and the reasons that getting out and about is so important for ageing well in place.

1.4 Conclusion

In this chapter, I have provided an overview of this thesis topic, which included the primary research questions and the justification for this research. I have summarised the methodological approach taken, the key findings and the implications of this research, as well as identified the theoretical, methodological, and empirical contributions of this thesis and the research gaps that it seeks to address. I provided an overview of the ageing policy and demographic context of Ireland to provide the backdrop for this thesis, highlighting that policy landscape and key documents related to ageing well in place, including the National Positive Ageing Strategy, as well as the policy drive towards Age Friendly Environments and the desire for Ireland to be "A Great Place to Grow Old". However, I also highlighted health and environmental disparities across the older adult population, which will have implications for the type of experience that may be available to older people as they age in place. To conclude this chapter, I now summarise the structure of this thesis.

1.4.1 Structure of this thesis

In the next chapter (Chapter 2), I present the overall conceptual framework for this thesis: Ageing Well in Place. I begin by reviewing the concepts of ageing in place and ageing well, showing how I consider these within this thesis. I begin by critically examining the concept of ageing in place from a health geography perspective. This recognises that getting out and about and engaging with the broader physical and social environment is highly valued by older people and can influence health and wellbeing both positively and negatively. I then consider the concept of ageing well, showing how it can be differently defined and highlight the growing movement towards lay interpretations of ageing well, as well as the application of a Capability Approach lens as a way of examining what ageing well in place means to older people. In Chapter 3, I present an overview of the literature that explores the importance of community mobility and getting out and about. I begin by summarising the various ways that this has meaning to older people and can influence their health and wellbeing, focusing on the importance of socialising with others as a key motivator for leaving the house. Alongside this, I demonstrate that whilst getting out and about is valued, it can also be challenging for some older people, summarising the main literature that has explored this, as well as some of the ways this is negotiated and navigated by older people.

Owing to the importance of older adult perspectives, perceptions and experiences, combined with a strong place-based component within this research project, a multi-stage qualitative, spatial and in-situ methoodology will be used. In Chapter 4, I outline the ontological, epistemological, and methodological underpinnings of this thesis, showing how I have used a qualitative and spatial approach to answer my research questions. I outline the study design and research methods used, discuss the sampling and recruitment process and the study settings chosen. Within this thesis I have carried out a flexible, inclusive and care-full approach and I show how I have thought ethically about this research. I also summarise the data analysis steps for each of the empirical chapters.

Chapters 5, 6 and 7 are empirical chapters. Chapter 5 explores the importance of getting out and about to my participants, how this fluctuated, and why this was

connected to how they defined a good quality of life. I conclude this chapter by conceptualising the overarching contribution of this thesis: ageing – *as well as you can* – in place, which I define as having 'good enough' health and mobility, to be able to get out and about to participate and engage in meaningful activities or interactions. In Chapter 6, I will demonstrate how participants' wellbeing is influenced both positively and negatively by getting out and about, focusing on a component that was most valued by my participants: socialising and connecting with others. Here, I summarise participants' *experiences* of getting out and about, applying a framework developed by Gardner (2011) to show how social interactions occurred within different places or 'phases'. I consider the nature of these interactions (including whether they were positive or negative), why they were important, how planned and frequent they were, and the types of routines and schedules developed by older people to ensure that they happen.

A common thread throughout all the empirical work is that getting out and about was easier for some participants than others and I demonstrate how this varied across my entire participant sample. For example, in Chapter 6, I demonstrate how the need and ability to get out varied between participants, as well as for the same participant at different times, depending on seasons, weather conditions and times of day. I also provide insight into how some participants avoided certain forms of getting out and about and the reasons for this. Within Chapter 7, I focus in-depth on four participants with differing health and mobility challenges and show their experiences of ageing – as well as they can - in place and how they navigate and negotiate getting out and about in ways that are meaningful to them. Each individual's 'lifeworld' is described as a geo-narrative with related annotated maps. I provide insight into the patterns, routines and decision-making processes that happen gradually over time and highlight the sheer determination to keep connecting with what matters most to them.

In Chapter 8, I situate my findings in relation to existing literature and consider the implications of what I have found. I present and further develop the theoretical model I have developed for this thesis: ageing – *as well as you can* – in place. I provide an overview of four parts of this model and situate these components in relation to existing literature. I reflect on some of the challenges and limitations of

this research, including a reflection on the Covid-19 pandemic and outline two key recommendations that geographers and planners could implement to support older people to age – *as well as they can* – in place. I now turn to my review of relevant literature and conceptual thinking for this thesis.

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Chapter 2. Ageing Well in Place: A Conceptual Framework

2.1 Introduction

As demonstrated in Chapter 1, Ireland has developed several policy responses to its demographic ageing context, which focus on supporting older adults to age in place through promoting age friendly environments and ageing well. In this chapter I more critically examine these concepts drawing from the relevant academic literature and provide a theoretical and conceptual framework for this thesis. In Section 2.2, I summarise the well-established literature that discusses 'ageing in place' and show how I have been informed by more geographical understandings of place. To do this I draw on perspectives from Geographical and Environmental Gerontology, as well as Health Geography sub-disciplines. I highlight literature that demonstrates the importance of physically being in and feeling in place whilst ageing in place. This involves older people leaving the home and engaging with the broader neighbourhood and community. In Section 2.3, I consider the existing literature on the topic of 'ageing well', highlighting how it can be differently defined, by older people and practitioners, and why this is important to recognise. I then introduce literature which examines ageing well through a Capability Approach lens. In Section 2.4, I integrate these two concepts to consider ageing well in place and how I conceptualise this, informed by the health geographies of ageing. Finally, I conclude this chapter in Section 2.5.

2.2 Ageing in Place

'Ageing in place' is typically defined as staying in your own home or community as you age, or "growing older without having to move home" (Phillips et al., 2010, p.17; Wiles et al., 2012). Traditionally, policies supporting older people to age in place have focused on providing adaptations and support services within the home (Wiles et al., 2012), to allow people to continue ageing within their homes for as long as possible. Such policies stem from concerns about costs of institutional care on the one hand, and assertations and assumptions that ageing in place is what older people themselves desire and prefer (Wiles et al., 2012). More recently, scholars within Environmental Gerontology and Geographical Gerontology disciplines have

engaged critically with the concept of ageing in place (Lager, 2015). This has included more geographical understandings of place being employed (Finlay and Finn, 2020; Finlay et al., 2019; Finlay, 2018; Lager, 2015; Phillips et al., 2010; Wiles et al., 2012). Such an approach recognises that whilst home is an important component of ageing in place, there is a need to think beyond the home to consider the broader neighbourhood and community as important factors in the overall experience (Hillcoat-Nalletamby and Ogg, 2013; Lager and van Hoven, 2019; Pani-Harreman et al., 2020; Peace et al., 2011; Phillips et al., 2010; Wiles et al., 2012). Some researchers have called for a change in term from ageing in place to ageing in community to recognise the broader than home and relational elements of ageing in place, as well as the need for adults to be meaningfully involved within their communities for their health and wellbeing (Black et al., 2010; Provencher et al., 2014; Thomas and Blanchard, 2009).

The importance of incorporating a broader interpretation of *place* within ageing in place has been reinforced within a recent scoping review of thirty four studies. Pani-Harreman et al. (2020) identified five key themes related to ageing in place as a concept, of which *place* was the most important theme. Throughout the studies, place could be used to describe home, the home environment, or wider neighbourhood and community. Whilst this included physical or tangible aspects of place, such as physical environment characteristics, it also included more intangible, emotional and experiential aspects, such as place attachment and belonging (Pani-Harreman et al., 2020; van Hees et al., 2017). Pani-Harreman et al. (2020) emphasise that ageing in place is about "not only staying in one's home", but also includes "remaining in a stable and known environment where people feel that they belong" (p.25). This involves feeling a sense of "*being in place"* (as opposed to "*being out of place"),* which Rowles (2018) argues is the "essence of well-being in later life" (Rowles, 2018, p.202 and p.208).

Research has shown that older people themselves define ageing in place more broadly than the home environment. Wiles et al. (2012) explored what ageing in place meant to older adults in New Zealand through a series of focus groups and interviews. Results showed that ageing in place was valued by older people but that whilst it was a term common amongst service providers and policy makers, it was

not familiar to most older people, highlighting that its definition is not always "fixed" or clear (Wiles et al., 2012). However, "staying in one's home or community" was perceived as beneficial in several ways, including through providing a sense of attachment to communities and social connection (p.360). It was linked to a sense of security and familiarity, with home seen as a "refuge" and community perceived as a "resource" and form of support (Wiles et al., 2012, p.361). Finally, ageing in place ensured a continued sense of identity and this was linked to feeling independent and autonomous, highlighting the importance of being able to make choices about *how* to age in place. As a result, this research confirmed that engaging with the broader than home environment is very important to older people.

Although research has demonstrated benefits to ageing in place, a "blanket" political and policy prioritisation of ageing in place has been criticised by many (Phillips et al., 2010) and caution has been raised about viewing ageing in place "as a 'one stop' solution to later-life aspirations and needs" (Hillcoat-Nalletamby and Ogg, 2013, p.1780). Critiques focus on the *assumption* often placed on ageing in place about it automatically being desirable, without considering the diversity of the population who are ageing in place, how these needs may change over time, and the dynamic environmental circumstances that individuals are ageing in (Phillips et al., 2010). Whilst policies that assume older people prefer to age in place, draws from geographical concepts and theories such as place attachment and familiarity (Wiles et al., 2012), they lack consideration of individuals' diverse lived experience and realities. For example, the experience an older person may have as they age in place, and how positive this proves to be, depends not only on how attached they are to their home-place, but also how well this environment suits their shifting needs and abilities. It will depend on an individual's person-environment congruence (Lawton and Nahemow, 1973) and will be influenced by how well they can adapt to, and cope with changing circumstances over time (Peace et al., 2011).

Such a view of ageing in place recognises that it is "not a continuous, uniform experience or solution, but will vary in its 'do-ability' depending upon evolving lifecourse needs" (Hillcoat-Nalletamby and Ogg, 2013, p.1788). Existing research has demonstrated the importance of thinking about ageing in place relationally, recognising that "older adults' experiences are viewed as an outcome of the complex and dynamic interplay of self, others, place and time" (Lager et al., 2015, p.3).

Ageing in place therefore needs to be recognised as the complex and dynamic process that it is, where older adults are continually navigating and negotiating their relationship with and to people and places (Andrews et al., 2007; Hopkins and Pain, 2007; Lager et al., 2013; Skinner et al., 2014; Wiles et al., 2012; Ziegler et al., 2012).

Research has shown that ageing in place is not always a desirable, ideal or an easy option for older people, particularly when ageing "in the margins" (Finlay et al., 2018), and ageing in "unsuitable" (Severinsen et al., 2016), or "difficult" places (Scharf et al., 2007). Finlay's (2018) work exploring the lived experiences of older adults in Minneapolis, Minnesota in the US, adopted a broad perspective on the experience of ageing in place and demonstrated how place attachment can be unattainable for many. Furthermore, it has shown that staying in one's home can involve risk and hazards, as well as social isolation due to lack of supportive infrastructure and crime. Reaching these 'tipping points', participants had a lack of options to change their situation, leading to exclusion, where they were "striving to age well 'in place'", but unable to do so (Finlay et al., 2018, p.768).

Owing to differing person-environmental contexts and the heterogeneity of older adult experiences, it is important to recognise that there may be situations where individuals feel "out of place" (Brittain et al., 2010) or "unfamiliar" (Phillips et al., 2013) whilst ageing in place. This could be through personal factors such as mobility or cognitive impairments or through a variety of physical and social environment factors, as well as including urban transformation and change (see Lager et al., 2013; Brittain et al., 2010). Phillipson (2007) argues that globalisation has the potential to create more extreme inequalities amongst older adults, whereby the "elected" have more agency, knowledge, and control to improve their existing environment, or to move to more age friendly environments. On the other hand, there are then the "excluded", typically in more deprived communities, who may be living in areas with fewer services and provisions. They are less able to influence their situation, are more negatively impacted and disempowered by their immediate physical and social environment and may lack the financial resources to move to an alternative location which may be more supportive. Phillipson (2007) highlights the importance of considering how macro-level forces serve to influence and change the everyday experiences of older adults within their neighbourhoods. Considering the experiences of more disadvantaged older adults is therefore an important step to "address

growing inequities and reimagine ageing 'in place' along more inclusive and socially just lines" (Finlay et al., 2018, p.781).

2.2.1 Summary

Building on existing research that critically engages with the term ageing in place, this thesis applies a geographical interpretation. Whilst the importance of the home environment has been identified by many as an important component of the experience of ageing in place (see Sixsmith and Sixsmith, 1991; Stones and Gullifer, 2016 for example), within this thesis I focus predominantly on the broader local physical and social environment, neighbourhood, and wider community in which a person lives. I incorporate both the physical experience and the emotional feeling of being *in place*. Whilst policies that assume older people prefer to age in place, stem from geographical concepts and theories such as place attachment and familiarity (Wiles et al., 2012), they can also lack consideration of individuals' diverse lived experience and realities (Golant, 2018). Existing research has highlighted the need for further research that considers how older adults are ageing in place, including the quality of experience, which is lacking within an Irish context. A key component of this is how *well* individuals can age in place. To consider this, it is first necessary to clarify how ageing well can and should be defined.

2.3 Ageing Well

Alongside ageing in place policies and research, are parallel debates relating to 'ageing well'. Several terms relate to ageing well, which I use here as the umbrella term to consider the varied types of ageing well. These include successful ageing, positive ageing, productive ageing, active ageing, and healthy ageing. Whilst various desirable forms of ageing are referred to within gerontology literature and policy, successful ageing remains dominant. The wide variation in types of optimal forms of ageing reflects the lack of consensus and complexity as to what a desirable form of ageing is. Within this section, I consider how existing literature defines ageing well and why this is important.

The term successful ageing is multi-dimensional (Martin et al., 2015; Phelan et al., 2004; Rowe and Kahn, 1997), and several definitions are presented within the

literature. Definitions are typically categorised within the literature into biomedical and psychosocial definitions. Biomedical approaches emphasise the importance of optimal functioning and engagement (Phelan and Larson, 2002) and is seen as a "better than normal" status (von Faber et al., 2001, p.2694), in that an individual goes beyond "usual" ageing" (Tate et al., 2003, p.737). An example of a dominant biomedical model of successful ageing is that of Rowe and Kahn (1997), who defines successful ageing as the achievement of the following (p.439): avoidance of disease and disability; maintenance of high physical and cognitive functioning; and sustained engagement in social and productive activities.

Psychosocial approaches on the other hand, recognise more subjective components of successful ageing. In this instance, successful ageing is viewed as more of a mental state or outlook (Glass, 2003), as well as a lifelong process of adaptation and adjustment (Tate et al., 2003; Baltes and Baltes, 1990), as opposed to an objective standard or criteria. Bowling and Dieppe (2005) highlight the importance of concepts such as life satisfaction, social participation, and functioning, as well as psychological resources (p.1549). Such psychological resources for successful ageing include: a positive outlook and self-worth; self-efficacy or sense of control over one's life; autonomy and independence; and finally, effective coping and adaptive strategies in the face of changing circumstances (p.1549). Phelan and Larson (2002) conducted a review of the definitions of successful ageing and identified seven major elements that are typically included in successful ageing studies. These include: life satisfaction; longevity; freedom from disability; mastery or growth; active engagement with life; high or independent functioning; and positive adaptation (p.1307). Some of these studies focused on predominantly biomedical definitions, whilst others looked at more psychosocial components.

Traditionally, it has been clinicians that have referred to objective definitions and lay people or older adults themselves that have preferred more subjective interpretations (Glass, 2003). A major criticism of earlier research on successful ageing was the lack of consideration of how older adults themselves viewed successful ageing (von Faber et al., 2001). In recognition of this, researchers are increasingly arguing for the need to pay greater attention to the voice(s) of the older adult population (Tate et al., 2003), and for a more 'lay' or patient-centred definition of successful ageing that

would be of greater relevance and validity to those who are ageing (Phelan and Larson, 2002; Bowling and Dieppe, 2005).

Phelan et al. (2004) sought to identify which aspects or attributes of successful ageing were most important to older adults and found that many of these were strongly related to health. These included: remaining in good health until close to death; being able to take care of themselves until close to time of death; and remaining free of chronic disease (p.213). This highlights the overlap between ageing well and health. Subjective components of successful ageing were also valued. These included: being able to act according to their own inner standard and value; being able to cope with the challenges of later years; being able to meet all their needs and some of their wants; being able to make choices about things that affect how they age, such as diet, exercise, and smoking (p.213). Many of the attributes identified were consistent with maintaining a sense of self, resilience, and coping, being able to get by but also to flourish, and have sufficient choice. A key finding of Phelan et al. (2004) was that quality of life was perceived to be more important than quantity, emphasising the importance of quality of life as a core component of ageing well.

An important difference between the biomedical (more objective) and psychosocial (more subjective) aspects of ageing well, is the degree of success that older adults can attain, with objective definitions tending to have much stricter criteria than subjective definitions. The number of people that meet objective successful ageing criteria and measurements is typically far lower, however the number of people that *think* they are successfully ageing is typically higher. For example, in a study looking at older adults aged 85 and over, only 10% met successful ageing criteria pertaining to optimal levels of functioning and wellbeing, yet nearly half of the participants reported an ‘optimal’ state of wellbeing. This was despite identifying physical limitations (von Faber et al., 2001). In qualitative interviews within the same study, successful ageing was perceived by older adults to be about the “successful adaptation to physical limitation” with older adults rating wellbeing and social functioning more highly than physical and psycho-cognitive functioning (von Faber et al., 2001, p.2699).

In a review of successful ageing definitions, Jeste et al. (2010, p.80) identified that only a small percentage of older adults were successfully ageing according to objective definitions based on absence of disease (15%) and freedom from disability (38%). However, a far higher percentage believed they were ageing successfully according to more psychosocial domains, such as: active engagement with life (74%); positive adaptation (81%); life satisfaction (84%); self-rated successful ageing (90%); and independent living (94%). With increasing policy and societal pressure targeted at older people to adopt and follow a successful ageing lifestyle, we are witnessing "societal demands to age well and positively" (Breheny and Stephens, 2010, p.41). However, depending on whether this is defined objectively or subjectively, will influence the number of those that can achieve this. If defined objectively, then far fewer individuals will meet the criteria.

The policy response to encourage successful, positive, and productive ageing aligns with neoliberal responses to health promotion, which put the responsibility of achieving good health on individuals, without considering the variability in people's capacity to achieve it, whether due to individual circumstances, or wider structural, societal, or environmental factors. Focusing on individuals and lifestyle choices in influencing a healthy older age, runs the risk of making older people who cannot attain it feel like failures, instead of recognising the "complexities of life choices and chances and the impact they may have on the later life circumstances of older people" (Breheny and Stephens, 2010, p.46).

A positive ageing discourse benefits older people who can take advantage of opportunities to engage beyond retirement and who want to. However, those with fewer resources, who may have chronic conditions and reduced mobility, are "additionally burdened by the demands to age positively, rather than supported by an expectation of care as they age" (Breheny and Stephens, 2010, p.46). Individuals that cannot objectively age positively, actively, or successfully are "excluded from participating in an acceptable way of life", but not from the "imperative to age well" (Breheny and Stephens, 2010, p.42). Breheny and Stephens (2010) argue that the only option available to those restricted by poor health and material resources to demonstrate agency and attempt to age well, is to focus on more subjective aspects of successful ageing, through a "determination to have a 'positive attitude' toward their situation" (p.44). However, the problem with this, is that underlying structural

factors that created inequalities to begin with are not addressed (Breheny and Stephens, 2010). Stephens et al. (2015) warn about the dangers of idealising older adults as a healthy, active, and homogeneous group that are willing and able to continue to contribute towards society. Such an approach ignores the diversity within the older adult population and the structural inequalities that may exist between older adults, which can influence their ability to age well (Stephens et al., 2015).

Parallel debates are taking place about how to define concepts such as health, quality of life, and wellbeing, which as I have already shown, are strongly interrelated with ageing well. Such debates revolve around how to define these concepts and whether more idealistic, medicalised, consistent, and objective measures should be used, versus more realistic, subjective, lay, and flexible definitions. Within the health field, the traditional definition of health developed by the World Health Organization (1946) as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity" is increasingly being criticised as "no longer fit for purpose" (Huber et al., 2011, p.1). This is largely in response to the rising prevalence of chronic conditions and ageing populations, which means that perfection is beyond many. Instead, an alternative definition of health has been presented by Huber et al. (2011).

Rather than focusing on an idealised and unattainable version of health, Huber et al. (2011) define health as "the ability to adapt and self manage in the face of social, physical and emotional challenges" (p.1). The important distinction between the traditional definition of health and the more recent definition of positive health is that you can attain and achieve positive health in a less than perfect state. What matters is not whether you have an underlying condition or disease, but whether you are able to cope and manage this disease and whether you have the skills to adapt your circumstances in such a way that you are able to lead as normal a life as possible and that you perceive yourself to be healthy. This connects with Antonovsky's ideas about an individuals' sense of coherence (how an individual sees their world and how they fit within this) and ideas about *salutogenesis*, which is a more enabling and proactive view of health, which considers what creates health, rather than what causes disease or illness (Antonovsky, 1987). More recently, this work has been applied to consider healthy ageing in place (see Walsh, 2014).

This work also aligns with Baltes and Baltes' (1990) psychosocial model of selective optimization with compensation (SOC), where ageing involves three components. When an individual is faced with physical or cognitive challenges or restrictions, they will *select* and focus their attention to those areas within their life that are of the greatest priority to them. In addition, individuals will also *optimise* by continuing to engage in those behaviours that enhance their physical or cognitive capacities. Finally, individuals may *compensate*, or negotiate, by using certain psychological or technological strategies. As a result, the older person engages in a process of adaptation and negotiation, using their agency and resources to maximise their desired outcomes and avoids negative outcomes. Ageing well in this instance is their ability to navigate this successfully.

2.3.1 A Capability Approach to Ageing Well

Owing to the challenges of defining ageing well, quality of life, health and wellbeing described above, some researchers have begun to employ more novel ways to conceptualise these elusive terms. One increasingly common way of doing this is to define ageing well using the Capability Approach.[1] Originally developed by Amartya Sen, the Capability Approach is "based on a view of living as a combination of various 'doings and beings', with quality of life to be assessed in terms of the capability to achieve valuable functionings" (Sen, 1993, p.32). There are two overarching principles. The first is that having the "freedom to achieve well-being is of primary moral importance" and secondly, well-being should be defined in relation to people's capabilities and functionings (Robeyns and Byskov, 2021). Functionings are 'beings' and 'doings', the "various states of human beings and activities that a person undertakes", while capabilities are an individuals' "real freedoms or opportunities to achieve functionings" (Robeyns and Byskov, 2021). It is the individual who must specify which capabilities are most valuable. However, whether someone can achieve a functioning depends on "personal, social political, and environmental conditions" or "conversion factors" (Robeyns and Byskov, 2021).

[1] This is often used interchangeably with Capabilities Approach but in this thesis, I use the term Capability.

Developing a Rawlsian critique of the founding principle of the World Health Organization (1946), Daniels (1985, p.28) insists that expectations should be constrained by "normal species functioning", and that the implied right to health care is limited to a fair share of medical resources. The Capability Approach to human rights suggests that people have a fundamental right to the various bases of human flourishing, but in each case, the standard is socially and contextually specific. Thus, among other capabilities, the right to life is to one of "normal length", bodily health includes the right to be "adequately nourished, to have adequate shelter", and the capacity for "sense, imagination, and thought" should be "cultivated by an adequate education" (Nussbaum, 2003, pp.41–2). Notions of 'normal' and 'adequate' have both individual and societal frames of reference. For the purposes of this thesis, it can be expressed as an interest in understanding how and whether individuals can age as well as they might want given their limitations.

More recently, Stephens (2016) has applied a Capability Approach to types of ageing well. Rather than putting the responsibility on older people to age successfully with no consideration of their ability to do so, this approach prioritises supporting older people to "achieve valued functionings" based on their existing capabilities, and to understand their specific needs in "actual circumstances" (Stephens, 2016, p.7). This aligns with more psychosocial descriptions of both health and ageing well, rather than biomedical and objective standards. Stephens et al. (2015) conceptualised and defined health in their research as being able to carry on doing the things that are valued by older adults, which makes it more accessible to all and means that it can be attained with physical decline. They argue it is a "more nuanced version of health", in that is also takes into consideration the "role of social structure, unequal incomes, spatial contexts and social provisions" (pp.728–9). Considering ageing well through a Capability Approach lens, can help to identify the wider social and physical environmental influences on health, as well as the wider societal contexts within which older adults are situated and affected by. Such an approach would ask questions such as: "What are the environmental and social conditions which support these particular capabilities?" and "how are these capabilities valued by older people in a particular context?" (Stephens, 2016, p.6). Stephens (2016) has also been informed by Baltes and Baltes (1990) model of SOC and has combined this with a Capability Approach, recognising that the ability to navigate this is influenced by the

"social circumstances of people as they age" (p.6) and the need to understand "the actual goals of older people, and their capability to select, optimise and compensate to achieve those goals" (Stephens, 2016, p.6).

Meijering et al. (2019, p.232) ask for more research on "how older adults can live a meaningful life in the context of the impairments they experience" and argue that a Capability Approach offers a useful lens to explore this. With a focus upon how individuals value for themselves the ways they can realise their capabilities in meaningful activities, i.e., their various "functionings", the Capability Approach provides a way of "valuing and giving voice to people's own conceptions of what matters" (Gopinath, 2018, p.258). Such an approach would lead to a "shift in focus towards the capabilities that support older adults to achieve independence as their valued functioning, rather than on how 'successfully' they age" (Meijering et al., p.251).

Ageing policies that use terms such as productive, successful, and so on have a particular theoretical underpinning that stems from more biomedical and objective definitions of quality of life. As a result, they typically have less relevance to what matters most to older people themselves. Within this thesis I am interested in exploring ageing well subjectively and based on what older adults themselves feel is of most importance to them. The Capability Approach is a useful way to combine ideas around ageing well and ageing in place through a lay person lens. There is a small but growing literature that has explored the valued functionings that are of most importance to older people themselves and this is now considered.

2.4 Ageing Well in Place through a Capability Approach lens

Broadly, health geographies of ageing are concerned with understanding how place can impact older people's health (Wiles, 2018). As a sub-discipline, this has moved and evolved over time from more biomedical understandings of health as being the absence of disease, to embracing "more holistic socio-ecological understandings of ageing and health in social, physical and symbolic contexts" (Wiles, 2018, p.31). As a result, this discipline is well situated to integrate the concepts of ageing well and ageing in place, to consider "how environments are supporting quality of life for older people" (Gilroy, 2006, p.343). This recognises the complex factors that

influence the overall experience of ageing in place, including the role of broader structural forces (such as inequalities), which can influence the experience of, and ability to age in place in a beneficial way. In sum, individuals realise valued activities and meaningful engagements to an extent that is strongly influenced by context:

> One of the key determinants of the capabilities of older people, and whether they can achieve the things that are meaningful to them, is the environment in which they live (Beard and Montawi, 2015, p.5).

There are several empirical studies that have examined the lived experience of older adults through a Capability Approach lens and have broadly summarised the valued functionings of older people. In semi-structured interviews with 145 older adults aged 63–93 years and living independently in both urban and rural locations in New Zealand, Stephens et al., (2015) asked participants to talk about their daily needs and practices, including the resources that they currently lack or would like, the characteristics of their community and physical environment, how this influenced their ability to participate socially, as well as their ability to manage on their income. Six broad domains of functioning were valued by older adults: Physical Comfort; Social Integration; Contribution; Security; Autonomy; and Enjoyment (pp.720–4).

With regards to *Physical Comfort*, everyday goods, such as clothing, housing and health services were identified. Using the example of food, participants claimed that having choices provided them with agency and enhanced their wellbeing. In terms of *Social Integration,* opportunities to engage with friends and family, to attend activities and events were highly valued. Participants felt that this helped them to feel a part of everyday life and not miss out, however some acknowledged limitations in being able to carry out such activities due to transport or financial restrictions, which led them to feel socially isolated. Participants identified the importance of continuing to make a *Contribution*, whether that was giving time or money to family, friends, or the wider community through volunteering. This was seen as a source of satisfaction for many and helped them to feel needed. Often participants put their family members' needs before their own.

Both financial and personal *Security* were identified. Having the resources to provide for the rest of your life was seen as very important, along with daily security, such as

knowing that you could cope with any event. Fear of the unknown and burglars was common amongst older people living alone and there was a recognition that health conditions and physical frailty led to feelings of decreased safety. Health care security was also valued, along with having access to medical care. *Autonomy* was highly valued amongst participants, in particular the ability to make one's own decisions, about what to buy, how to spend one's own time and where to live. Living independently was highly valued even though it contributed to social isolation. A sense of freedom and wellbeing was expressed by individuals in economic terms, i.e., having enough money to do what you want. Many people raised concerns about losing the ability to get around, either by private car or public transport and the impact this would have on them achieving independence and retaining control over their lives.

Finally, *Enjoyment* was identified as a valued functioning. These pleasures included everyday activities, as well as special outings or treats. Having things to look forward to and enjoying rewards was especially important. However, participants often had to adjust to continue doing the things they enjoy as their health declined to bring about happiness and maintain identity. Those with fewer resources tended to emphasise "small pleasures" (p.724), which may not necessarily be health-promotive (e.g., gambling or eating chocolate), but they did contribute to that individual's overall happiness.

Applying a Capability Approach to the quality of life of older people within a UK context, Gilroy (2006) identified several domains that were important to older people themselves, as well as how environments can contribute towards supporting a good quality of life for older people. The domains identified included: health; an adequate income; mobility; a safe neighbourhood; a comfortable and secure home; and social relations and support (pp.346–53). Whilst home was mentioned as an important domain, engaging safely with the broader than home environment was significant. Valued functionings such as being mobile and engaging socially were vital components of this:

> Factors that tend to produce a good old age are: a secure home, a supportive neighbourhood, the ability to get out and about, a strong social network, health and income that allow participation in social life, the capacity to make a

> contribution to the life of the community, and the ability to access information and activities, including opportunities for learning (Gilroy, 2008, pp.149–152).

Gilroy (2008) notes that there is strong "interdependence" between these domains but that the "qualities of local environment are most fundamental", as place is "the arena in which other elements of a quality old age may be achieved or eroded" (p.152). Gilroy (2006) demonstrates how these vital components of quality of life can often be "compromised by poor policy provision" (p.343) and identifies the need to broaden the focus of ageing policy "from the intensive needs of the frail" and instead consider the ways that older people can be "supported to live lives characterised by independence and well-being" (Gilroy, 2006, p.354). This is also reinforced by Phillips (2018), who notes that "to date, planners and designers have done little to explicitly enhance and support the well-being of older people" (p.68). Meanwhile, Burton et al. (2011) argues that for "ageing in place to work well, housing and neighbourhood environments need to facilitate older people's independence and wellbeing" (p.2).

> There is … increasing recognition of the need to design and plan for ageing populations and communities across the globe in terms of designing suitable, sustainable environments providing the opportunities to age well in place, to retain independence and to be mobile and socially connected (Phillips, 2018, p.68).

In the Netherlands, Meijering et al. (2019) carried out in-depth interviews with older people living both independently and within sheltered housing to explore the various capabilities of importance to older people. They identified three key capabilities that contributed to the achievement of being independent which Meijering et al., (2019) argue is the overarching goal for older people. These included: 1) to be comfortable at home and in the neighbourhood, 2) to enjoy a fulfilling social life (including maintaining reciprocal social relationships) and 3) to be mobile (p.240). Results highlight the ways that capabilities are shaped by both contextual and individual factors, which influence the functioning of being independent and what that looks like to an individual. As a result, it provides a more "nuanced view on how older adults themselves define capabilities that are crucial to their independence" (p.247), as well as how they draw on resources, conversion factors and agency to negotiate this. Capabilities, therefore, are about being able to do something, whereas

functionings are about what an individual actually does, which are weighed up by factoring in the resources or conversion factors they may have. There are then many different pathways to independence with great variation in the specific ways that this is defined and enacted by an individual.

Most recently, Bigonnesse and Chaudhury (2021) have proposed a conceptual framework exploring ageing in place through a Capability Approach lens, emphasising that ageing in place is influenced by the following five components: place integration; place attachment; independence; mobility; and social participation (p.64) and that these components are in turn influenced by the following four factors: individual characteristics; the accessibility of the built environment; proximity of services and amenities; and finally, the development and maintenance of meaningful social connections (p.64). Bigonnesse and Chaudhury (2021) define ageing in place as an "ongoing dynamic process of balance between the demands and resources of the environment and the individual capacities" (p.69).

2.5 Conclusion

This chapter has presented the conceptual framework for this thesis. I began with a critique of the concept of ageing in place, and informed by existing literature, have adopted a geographical interpretation within this thesis, which emphasises the importance of not just ageing at home, but also remaining connected with the broader community and neighbourhood, to maintain a sense of being in place. Recognising that this is easier for some places than others, increasingly the *quality* of the ageing in place experience and how wellbeing is influenced, is regarded as a key concern for academic research.

Within this thesis, I align with literature that explores ageing well through a subjective lens, as opposed to more objective interpretations. This is particularly important when recognising that older adults within Ireland are ageing in place with a variety of health and mobility challenges. I adopt a lay interpretation of ageing well, recognising that only an older person themselves can define what this means and owing to the heterogeneity of older people, this is likely to vary. Within this thesis, I recognise that lay interpretations of ageing well can often conflate ideas of quality of life, wellbeing, health and ageing well. My interpretation of ageing well

therefore incorporates all these elements and I often use these terms interchangeably. Within this thesis I examine the concept of ageing well through a Capability Approach (CA) lens. This is a way of looking at quality of life and wellbeing, which emphasises the importance of being able to carry out valued functionings, i.e., the beings and doings of importance to an individual.

The importance of being and feeling in place in a way that specifically captures the importance of moving beyond the home to engage with a broader neighbourhood environment, has been under-developed within quality of life and ageing well research. However, work within the sub-discipline health geographies of ageing has moved towards an emphasis on ageing *well* in place on the one hand and the importance of *place* for ageing well on the other. This conceptual framework integrates and explicitly links these concepts through a Capability Approach lens. Ageing well in place, examined through this lens, is about having the capability to engage with the broader than home environment and to be able to do this safely and comfortably to enact the specific components that lead to a sense of independence for an individual. It is about carrying out those valued functionings that are of most meaning to an individual and often, these can only happen by engaging with the broader than home environment.

Exploring ageing well in place through a Capability Approach lens, reveals the inherent spatiality of these beings and doings. In most instances, valued functionings, as well as capabilities, happen at a particular time and place (also argued by Robeyns, 2020). Furthermore, many of the valued functionings of importance to people, require older people to leave their homes to engage and participate within their broader neighbourhood and communities. As a result, *place* matters. Existing research has identified many reasons for this and cross-cutting strands across this work include mobility, independence, and social participation or connection. In the next chapter, I consider the existing literature that explores *why* these themes are so important to older people.

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Chapter 3. The Importance of Getting Out and About for Older People: A Literature Review

Within this chapter, I explore the existing literature that identifies why moving and engaging beyond the home is valued by older people. In Section 3.1, I explore the literature on community mobility or 'getting out and about' as a lay term of this, outlining the main ways that it can contribute to older adult wellbeing both as an extrinsic activity (to get to somewhere) and intrinsically (in and of itself) (Graham et al., 2020). I then focus on the possibilities for social interaction whilst out and about, which existing literature suggests is one of the strongest motivators to leave the house for older people. In Section 3.2, I summarise literature that specifies the key places where social interaction occurs beyond the home, as well as the types of social interactions and relationships with others that are most valued. Recognising that getting out and about can be easier for some than others, in Section 3.3 I explore literature that has identified the challenges associated with this, particularly focusing on literature that looks at the dynamic and varied nature of these challenges, which can often be overlooked within policy. I then summarise literature that has explored how these challenges are navigated and negotiated by older people, before concluding the chapter in Section 3.4.

3.1 Community mobility and its importance for older adult wellbeing and quality of life

Existing literature suggests that humans have a fundamental and inherent *need* to leave their homes, expressing the "limits" to the comfort and security a home environment can provide (Tse and Linsey, 2005, p.137). Instead, escaping from the home environment and the tasks within it, on occasion, appears to be vital for quality of life, health, and wellbeing in old age (Gardner, 2014; Olsson et al., 2013). Getting away from the home environment can provide a distraction from the challenges or "troubles" of home life, can help to obtain perspective, and provide a more positive outlook upon return (Beard et al., 2009, p.231). There is a wealth of research demonstrating that the home environment can be a place where negative feelings and emotions such as boredom, frustration, worry, and distress can manifest for older people (Sixsmith and Sixsmith, 1991; Tse and Linsey, 2005). This is particularly the

case when physically or metaphorically "trapped" (Tse and Linsey, 2005; Olsson et al., 2013), "stuck" (Franke et al., 2018; Ziegler and Schwanen, 2011; Coleman and Kearns, 2015; Rogers, 2017), or "imprisoned" (Gardner, 2014; Olsson et al., 2013; Sixsmith and Sixsmith, 1991) within the home (Davidson et al., 1993). Participants have described how leaving the house can offer a change of scenery and fresh air, as opposed to the stale "sameness" at home (Gardner, 2014, p.1252).

3.1.1 Mobility and Wellbeing

Mobility is in general, defined as "the ability to move oneself (e.g., by walking, by using assistive devices, or by using transportation) within community environments that expand from one's home, to the neighborhood, and to regions beyond" (Webber et al., 2010, p.443). Like Gardner (2011), Webber et al. (2010), distinguish between what they describe as different "mobility zones", defined as "concentric areas of expanding locations", beginning within the home and expanding outwards (p.446) (see also Buttimer, 1976). Mobility is commonly measured by defining a person's activity space, or life-space (Baker et al., 2003), which is the "spatial area a person purposefully moves through in daily life" (Tsai et al., 2015, p.e368). There is a growing literature that has examined the activity spaces of older people (see for example, Hirsch et al., 2016; Hirsch et al., 2014; Perchoux et al., 2019; Tsai et al., 2015; 2016). Whilst this is useful for capturing the "extent of travel", it does not tend to capture the experience of travel and how this can influence the quality of life and wellbeing of an individual (Stalvey et al., 1999, p.472). Subjective experiences of mobility have tended to be been overlooked within mobility research (Curl and Musselwhite, 2018), although increasingly the importance of this is being recognised and incorporated (see Franke 2018; Meijering and Weitkamp, 2016; Milton, 2015; Sturge et al., 2021; van Hoven and Meijering, 2019).

Mobility is often used synonymously with the word travel but within this thesis I draw from Metz's (2000) conceptualisation of mobility, which includes both travel but also the additional and often unanticipated benefits to wellbeing and quality of life which are experienced as a result. Metz (2000, p.150) identifies five components of mobility that are important to older people. This includes the traditional view of mobility, which is "*Travel to achieve access to desired people and places*". In

addition to this, Metz (2000) highlights the importance of the "*Psychological benefits of movement – of "getting out and about*", however they also recognise that these benefits may be "offset by feelings of vulnerability" if this becomes too challenging or risky. Mobility provides "*Exercise benefits*", the extent of which will depend on the mode of travel taken. It also provides opportunities for "*Involvement in the local community*", allowing older people to obtain benefits from their "informal local support networks". Finally, Metz (2000) recognises the value of "*Potential travel*", so that when an individual knows that a trip could be made, there are benefits even if not undertaken. Places therefore do not even need to be actively visited to be meaningful to individuals (see Coleman and Kearns, 2015).

Existing research has therefore shown that mobility, getting outdoors, or getting out and about, is about far more than just travelling from A to B, it is in fact a vital component of wellbeing and quality of life to older people (Alves and Sugiyama, 2006; Carp, 1988; Curl and Musselwhite, 2018; Gabriel and Bowling, 2004; Gilroy, 2006; Goins et al., 2015; Holland et al., 2005; Metz, 2000; Mollenkopf et al., 2011; Musselwhite, 2017; Nordbakke and Schwanen, 2014; Parkhurst et al., 2014; Schwanen and Ziegler, 2011; Sugiyama and Ward-Thompson, 2007; van Hoven and Meijering, 2019; Walsh, 2014; Webber et al., 2010; Ziegler and Schwanen, 2011). Mollenkopf et al. (2011) capture the various ways that mobility provides meaning to older people. They argue that mobility is an "emotional experience" and is something "essential for life itself", identifying physical movement as a "basic human need" (p.789). In addition, mobility allows for engagement in natural environment settings, which can provide additional wellbeing benefits, as well as allow social needs to be met, recognising older adults' "desire for social integration and participation" (p.789). Like Metz (2000), they identify the importance of the possibility of movement and having this available as an "expression of personal autonomy and freedom". Mobility can also be a "stimulating" activity but also a "diversion". Overall, they argue that being able to move is a "reflective expression of the life force one still has" (p.789).

This thesis has been informed by Gardner's (2014) definition of "community mobility" as "independent outdoor locomotion", which includes participation in a range of activities that are both "required for daily living", as well as for "personal

well being" (p.1249). Such a definition recognises that the journey from A to B is a "meaningful lived space in itself" and holds value to older people (see also van Hoven and Meijering, 2019). In a thematic synthesis of qualitative research that explored older people's everyday travel experiences, Graham et al. (2020) highlighted that mobility was valued by older people for both extrinsic reasons such as reaching a specific destination, as well as intrinsic reasons, where travelling was valued and perceived as beneficial to wellbeing in and of itself. Furthermore, Musselwhite (2017) has identified the importance of "discretionary travel", travel for its own sake to older people and how this is important for overall health and wellbeing. Van Hoven and Meijering (2019, p.1) argue that what might appear as more "mundane" or "everyday" forms of mobility, such as short and regular trips in urban neighbourhoods, may be overlooked within urban planning, but play an important role in the overall wellbeing of older adults and contribute to place attachment over time.

The number of outdoor personal projects older adults participate in is positively associated with self-rated quality of life (Curl et al., 2016). However, the nature of these projects is important. For example, a negative relationship was observed between participation in utilitarian projects (i.e. chores) and quality of life. Curl's (2016) findings demonstrate that not all forms of getting outdoors are equally beneficial for wellbeing. If individuals *have* to get out, particularly in more unsupportive environments, this could have adverse impacts on quality of life

3.1.2 Mobility and Independence

A core wellbeing benefit that results from mobility is that it enables older people to be independent (Graham et al., 2020; Schwanen et al., 2012; Schwanen and Ziegler, 2011). Schwanen et al. (2012) conceptualise independent mobility as:

> older adults' ability to move fluidly through geographical space; their ability to do things at different sites in geographical space and thereby be socially connected, participate in civil society, and enact desired identities (p.1321).

As highlighted in Chapter 2, independence is the overarching valued functioning of older people and is the portal through which all other valued functionings are

accessed through (Meijering et al., 2019). As a result, mobility is intrinsically linked to older peoples sense of identity and getting out is therefore a way of enacting and preserving that identity (Gardner, 2014; Kellaher et al., 2004; Peace et al., 2005; Schwanen et al., 2012). In a metasynthesis of qualitative studies on older adults' perception of mobility, mobility was found to be an "integral part of sense of self and feeling whole" (Goins et al., 2015, p.935). Recognising the contribution that older people can provide both to others and to their communities (Wiles and Jayasinha, 2013), Croucher et al., (2020) have demonstrated that mobility is important to provide support and can be an "act of care" (Croucher et al., 2020, p.1789). Whilst the ability to get outside is crucial for older adults' sense of independence, research has also shown that independence is a "complex and fuzzy notion" (Schwanen et al., 2012, p.1313), and is typically defined broadly and fluidly by older people, based on existing contexts and abilities that change over time (Allam, 2015). Schwanen et al. (2012) found that participants in their research described dependency as relying on other people for lifts and provoked feelings of being a burden, whereas being independent meant being able to drive, walk, use buses or taxis.

3.1.3 The importance of mobility for social interaction and connectedness

A key reason that mobility (intrinsic or extrinsic) is so highly valued by older people, is because it is important for social interaction and connectedness (Graham et al., 2020). Existing research exploring the lived experiences of older people within their local physical and social environments using 'go-along' methods, has shown that socialising with other people is one of the strongest motivators for leaving the house and getting outdoors (Carroll et al., 2020). For many people, the home can be be a place of loneliness and isolation, particularly if individuals live alone and have few visitors (Gardner, 2014). Often, to overcome a sense of loneliness or social isolation, older people *need* to leave the home. Several studies have shown that older people leave the home to counteract "the loneliness and tedium of home life", which in turn helped them to feel connected to the "wider social world" (Graham et al., 2020, p.864).

Social participation and engagement are crucial components of the overall quality of life of older people (Bowling and Gabriel, 2007; Victor et al., 2004). This is unsurprising, as existing literature has also shown that individuals who have fewer social relationships, are socially isolated, who perceived themselves to be lonely, and who live alone, are at greater risk of premature mortality (Glass et al., 1999; Holt-Lunstad et al., 2015). Furthermore, these risk factors are comparable to well-established mortality risk factors such as obesity and smoking (Holt-Lunstad et al., 2015; Holt-Lunstad et al., 2010). I distinguish here between loneliness as a perceived state and social isolation as a measurable amount of social contact (Holt-Lunstad et al., 2015). Someone may be objectively socially isolated but not feel lonely and vice versa. Equally, someone living alone may or may not feel lonely, depending on the extent that they feel socially connected (Holt-Lunstad et al., 2010).

In ethnographic research with older people aged 75 and over who lived alone in Toronto, Canada, Gardner (2014) observed the "push of loneliness and the pull of "others"" (p.1252), that encouraged older people to leave their homes. When asked why individuals leave the home, the most common response was the "desire to interact with others" (Gardner 2014, p.1252). Gardner's (2014) work highlights the important role of social engagement in community mobility and how getting out and about to interact with others was of great importance to older people themselves. Community mobility is therefore vital for feeling socially connected, which Morgan et al. (2019, p.1126) argues is a "multi-level concept" including interpersonal relationships, as well as more broadly the neighbourhood and wider society.

Connecting back to the need for relational understandings of ageing in place identified in Chapter 2, owing to the importance of the social environment, mobility also needs to be thought about relationally (Ziegler and Schwanen, 2011). This connects to Duff's (2011) work on enabling places, recognising the social, affective, and material resources that can support individuals, as well as the relational nature of agency. In particular, social participation needs to be viewed as "spatially and temporally embedded everyday relational practices" (Ziegler, 2012, p.1297), which are influenced by the design of the built environment owing to the role they play in the "construction" of social relationships. (Phillips, 2018, p.74). Certain places along

the way and at destinations appear to be of particular significance for older people to engage with others whilst they are out and about, and these are now considered.

3.2 Places of Importance for Social Interaction

The importance of social connectedness and social participation to older people, raises the importance of considering the types of physical environment characteristics or 'Social Infrastructure', that can provide the "stage on which networds of social interaction take place" (Buttimer, 1976, p.285). Social Infrastructure is defined by Klinenberg (2018) as any place where people congregate, engage or interact in some way:

> Social infrastructure is not "social capital"–a concept commonly used to measure people's relationships and interpersonal networks–but the physical conditions that determine whether social capital develops (Klinenberg, 2018, p.5).

Gardner (2011) offers a useful way of exploring this through the identification of the "social places of public life" (p.264) and key "sites of significance" for older people (p.268). This involves three categorisations of places: thresholds, transitory zones, and third places. *Thresholds* are "hybrid" and "semi-public" areas, building on the work of Peace et al. (2005), who recognise the importance of the "intervening space between accommodation and street life" (p.202). Examples of thresholds would typically be a garden (Peace et al., 2005), but also porches, patios, or balconies (Gardner, 2011). These places provide "easy and readily available opportunities for social interaction", typically involving neighbours (Gardner, 2011, p.266). Existing research has shown that gardens are of great importance to older people for social interaction (see Bhatti, 2006; Bhatti and Church, 2001; Burton et al., 2015; Milligan et al., 2004). For older people less able to get out, thresholds can be of particular significance, for example by enabling them to continue to engage more passively with nature (Orr et al., 2016). These "micro-mobilities" can provide ways for older people to remain connected with the "vitality" of a neighbourhood, as well as help to confirm their "presence and status" (Lord et al., 2011, p.58). The second category is *transitory zones*, which are not destinations, but instead the "places we pass through during the course of daily public life", often travelling to get to destinations (p.267).

These include footpaths, building lobbies, a train or underground station, a seat on a bus, or a queue at a supermarket or bank. I now consider the importance of social interaction whilst travelling.

3.2.1 Social Interaction Whilst Travelling

While travelling is important to reach destinations for social interaction (discussed later), travelling itself can also be an important "site" and there is a need to recognise "*the social worlds of travel"* (Graham et al., 2020, p.861), with certain modes of more importance for this than others. Existing literature has shown that social exclusion of older people is multi-dimensional and influenced by several inter-connected domains, including: neighbourhood and community; services, amenities and mobility; social relations; material and financial resources; socio-cultural aspects; and civic participation (Walsh et al., 2017, p.92). Within this, the neighbourhood context and the availability of accessible transport vital sub-domains and can support older people to remain connected and socially engaged within their communities (Sutton and Hill, 2010; Walsh et al., 2017). I now consider the key modes of travel: walking, cycling, public transport and driving and how social interaction can vary amongst these.

Walking is an activity that is highly valued amongst many older people (Franke et al., 2013; Graham et al. 2020; Lager et al., 2019). Walking can be beneficial to health and wellbeing through benefits associated with physical activity and exercise (Graham et al., 2020). Depending on where the walking takes place and the quality of this experience, it may also provide therapeutic benefits (see Gatrell, 2013), for example when walking in or near blue, green or white spaces, and in areas of higher aesthetic quality (Day, 2008; Finlay et al., 2015; Roe and McCay, 2021). Furthermore, therapeutic benefits of walking and being outdoors have been found specifically for people with dementia (see Brittain et al., 2010; Cedervall et al., 2015; Odzakovic et al., 2020; Olsson et al., 2013). Engaging with nature is highly valued by older people as a restorative and therapeutic activity, and can be an important motivator to leave the house for a change of scenery and be an important destination in its own right (see Finlay et al., 2015; Milligan et al., 2004; Gardner 2014; Graham et al., 2020). Whilst some older people may prefer to engage with nature to escape,

find solitude, peace, or tranquillity (Orr, 2016), research on green spaces has shown that they can also be important sites for social interaction and developing social networks (Finlay et al., 2015; Gardner, 2011; 2014; Home et al., 2012; Kemperman and Timmermans, 2014; Kweon et al., 1998; Sugiyama et al., 2009; van Eck and Pijpers, 2017). However, research has shown that role of green spaces for social interaction for older people is strongly influenced by perceived safety (Hong et al., 2018; Kemperman and Timmermans, 2014; Sugiyama et al., 2009).

Walking as an activity is important for providing opportunities to socialise with others (Day, 2008; Franke et al., 2013; Lager et al., 2019; van Eck and Pijpers, 2017; van Cauwenberg, 2012; Walsh, 2014) and research in Galway in Ireland has shown that more walkable neighbourhoods can lead to the development of social capital for all ages (Leyden, 2003). Van Eck and Pijpers (2017) explored the daily walking routines of older people in an urban park in the Netherlands using participant observation and walking interviews. They found that going for a walk is a strong motivator for leaving the house for those older people who are in the routine of doing so, highlighting the power of these walking habits and routines to older people. In addition, the layer of social relationships as an important part of this routine was revealed, showing how the "recurring encounters between familiar strangers" are "full of significance" (p.166). Such walking patterns provide opportunities for and can sustain "an atmosphere of fellowship that encourages people to notice, and care for, each other", as well as notice when someone may be absent (p.166).

A study in Copenhagen exploring the importance of neighbourhood open spaces surrounding older people's homes, including local parks and village greens, has shown that walking was more prevalent in areas with adequate shade, seating, landscaping, and where footpaths are in a good condition (Schmidt et al., 2019). Social interaction, however in this instance, was negatively associated with walking, which emphasises that older people in the study often prefer to sit and talk in parks, therefore raising the importance of benches. Other studies have shown that benches can "become like porches" (Ottoni et al., 2016, p.33) in how they foster social interaction, highlighting the need for walkable local environments to include resting places (see also Gardner, 2014). The quality of the local walking environment,

however, is a key factor in the levels of social interaction. Van Cauwenberg (2012), for example, highlights that to promote walking for transport, neighbourhood environments should have:

> good access to shops and services, well-maintained walking facilities, aesthetically appealing places, streets with little traffic and places for social interaction. In addition, the neighborhood environment should evoke feelings of familiarity and safety from crime (p.1).

This raises the importance of the context in which walking occurs, which can influence the quality of experience, as shown by Curl and Mason (2019). For example, in areas less well served by public transport, individuals may *have* to walk rather than *choose* to walk as an enjoyable activity, which can provide a very different experience and impact either positively or negatively on wellbeing.

Another place that can serve as both an important site for travelling (particularly walking), and serve as a destination, is the high street. Existing research has shown that "street socialising (Day, 2008, p.308) is very important to older people (McDonald et al., 2021; Phillips et al., 2021). In general, research has shown that having destinations and amenities within close proximity to the home can encourage opportunities for social interaction, as well as increase the walking patterns of older people (see Nathan et al., 2012). Day (2008) highlights the way that exercise, walking, nature, and social interaction are interrelated, and has identified five qualities of the local outdoor physical environment that can either support or challenge health. Day (2008) argues that a "healthy outdoor environment" for older people is one that is (pp.304–309):

- clean and free from pollution
- peaceful and quiet
- facilitates physical exercise – predominantly through walking
- supports social interaction
- is emotionally uplifting e.g., through pleasing or inspiring views or aesthetics.

Many of these factors are components included within the *Restorative City* framework, which has been informed by theories of restorative environment and the

concept of salutogenesis and is designed to support practitioners to implement what Roe and McCay (2021) call “restorative urbanism” (p.1). As shown in Figure 3.1, the framework identifies seven inter-connected pillars of a restorative city: green, blue, sensory, neighbourly, active, playable, and inclusive and highlights the complex ways that these factors can influence mental health and wellbeing (Roe and McCay, 2021).

Figure 3.1 Restorative City Framework (Source: Roe and McCay, 2021, p.13)

In Ireland, results from the Healthy and Positive Ageing Initiative (HaPAI) survey showed that 66% or two-thirds of participants aged 55 and over walked in their local area for health or fitness. Meanwhile one-third either did not walk (29%) or were physically unable to due to mobility challenges (5%) (Gibney, 2018). In the Irish National Travel Survey from 2019, 70.8% of males aged 65–74 walked weekly and of these, 46.4% walked at least 5 times per week (CSO, 2019). This reduced to 39.8% for men aged over 75, whilst 52.2% never take a journey by foot. Similar rates are shown for women aged 65–74, with 69.5% walking weekly, and 41% of walking 5 times a week. However, a much higher percentage of women aged over 75

walked weekly at 55.5%, with 27.9% walking at least five times a week, whilst 33% never walked. The average length of journey taken by foot for men aged 65–74 was 2.6km, compared with 4.3km for women of the same age. For men aged 75 and over 2.6km compared with 2.3km for women. Walking for most older people in Ireland is therefore a daily or weekly practice, although this does decline with age.

Existing literature has shown that cycling can be beneficial for social interaction (see Garrard et al, 2012). However, Ireland does not have the rates of cycling observed in other countries, with just 15% people aged over 18 choosing to cycle as a mode of transport (CSO, 2019). In TILDA (The Irish Longitudinal Study on Ageing), which is a nationally representative cohort study of older adults aged 50 and over, just 6% of people aged 50 and over travelled by either bicycle or motorbike (Donoghue et al., 2017). These low figures reflect the "underdeveloped" cycling infrastructure within Dublin and Ireland (Conway et al., 2019).

Owing to the "public" and "shared" nature of public transport, existing research has shown this mode of travel can be important for social interactions, although this depended on perceptions of the safety of engaging with strangers. As a result, social interaction was not always guaranteed and was often fleeting (Currie and Stanley, 2008). Research in Northern Ireland exploring the experiences of older people using a rural transport community bus service, has shown how it is highly valued for "helping escape isolation, maintaining autonomy, and providing an informal space for relationship building and accessing local news" (Hagan, 2019, p.2519). Initiatives such as free public transport travel, which is the case in Ireland for those aged 66 and over, can support older people to be more mobile, but only if they are able to avail of this (Shannon, 2012). Existing research has shown the importance of concessionary or free bus travel for social interaction amongst older people (Green et al., 2012) and how it is associated with reduced loneliness and depressive symptoms (see Reinhard et al., 2018). However, studies have also shown that many older people face barriers using public transport, owing to unreliable bus services, lack of help with getting on and off the bus, as well as racial discrimination for older adult migrants (Jones et al., 2013; Morgan et al., 2019).

Driving as a mode of travel can lead to reduced opportunities to socialise with others, but this depends on who is in the car and whether individuals are receiving or giving lifts. Being able to drive can provide more opportunities to socialise with others in areas that could be inaccessible otherwise (Ziegler, 2011). Existing research has demonstrated the negative impacts on wellbeing associated with having to give up driving (e.g. Davey et al., 2007; Goins et al., 2015; Mezuk and Rebok, 2008; Zeitler and Buys, 2014) and relying on lifts, as this can lead to individuals feeling like a burden (Schwanen et al., 2012). Literature suggests that older people are "increasingly (auto)mobile" (Böcker et al., 2017, p.831) and this is certainly the case in the Irish context. According to findings from TILDA, almost 90% of people aged 50 and over travel predominantly by car and of these just over 72% drove themselves (Donoghue et al., 2019). Meanwhile, one in ten rely on public transport and this increases to one quarter of people living in Dublin, reflecting the increased availability of services compared to more rural locations. 14% of people aged over 50 use taxis as a form of travel (Donoghue et al., 2017). TILDA research has explored the relationships between transport modes and driving status, with measures of depressive symptons, quality of life, loneliness, monthly involvement in social leisure activities or volunteering, and social network strength (Donoghue et al., 2019). Results found that individuals whose main mode of travel was driving themselves or travelling by public transport reported greater participation in social activities or volunteering, compared to those who relied on a lift from others (Donoghue et al., 2019).

3.2.2 Destinations of Importance for Social Interaction: The Role of 'Third Places'

The final category Gardner (2011) identifies as being an important site for social interaction is *third places*. Originally developed by sociologist Ray Oldenburg, these places are not home (first place), or work (second place), but are "informal public gathering places" (Oldenburg, 1997, p.6). They include places such as bars, main streets, pubs, post offices, cafes or coffee shops, bookstores, and hairdressers (Oldenburg, 1989). In his influential book "*The Great Good Place*", (Oldenburg, 1989) identifies seven key distinguishing features of third places: neutral ground; social levellers; conversation is the main activity; accessible and accommodating;

visited by regulars; a low profile; a playful mood; and a home away from home (p.22–42). Whilst Oldenburg (1989) recognised that third places were important for older people, especially those who are retired, he did not focus specifically on them within his work. However, Gardner (2011) has updated and applied the work of Oldenburg to explore the key third places of importance to older people. These include public parks and certain types of local businesses, including diners, bakeries, barbershops and small grocery stores or local shops. Gardner (2011) argues that smaller "single purpose shops" can be more "accessible" and "comfortable" for older people to use than larger supermarkets (p.66).

Alongside Gardner (2011), there is additional research that has explored the importance of a range of (third) places for older people for the purposes of social interaction, and have shown how they can contribute to wellbeing in later life (Alidoust, et al., 2019; Cheang, 2002; Fong et al., 2002; Hutchinson and Gallant, 2016; McDonald et al., 2021; Morgan et al., 2019). Alidoust et al. (2019) observed older adults aged 65 and over as they participated in third places and carried out semi-structured interviews with over 50 individuals. The field work was carried out in suburban areas in Australia with different built forms, including more conventional suburban developments, as well as master planned areas including age-segregated developments. Results highlighted the important role of third places in providing opportunities to engage with others in the surrounding community, and how this contributed to both social health and wellbeing. Several groups of third places were identified as being important to older people (pp.1470–3). This included mixed-use places such as shopping areas, banks, post offices, and cafes and restaurants. Often these were located together, for example, on a high street and this was valued for convenience and accessibility and to reduce the number of trips needed. Another group of third places were more local and included churches, shopping centres, public libraries, and clubs. Participation in age-segregated clubs and social groups were identified as important and led to older people having a high number of social ties. Finally, common areas and leisure centres in master planned communities were identified, although the frequency of use of these facilities was mixed.

An important consideration of the use of these third places was how accessible they were, and this strongly influenced whether older people could participate. In the more suburban built forms of Alidoust's et al (2019) study, many participants would have found it challenging to travel to these third places without a car and raised concerned about what they would do if no longer able to drive in the future. Participants described how they would avoid travelling in some areas that were busier or less familiar. Many barriers with using public transport were also identified. This was particularly the case for individuals living in cul-de-sacs where the bus stop was located a "considerable distance" from their homes and the frequency was unreliable (Alidoust et al., 2019, p.1466). This suggests that older people living in more suburban locations and no longer able to drive, or have never driven, may struggle to attend third places, and engage in social activities, which could lead to restricted social lives, with implications for quality of life and wellbeing.

The Importance of Social Groups to Older People

Whilst Oldenburg (1989) emphasised the unstructured and informal nature of third places, Gardner (2011), like Alidoust et al. (2019), noted that more formal community organisations and institutions, such as community centres, older adult specific activity centres, and local churches, can "operate" as third places (p.266), applying a far less rigid criteria compared with Oldenburg's original work. These destinations are of relevance to older people and are typically attended on a regular basis and at a specific time, either for all ages or specifically for older people.

Several studies have explored older people's experiences of these social groups or clubs (see Alidoust et al., 2019; Fong, 2020; Gardner, 2011; Hutchinson and Gallant, 2016; Morgan et al., 2019; O'Brien et al., 2004; Tse and Linsey, 2005; Wiles et al., 2009; Ziegler et al., 2012). Whilst several benefits were found, not all experiences were positive and this largely depended on the quality of the space and experiences offered, as well as how on well it aligned with the interests and matched the abilities of attendees. Fong et al. (2020) carried out focus groups with 31 older people who attended the same bridge club in a suburban location in Australia. Results identified the various ways that this club was important to older people, by providing purpose,

a “reason to get out of bed” (p.14), a “permanent place to go”, a “stable routine in their daily lives” (p.11), a shared identity, and long-lasting social supports, even when individuals were no longer able to attend. Participants described a “ripple effect” of social interaction (p.18), where attending this group led to additional opportunities for interactions outside of the club. Fong et al., (2020) also described some of the challenges with the club, including practical challenges with using the space due to it not being large enough. Participants described a shared desire to improve the facilities through fundraising and the space provided a base for “collective action”, as participants expressed frustration and felt that the provision of community spaces had been “overlooked” by politicians as it was a more affluent neighbourhood (p.16).

Hutchinson and Gallant (2016) carried out community-based participatory research with members of a ‘senior centre’ in Canada. Whilst results showed that the centre provided opportunities for meaningful engagement, sociability, and providing participants with a role, the opening hours were deemed restrictive and there were limited opportunities to take leadership and be involved in the decision-making of activities. Hutchinson and Gallant (2016) questioned whether senior centres could truly operate as third places owing to the age-segregated nature of them. Another study from Canada evaluated the impact of a community-engaged arts programme on the wellbeing of older people, which involved weekly workshops over a period of three years (Phinney et al., 2014). Results demonstrated that older people improved their perceived health, experience of pain, and sense of community. During group interviews, multiple benefits were identified (pp.340–2). The first was that attending the workshops *provided structure and discipline,* as well as motivation to “rediscover and sustain a healthy lifestyle through increased activity and interaction” (p.340). Secondly, the programme was helpful for *facilitating coping* and helped participants to “better manage the physical and emotional challenges they faced”, as well as provided a “distraction from the discomforts of everyday life” (p.340). Participants enjoyed that the programme provided a “sense of being challenged”, *requiring hard work* (p.341) and through the creative process, allowed participants to “develop and explore their identity”, *bringing out one’s artistic side* (p.341). The workshop was important for *promoting social involvement,* providing opportunities for participants to “build a community and create strong social ties”, both within the

group and outside the group (p.341). Finally, the programme helped participants to feel like "valued members of society" and that they were *making a contribution* (p.342).

Within an Irish context, using case studies of two towns in a suburban county within the Greater Dublin Area, McDonald et al. (2021) identified places of importance for social interaction of older people and demonstrated how older adults engage socially through daily activities whilst out and about. This included whilst out walking and shopping, as well as through attending organised groups and Mass. In addition, Gallagher (2012) conducted research in Ireland exploring the social and communal life of older people, carrying out ethnographic research, observation work, and interview-based surveys older adults in a suburban area of Dublin city, as well as a rural village in the north-west of Ireland in Co. Donegal. Results confirmed that older people in Ireland had a broad and varying range of leisure interests and engaged in a variety of forms of social engagement. Approximately half of the larger sample in suburban Dublin were members of some sort of social group, which provided opportunities for "meaningful engagement" (p.91). However, results identified that there were some participants that did not attend these types of groups for varying reasons. Some specified that they were not for them, e.g. "I am not a joiner" or that they were "a home bird" (p.91). Others claimed they were shy and needed a bit of encouragement to attend, whilst some did not like groups that were just for older people, preferring activities that included a broader range of ages (Gallagher, 2012).

Gallagher (2012) identified several important social and communal settings, including "sports and social clubs, churches, voluntary groups, day centres, pubs, special interest groups and community events" (Gallagher et al., 2012, p.91). Attending church and Mass was also identified as being of importance to older people. Results emphasise that many older people in Ireland "are connected within vibrant informal ties of neighbouring, church and community settings" and that these are a "rich landscape of relatedness consisting of multidimensional relationships based on kinship and friendship" (p.98). Gallagher (2012) argues that policymakers and service providers need to recognise the "holistic nature of well-being and the enormous value added to people's lives by neighbourhood social groups and clubs"

(p.99). To put this into context, TILDA results demonstrate among the 90% of the older Irish population who identified as being a member of a religious group (of which 90% were Catholic), 67% of older people aged 65–74 attended a religious service at least once per week and this increased to 76% for those aged 75 and over. Religion was identified as being more important to women than men (Timonen et al., 2011). Meanwhile, results from the HaPAI Survey reveal that 48% of people aged 55 and over participate in community activities at least once a month.

Existing literature has highlighted the importance of paying attention to the daily rhythms and routines of older people, as this can influence the experience of ageing in place (Franke, 2013; Lager et al., 2016). Informed by the work of Lefebvre (2014) on *Rhythmanalysis*, Lager et al. (2016) explored the daily rhythms and routines of older people in the Netherlands using go-along interviews. Results revealed a "slowing down" of activities in many instances for participants, along with a "shrinking life world" (p.1571). Alongside this, there was evidence of participants participating in regular activities and routines as "anchors", to provide structure to their days. This included walking, shopping, cleaning, and participating in club activities, "punctuating time" to make life more eventful and to ensure that a perception of "keeping busy" was maintained, the "preferred rhythm" of most participants in the study (p.1574). Results highlighted some "discontinuities" between generations, as well as with older people themselves and their expectations based on their younger selves (p.1574). This led to older people feeling "out of synchronicity in time and place" (p.1575). They were also influenced by seasonal rhythms which influenced their daily experiences. Furthermore, research elsewhere has highlighted that mobility patterns can vary across the day, with many older people less likely to travel at night (Scharf et al., 2001; Smith, 2009).

Overall, travelling to a destination can provide additional motivation to get out, by providing "structure and focus to the trip" and "enhance the opportunities to socially interact with others" (Graham et al., 2020, p.856). Furthermore, the availability of local destinations to visit can enhance motivation and experience of travel and provide additional opportunities to socially interact with others (Graham et al., 2020). I now consider the nature of relationships and interactions that can happen

whilst engaging in the different sites or phases of getting out and about identified by Gardner (2011).

3.2.3 Nature of Social Interactions and Relationships

Klinenberg (2018) argues that different types of social infrastructure "play different roles" within a community or neighbourhood and in turn foster different forms of "social ties":

> Some places, such as libraries, YMCAs, and schools, provide space for recurring interaction, often programmes, and tend to encourage more durable relationships. Others, such as playgrounds and street markets, tend to support looser connection – but of course, these ties can, and sometimes do, grow more substantial if the interactions become more frequent or the parties establish a deeper bond (Klinenberg, 2018, pp.17–18).

Gardner (2011) identifies three types of relationships that older adults typically experience whilst out and about. These include: relationships of proximity (for example with neighbours), relationships of service (for example with cab drivers, wait staff and 'sales clerks', and finally, relationships of chance (typically with strangers) (pp.267–8). Gardner (2011) demonstrates how these relationships combine and culminate to create an "informal, neighborhood social network", or what she describes as a "natural neighborhood network" (p.267), defined as:

> a web of informal relationships and interactions that enhance well being and shape the everyday social world of older adults aging in place (p.268).

Gardner (2011) considers the different types of interactions that occur within third places and transitory zones and argues both tend to encourage more "natural relationships and interactions":

> Natural in this context means they are not 'forced' or 'formal' (i.e., they were not paid service staff, volunteers from support agencies, or healthcare professionals), nor are they 'familial'. Instead, these interactions are more universally shared (e.g., across age groups), often spontaneous, informal, everyday encounters and relationships with non-family members (p.267).

Furthermore, she argues that these networks are situated within, and complement a layer of additional forms of informal and formal support systems:

> Natural neighborhood networks do not replace or negate the importance of informal systems of family and friends, or formal support systems provided by public and private agencies and services. They complement them (p.269).

In a systematic literature review of the social needs of older people Bruggencate et al. (2017), found a diverse array of social needs. Expectations of social needs and neighborliness can vary significantly between older people (Yen et al., 2012). Both close relationships, as well as peripheral relationships, are important to older people and contribute to a sense of social connectedness and safety. Existing research has highlighted the role of third places and social groups as being important for the development of peripheral relationships. For example, Alidoust et al. (2019) identified that the nature of social ties within the bridge club were predominantly weak, where there may be some degree of acquaintance, or absent, where an individual may merely nod to a stranger. In some instances, they were stronger and had led to friendships and deeper ties. In the mixed-use third places, participants would often meet people they already had strong ties with, which were developed through participation in other activities.

The importance of informal, or weak ties to older people has been shown elsewhere, for example Franke et al., (2019) has highlighted the importance of "superficial contacts" to older people, which are the "everyday encounters people have with others they do not know while out" (p.1654). However, existing research has shown instances where opportunities for this have decreased, particularly in areas experiencing change or where there are fewer reasons to engage with others (see Ziegler, 2012; Day, 2008). Day (2008) compared the experiences of older people living either in inner city or suburban locations and found fewer opportunities to walk and visit local services in the suburban locations, and thus fewer opportunities to engage with others. Ziegler (2012) has highlighted that thresholds and streets can be important places for social interaction. However, presenting two in-depth case studies of working-class older women, Ziegler (2012) showed how social interaction had reduced in these places over time, predominantly due to the presence of cars.

Instead, the women had to rely on participating in social clubs for interaction with others.

Research has shown that older peoples' relationships with others can change over time and across the lifecourse. Some older people may pro-actively choose to reduce their ties "in accordance with one's age-specific needs" and this may contribute to improved wellbeing (Lang, 2001, p.321). Owing to the diverse social needs of older people, it is important from a Capability Approach perspective, that the social environment can match expectations or desired functionings, so that an individual can engage to the level that they themselves seek or desire. Some older adults are content with more limited encounters, whilst others may prefer solitude at varying times (Cattell et al., 2008) and that this is likely to be influenced by their situation at home. For example, research by Ziegler and Schwanen (2011) emphasised the importance of finding "a balance between social contact outside the house and solitude at home" and having the choice about "when to interact with others" (Ziegler and Schwanen, 2011, p.771). This research highlights that valued functionings, along with the social environments in which older adults engage with, are fluid and diverse. Wiles et al., (2009) have developed the concept of "social space" to capture this, recognising older peoples' elastic physical, imaginative, emotional and symbolic experiences of and connections to people and place across time and in scope" (p.664).

3.3 Navigating the dynamic challenges that can be associated with getting out and about

Whilst leaving the home has the potential for a variety of wellbeing benefits, depending on an individuals' personal and environmental context, it can also present challenges, fear, and risk. When an individual deems these to be too great, it may be altogether avoided (Peace et al., 2011). This highlights that whilst community mobility is usually valued by older people, the process is "complex, dynamic and often difficult" (Gardner, 2014, p.1249). Existing research has shown that as people age, their activity space may shrink and the importance of the immediate local environment becomes more apparent (Moeyersons et al., 2022; Schwanen and Páez, 2010). However, the relationship between activity space and the ability to be mobile

is complex, as certain modes of travel can lead to greater activity spaces than others (driving versus walking for example). The relationship between life-space, social connectedness and wellbeing is also complex. For example, a qualitative GIS approach to older adult mobility has shown that the way 'local environments' are defined by older people can "stretch" beyond administrative and neighbourhood boundaries and that conceptualisations of neighbourhood can change seasonally and over the lifecourse. Furthermore, mobility tends to be associated more with social factors than places (Milton, 2015). Nonetheless, research has shown that as life-space declines, so too does quality of life (Rantakokko et al., 2016) and that barriers to both mobility and outdoor social participation are associated with both increased loneliness and isolation (Rantakokko et al., 2014), as well as a reduction in social connectedness (Morgan et al., 2019). For those individuals experiencing reduced mobility and loneliness, they report a sense of a loosening "grip on the world" and describe a "literally and figuratively shrinking world" (Moeyersons et al., 2022, p.1).

A reduction in mobility does not necessarily reduce social connectedness, reduced wellbeing and increased social isolation, although research has shown it does "increase the necessity for leveraging pre-existing social capital" (p.1133). This can lead to feelings of burden. As a result, the experience of reduced mobility is influenced by the extent of an individual's existing social network and secondly, the willingness of the older person to draw on this. As a result, the size of an older persons' activity space does not always equate with reductions in wellbeing, and there is a need to consider the on-going experience of getting out and about. The size of an activity space does not appear to be as important for wellbeing, as what is available to an individual within it, the quality of this experience, or how well a transition or change is managed and coped with.

There is a wealth of existing literature that has identified features or characteristics of the local environment which can be barriers for older people getting out, particularly those older people whose mobility may be constrained (see Brookfield et al., 2017; Gardner, 2014; Gilroy, 2006; Lavery et al., 1996; Newton et al., 2010; World Health Organization, 2007). As highlighted in Chapter 2, many studies have described the ageing in place experiences of older people who are living in environments that are not conducive to ageing well. Both the design and

maintenance of the external physical environment can influence the ability of older people to get out and about (Newton et al., 2010), as well as a variety of material, social and psychological factors (Holland et al., 2005). During in-depth interviews including structured questionnaires and photo elicitation methods with 200 older people aged 65 and over in the UK, older adults identified several built environment characteristics that influenced their decisions about getting out and their sense of safety. Approximately half of the participants identified having mobility, vision, or hearing difficulties, which limited their daily activities. Just over one-third used some form of mobility aid, and one-fifth had either stumbled or fallen outside within the six months prior to the interview. Salient features included the need for well-maintained, firm, flat and wide pavements (including steps and ramps); safe pedestrian crossings; adequate seating to provide places to rest between home and local facilities; well-maintained greenery to improve the walking experience; bus shelters with seating; public toilets; and simple, easily visible, and understandable signage (pp.26–8).

Alongside a growing awareness of the need to plan for and design age friendly environments, and increasing understanding about environmental characteristics that may serve as barriers to older people, it is increasingly recognised that "an 'optimal' or 'ideal' environment for 'ageing well' is complex and multifaceted" (Phillips, 2018, p.68). Approaches that focus on more objective and universal environmental standards, characteristics or barriers have been criticised for a failure to recognise the heterogeneity of the older adult population and their experiences, and that what may serve as a barrier for one individual, may not for another (Phillips, 2018). The use of universal standards, therefore ignore context and difference (Buffel et al., 2018; Phillips, 2018; Handler 2014). Phillips (2018, p.70) raises an important question as part of this critique: "What kind of older people are age-friendly communities trying to reach?". This creates challenges, because the needs of older people are so different (Lavery, et al., 1996). Focusing soley on the needs of one group may serve to reinforce the exclusion of another, unless this diversity is recognised (Phillips, 2018). A key challenge for policymakers, planners and service providers, therefore, is how to plan for the varying needs and wishes of older people in a way that captures diversity of experience, recognises dynamic processes that influence both personal and environmental characteristics, as well as what is valued by the older person

themselves, whilst also recognising that existing inequalities that make it easier for some to age well than others?

Examining mobility from a Capability Approach lens, mobility can be defined as "the ability to choose where and when to travel and which activities to participate in outside the home in everyday life" (Nordbakke, 2013, p.166). Nordbakke (2013) shows that the opportunity to be mobile is not "fixed", instead it is "managed, shaped and directed by the individual" (p.166). Individual resources and contexts at a given moment in time, provide the opportunity to be mobile, as well as the strategies available to overcome barriers, which can then shape overall mobility patterns. Ryan and Wretstrand (2019) have applied a Capability Approach framework to explore the link between modes of travel available to older people and opportunities to participate in everday activities. Results highlight that a combination of health challenges and a lack of public transport infrastructure, particularly lack of services, can lead to participants being unable to have "the possibility to participate" in activities that were valued (Ryan and Wretstrand, 2019, p.107). However, research has also shown that older people can be highly strategic decision makers when determining how to interact with their broader than home environment (Holland et al., 2005).

Components that tend not to be incorporated into age friendly environment design are the more intangible qualities that are often of importance to older people themselves, as well as the dynamic nature of the person-environment relationship. Existing research has shown that health professionals and older adults themselves differ in the identification of places of importance for ageing in place. Health professionals are more likely to report more objective characteristics such as access to amenities, mobility, and meeting places, which can support older people to live independently. Older people, however, place more emphasis on their "specific lived experience and attachment to specific, intangible and memory-laden public places" (van Hees et al., 2017, p.11). Often these valued components can only be captured through more novel and creative methodologies (Handler, 2014) and this is discussed more in Chapter 4. The complexity of personal and environmental factors and how they interact to influence the experience, capability, and frequency of an individual to get out and about, as well as how this varies over time, shows that a "one size fits

all" approach to age-friendly environments is simply not possible (Hammond and Saunders, 2021, p.10).

Examples of dynamic environmental factors include weather conditions, as well as changes to the social and physical environments. Several studies have identified that certain weather and seasonal conditions can be a barrier to getting out and about, including the impact of rain on walking (Franke et al., 2013). Gardner (2014) showed that weather was a "constant consideration" for participants, and this was particularly the case during winter months (p.1252). This is reinforced by Hjorthol (2013), who showed differences in older adult mobility patterns between the summer and winter in Norway, and that winter weather conditions can produce additional risks to older people, particularly when using pavements. In a study in the US, Finlay (2018) explored the experiences of white spaces and found that both snowfall and icy weather conditions impacted the physical and psychological health of older people when they were unable to get out. However, this research also showed some of the benefits that can be experienced due to this weather, including the beautiful scenery, satisfaction that comes with shovelling snow, as well as strategies to navigate this, including the need to "walk like a penguin" (p.81).

Existing research has shown that neighbourhoods experiencing significant change through urban renewal or demographic composition, can influence the amount of social interaction available for older people and lead to them feeling dis-connected (Lager et al., 2013; Morgan et al., 2019). Furthermore, visiting unfamiliar local environments, whether due to environmental change or visiting new places can cause older people additional challenges (Phillips et al., 2013), and this can be particularly problematic for people with dementia (Brittain 2020, p.281). Research that has explored the experiences of people with dementia has highlighted the increased risk of getting lost, and that often this is more of a concern for carers than for the individuals themselves (McCabe and Innes, 2013). Some strategies to manage this include staying within more familiar areas, as well as relying on social networks for support. This is particularly the case in smaller neighbourhoods where people are known. Another adaptation mentioned by people with dementia is attending events for shorter periods of time (Sturge et al. 2021), allowing individuals to still benefit from getting out of the house. This highlights that changing mobility can often

"involve difficult decisions that were complex, emotional, and often influenced by others" (Goins et al., 2015, p.938).

Gardner (2014) highlights the remarkable determination of older people to continue getting out and about, despite facing numerous challenges, and identifies several adaptations older people made as they navigated this, recognising that:

> Participants' ability and willingness to journey into their neighbourhoods were challenged by a myriad of individual and environmental factors that changed from one day to the next (Gardner, 2014, p.1249).

Examples of adaptations include (p.1251): being flexible and changing plans if needed, adapting travel routes, and only availing of those that are perceived as safer, even if this takes longer, as well reconsidering or consolidating errands to reduce the number of trips taken. In some instances, participants physically prepared to go out by having a nap beforehand. Other considerations included choosing between more comfortable clothing and more weather appropriate clothing. In a study with 34 urban and rural older adults aged 70 and over, Rudman and Durdle (2009) explored the lived experience of older people with low vision. Results showed that a core aspect of their experience was "living with a pervasive sense of fear regarding one's body and way of being" (p.106). Results revealed that participants "continually gauged risks associated with mobility" and "engaged in risk avoidance and management strategies" (Rudman and Durdle, 2009, p.106). These perceived and physical risks often led to restricted community mobility, which in turn led to a reduced ability to participate in a variety of physical and social activities (Rudman and Durdle, 2009).

Another strategy available to older people with declining physical functioning is the use of mobility assistance devices. However, the use of assistive devices can bring mixed feelings, with participants describing both benefits including improved function, reduced main, stability, and psychological security, as well as barriers including embarrassment and a fear that this would lead to dependence (Goins et al., 2015, p.938). Often there was resistance to the use of mobility devices and their use would be delayed and only used as a "last resort". In some instances, individuals felt that their lives had improved, because of "renewed access" to environments that had

previously been unavailable to them and due to increased opportunity for more "supported social interaction" (Goins et al., 2015, p.938). For older people experiencing health challenges, ageing in place in suburban environments can lead to restricted mobility, with individuals having to prioritise travel closer to home. Lord et al., (2011) revealed how driving as a mode of travel for these individuals can be "the last chance for getting around independently" but is also adapted by older people in this situation where only those routes that are perceved as safer are selected, for example, those where disabled parking might be guaranteed (p.58). Lord et al. (2011) argue that this can lead to a more "fragmentation" (p.59) of someone's activity space, where parts of the city are "forgotten" (p.58).

For some individuals, the last response to increased mobility challenges is to disengage. Wiles (2003) demonstrates how some older people become more disinterested in getting out, even when it was previously enjoyed. Told from the perspective of a daughter who described how she tried to motivate her older adult parents, she revealed how they were no longer interested in getting out. Based on findings elsewhere, this may because it had become too difficult, was too much effort, they didn't want to ask for help, or had reluctantly accepted that it was no longer possible. For those older adults who become homebound, it is therefore likely that they have to give up leaving the house because it is perceived as too risky or because they are no longer physically unable to, rather than no longer desiring it. Whilst homebound older adults are at greater risk of depressive symptoms (Choi and McDougall, 2007) and health challenges (Cheng, et al., 2020), coping strategies and resources such as social support and engagement in frequent exercise, can help buffer these negative effects.

3.4 Conclusion

Within this chapter, I have considered literature that explores the importance of community mobility or getting out and about for wellbeing. Reviewing this literature, it becomes apparent that a vital component of the overall experience of ageing in place, stems from the experiences of the broader than home environment:

> aging well *in place* goes beyond being able to live independently in one's own home; it also encompasses feeling socially connected with one's local community (Fong et al., 2020, p.2).

Existing literature has shown that community mobility is vital for older adult wellbeing and quality of life for a variety of overlapping reasons, of which opportunities to connect with others and socially interact appears to be primary motivator for leaving the home. Whilst getting out and about has the potential to provide a range of wellbeing benefits to older people, the quality of this experience will be influenced by the ease with which an individual can get out, as well as the opportunities that getting out provide. Research has demonstrated that getting out and about can be challenging and difficult in certain contexts and for certain older adults, and that this is continually negotiated between older people and their environments. Even with considerable barriers to getting out, participants still chose to "maintain their community mobility" and "rarely elected to stay home" (Gardner, 2014, p.1252). As Holland et al., 2005 comment:

> People in general want and need to get out and about. Older people are no exception: shopping, working, socializing, using services, and giving and receiving support. Beyond the practical, most older people also relish the pleasures and challenges of life beyond the home and strive to maintain for as long as possible their independence and ability to get out and about. (Holland et al., 2015, p.49).

If we can better understand what is of most importance to people and how easy it is to attain these wishes, we may be better able to support older people to achieve those activities of most importance for a good quality of life. Recognising the impact that not engaging beyond the home can have on quality of life, supporting older people to extend this process for as long as possible is vital. Having the capability to be mobile and get out and about are therefore vital components of ageing *well* in place. Furthermore, challenges with getting out and about may be an indication that an individual may be finding it difficult to access and engage with their most valued functionings and may not be ageing in place as well as they could or might wish.

This research will explore what ageing well in place means to older people themselves and how they both define and enact it during their everyday lives. I am

interested in the lived experience of mobility for older adults, including those valued functionings that happen beyond the home, including the places, routes, routines, and interactions of importance to older people. I am interested in seeing how this is navigated by older people in Ireland, focusing on suburban settings, which appear to include many features which may constitute an unsupportive environment. To explore ageing well in place from the perspective of older people, will require spatial, subjective, and qualitative approaches, and with this in mind I turn now to the methodological approach taken for this thesis.

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Chapter 4. Methodology

4.1 Introduction

My overall aim for this thesis is to explore how *well* older people are ageing in place. I am interested in how easy and important it is for older people to get out and about to engage with meaningful activities, interactions, routines, and places, recognising that this is likely to have significant implications on their overall quality of life. As I am interested in individual experiences beyond the home space of older people, the most logical way to explore this is to apply a combination of both qualitative and spatial research methods. Within this chapter, I outline how I designed and carried out my fieldwork. I begin by outlining the overarching ontological, epistemological, and methodological underpinnings of this thesis (Section 4.2). From this, I demonstrate how applying a qualitative and geo-spatial approach aligned with the philosophical underpinnings of this thesis. In Section 4.3, I outline the study design and key methods used for the empirical work presented in later chapters. In Section 4.4, I discuss and reflect on the sampling and recruitment processes, as well as how I determined the study settings for this research. A vital component of this thesis was carrying out a flexible, inclusive, and care-full approach and in Section 4.5, I reflect on the ethical considerations. In Section 4.6, I identify the data processing steps to manage my data and in Section 4.7, I summarise the approaches taken to analyse my data and how I adapted my approach for different empirical chapters and research questions, before concluding in Section 4.8.

4.2 Philosophical Underpinnings of the Thesis

Building on the theoretical principles established in Chapters 1, 2 and 3, I now summarise the ontological, epistemological, and methodological underpinnings, which informed the study design and methods used for this project. A summary of these can be found in Appendix 1.

4.2.1 Ontological and Epistemological Assumptions

Ontology is the study of being and the nature of reality or the social world (Bryman, 2016; Denzin, 2008, p.31; Denzin and Lincoln, 2018). Closely related to ontology, epistemology is defined as the theory of knowledge and how social worlds should be studied by the researcher (Bryman, 2016; Denzin and Lincoln, 2018). Objectivism is an ontological stance, where social phenomena have a reality that is external to individuals that experience them (Bryman, 2016). This stems from more positivist epistemological approaches, where there is one objective truth that is independent of social actors. Constructionism or constructivism, on the other hand, is associated with interpretivist epistemological stances, and asserts that social phenomena and forms of knowledge are created by social actors through their perceptions, actions, and experiences (Bryman, 2016).

My worldview is pragmatic in nature, where depending on the research question in mind, it may be necessary to "blur" traditional paradigm dualities and incorporate objective and/or subjective approaches (Bryman, 2016). I accept the existence of both objective and subjective forms of truth, a perspective common within more applied and mixed methods forms of research (Tashakkori and Teddlie, 1998). Adopting a pragmatic stance, I recognise the existence of an objective or single "real world" but that in addition to this, I acknowledge that individuals can have a unique interpretation of this world, depending on their experiences and that "knowledge is produced through experience" (Elwood, 2010, p.99; Morgan, 2007). Within this research I considered "what difference it makes" to believe one form of truth over another (Morgan, 2007, p.68).

Whilst I accept the existence of both subjective and objective forms of knowledge, within this thesis I focus on *subjective* experiences. In my application of pragmatism, I lean towards a constructionist or relativist ontology and interpretivist or subjectivist epistemology. In doing so, I recognise that there are "multiple realities" and both the researcher and researched "co-create understanding" using naturalistic methodological approaches (Denzin and Lincoln, 2018, p.20). This means that to understand the "complex social world", I need to see it "from the point of view of those who operate within it" (Goodson and Phillimore, 2004, p.36). Within this

thesis, I recognise the diversity of experience and interpretations and that no two people will experience a place in the same way. As a result, I follow an interpretivist approach, which values and incorporates the "meaning that social actors give to events and behaviour" (Bowling, 2014, p.433). From a health geography perspective, this recognises that:

> meanings (of health, illness, experience) are *constructed* out of the interactions (which may be conversations or encounters) that we have with each other in everyday life (Gatrell and Elliott, 2015, pp.37–8).

There are two main ways that I have applied this stance throughout my thesis. The first is how I think about health and wellbeing, including concepts such as quality of life and ageing well. The second is how I think about place. Taking the example of defining a good quality of life, I recognise that quality of life can be defined objectively. An example of this would be CASP-19, used in The Irish Longitudinal Study of Ageing (TILDA), which defines quality of life through a needs model and identifies four key domains: Control, Autonomy, Self-realisation, and Pleasure (McGee et al., 2011). Defining quality of life in this way allows researchers to carry out assessments with large numbers of older people and allows for comparison across multiple datasets. A criticism of more objective quality of life definitions, however, is that they do not provide space to consider how an individual may define a good quality of life and what components may be more or less important to them. Within this thesis, I have adopted Sen's (1993) Capability Approach to well-being to explore the quality of life of my participants. This allows me to consider subjective definitions that focus on valued beings and doings that are of most importance to individuals. Whilst I recognise the existence of both objective and subjective ways of defining a good quality of life, in this thesis, I place greater importance on subjective forms of knowledge within this thesis, where the voice of "ordinary people", or lay people, have equal "status or validity" as that of a health professional (Gatrell and Elliott, 2015, p.38).

Turning now to place, within this thesis I recognise that there are multiple environmental layers of both objective and subjective reality. Whilst positivist approaches can be used to record or identify objective characteristics about an individual or their neighbourhood context, they are less suited to capture what that

means to the individual, for example their subjective (or psychosocial) experience. For example, in an older person's local environment, there may be certain places or characteristics that can be quantified and the existence of these is not questioned. An example could be a transport network or whether certain places or facilities are physically present. However, alongside this layer of objective reality, there are layers of subjective experience and interpretation. I recognise that just because a place is physically present, does not mean it will be used or experienced; instead as researchers we need to understand the "true" environmental exposure through activity spaces (Perchoux et al., 2013). Furthermore, to understand more fully "the social and spatial processes involved in shaping health-related behaviors and outcomes", we need to understand how people experience, interpret, and use their surroundings, rather than just focusing on what is merely present (Gatrell and Elliott, 2015, p.38). Within this thesis, I also value and incorporate "experiential knowledge" (Elwood, 2006), such as layers of perception and emotion, such as how an individual feels when they engage with a particular place. These perceptions are socially constructed and influenced by past experiences, as well as what is important to that individual, where "meanings of place are created through practice" (Cresswell, 1996, p.17).

The existence of both subjective and objective experiences of place has long been recognised within humanistic geography and the social sciences. For example, in *The Production of Space*, Lefebvre (1991) distinguishes between conceived, perceived, and representational space, recognising that place has physical, social, and experiential components (Pierce and Martin, 2015). Meanwhile, Tuan (1977) distinguishes between place and space, where place has layers or meaning, experience, perception, and attachment, whereas space is a more abstract notion about the relations between activities at different places. Considering older adults' subjective experience of place, also necessitates thinking about time, of which there are both objective and perceived time (Dodgshon, 2008) and everyday rhythms (Lager et al., 2016; Lefebvre et al., 2004).

A social interactionist perspective will tell part of this story, an individual's experience, and agency. However, there are often structural factors which can influence an individual's agency and their ability to carry out activities or

interactions that are most valued and important to them. Such an approach does not consider how unequal opportunities and individual circumstances can unfairly limit the ability to achieve health or a concept such as successful ageing. To recognise this, the thesis takes a structurationist stance. This recognises the role and the importance of the individual (their agency), but also recognises wider social and political forces (structure) that may influence the ability of individuals to achieve good health or to age well. Most notably, I recognise the role of health inequalities that can accumulate and produce a lifetime of advantage or disadvantage (Gilroy, 2021) A structurationist approach considers both these approaches and comes to a middle ground, in that it recognises the "duality of structure and human agency" (Gatrell and Elliott, 2015, p.50), where everyday life is "located within broader relations and distributions of power that play out unevenly within the particularities of time and place" (Dyck and McLaren, 2004, p.513).

I value and focus on subjective experiences within this thesis, as I believe they are underrepresented within both Healthy Urban Planning and Health Geography. Within this thesis, I place an emphasis on the importance of lay forms of knowledge. This stems from my background as a planner in practice and from my interest in community engagement and participatory planning practices. In terms of what difference it makes, there are existing power imbalances, where objective and quantitative approaches are often prioritised over qualitative, lay, and subjective experiences (Elwood, 2006). Furthermore, research has shown that more "official" versions of reality and sources of data, do not always align with "'lived' reality" (Knigge and Cope, 2009, p.104; Richard et al., 2005). A reliance on objective approaches alone risks excluding and undervaluing human centred experiences, which will have implications on the type and quality of places that we produce and value. This thesis therefore emphasises subjective and experiential knowledge to redress this power imbalance. As I will show in the next section, such an epistemological and ontological stance requires the use of a qualitative and spatial methodological approach.

4.2.2 Methodological Approach

Owing to the emphasis on the *subjective* lived experiences of my participants within this research project, I have adopted a qualitative methodological approach. I distinguish here between qualitative research that can refer to a particular qualitative *method*, which are techniques or approaches to data collection or analysis (commonly known as 'small q' research), and a qualitative research *methodology*, which is more than a method but a wider framework or paradigm in which to conduct qualitative research (known as "Big Q" research) (Braun and Clarke, 2013; Goodson and Phillimore, 2004; Kidder and Fine, 1987).

The qualitative research carried out within this thesis is Big Q research, in that I have applied a methodology built on the aligned epistemological and ontological underpinnings outlined in the previous sections. Using a qualitative inquiry, I place an emphasis on "understanding the world from the perspective of its participants" and value the importance of both interactions and interpretations of social life (Goodson and Phillimore, 2004, p.4). Within this thesis, I am concerned with participants' "subjective understanding of social reality" (Limb and Dwyer, 2001, p.6), recognising that qualitative research can provide "new insights and understanding about individual and social complexity" (Saldaña et al., 2011, p.4). Research within Health Geography and Gerontology is increasingly adopting qualitative methodologies to understand the social world of groups and the meaning(s) individuals place on this (Bowling, 2014; Fenton et al., 2016; Goodson and Phillimore, 2004, Phoenix, 2018).

Human and health geographers recognise the value of qualitative research and the need to access and understand the subjective and individual experience within particular places or settings where these meanings or interpretations develop (De Lyser et al., 2010; Limb and Dwyer, 2001). This requires researchers to recognise the:

> complexity of everyday reality, the multitude of influences that shape lived experience, and the importance of the spatial contexts of human interaction (De Lyser et al., 2010, p.7).

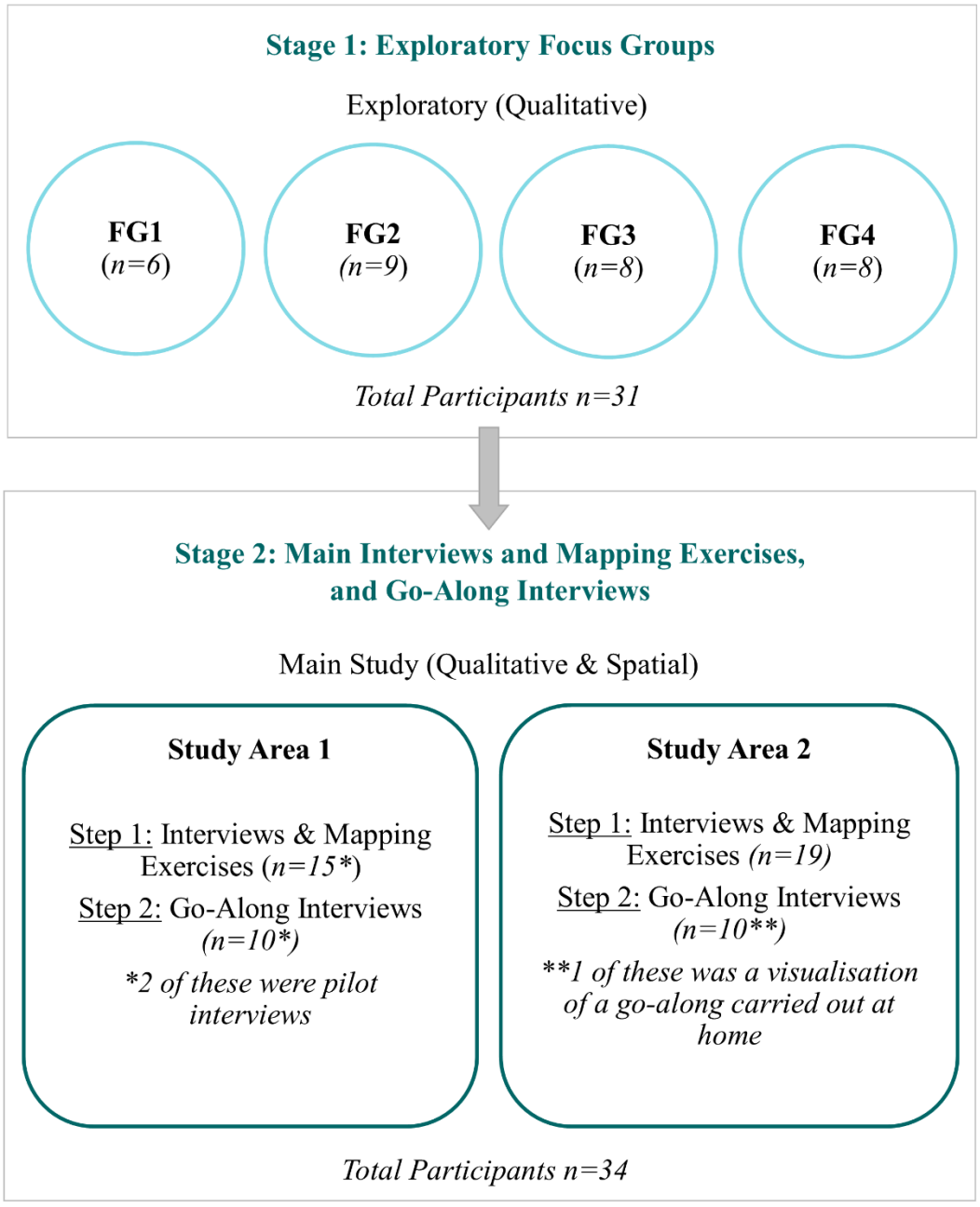
To do this, it is important to think both qualitatively and spatially. In addition to traditional qualitative approaches, health geographers are increasingly adopting more innovative and diverse methods and methodologies as part of this (Fenton et al., 2016). This includes the use of more geo-spatial and in-situ methods (Hand et al., 2017; Bell et al., 2015; Foley et al., 2020; van Hees et al., 2017). These approaches allow researchers to better understand "situated" meaning and experiences and to "interpret qualitative expressions of spatial knowledge" (Bell et al., 2015; De Lyser et al., 2010; Elwood, 2010; Fenton et al., 2016, p.4). As a result, I adopt a methodological approach that combines both qualitative and spatial or in-situ approaches within this thesis.

I am using spatial approaches in a qualitative (Big Q) way using multiple-methods, as opposed to mixed-methods research which combine both qualitative and quantitative methodologies. In doing so, I draw from existing Qualitative GIS literature, which recognises the qualitative potential of GIS and mapping. Qualitative GIS stems from critical and feminist GIS perspectives, which recognise that GIS is no longer tied to its originating epistemology (Cope and Elwood, 2009). Instead, GIS or spatial approaches (including technologies and applications) are not fixed but follow along more pragmatic lines depending on who is using it and how (Pavlovskaya, 2017; Cope and Elwood, 2009; Kwan, 2002). Through the work of Qualitative GIS, traditional GIS approaches have been challenged at an epistemological level and have been reimagined for qualitative research (Pavlovskaya, 2017). Although this research was informed by Qualitative GIS approaches, I prefer to use the term "geo-spatial" to reflect the methodological approach more accurately. This is because Qualitative GIS would traditionally involve using a mixed method approach including the use of more quantitative forms of data and the use of GIS databases to represent qualitative data (Cope and Elwood, 2009). Instead, my research was multi-qualitative methods and was geo-spatial in that "the participant [was] actively involved in collecting data related to locations or places" (Hand et al., 2017, p.e50). In short, GIS, geo-spatial approaches and mapping-based research can incorporate subjective representations, experiences, perceptions, and meanings; therefore, it can be qualitative.

4.3 Study Design and Methods

I now turn to the study design and data collection methods used for this thesis. I have applied a multi-staged and multi-method study design combining qualitative and geo-spatial methods. Data collection consisted of two stages and the use of several in-situ methods alongside more traditional qualitative methods such as interviews and focus groups. Figure 4.1 summarises the overall study design of this thesis.

Figure 4.1 Study Design Diagram



4.3.1 Stage 1: Exploratory Focus Groups

Stage 1 involved carrying out four exploratory focus groups with older people as a "preliminary data gathering" exercise (Barrett and Kirk, 2000, p.622). The aim of these focus groups was to acquaint myself to the Irish ageing experience. As I had only recently moved to Ireland from the UK in September 2015, it was important for me to obtain insight from older people in Ireland before carrying out the main research project, to ensure that I was not making any assumptions about this population group. Four focus groups were carried out with older adults (n=31) in June 2017 and lasted between 43 minutes and 1 hour 19 minutes. The purpose of these focus groups was to identify features of their local neighbourhoods that were important to them, to identify challenges older adults face in Ireland, and to consider what a supportive or unsupportive environment might look like for certain older adult sub-groups. I asked my participants about techniques for recruiting harder to reach population groups and for ideas about where to carry out my main study. For a full list of questions asked in the focus groups see Appendix 2.

The focus groups were helpful in that they allowed me to familiarise and explore this topic. The group dynamic provided a stimulating discussion and insight into the Irish context of ageing in place (Bowling, 2014). However, a key limitation of these focus groups was that they did not allow for in-depth examination of what was of most important to individuals. Furthermore, the group dynamic and camaraderie meant that it was difficult for individuals to disagree. The aim of Stage 2 was therefore solidified as a result, to focus on individuals' lived experience and to capture more in-depth information on what mattered most to older adults as they engaged with their local environments.

4.3.2 Stage 2: Main Study

Fieldwork for the main study was carried out between December 2017 and August 2018 and included two distinct steps for data collection. The involved a semi-structured interview, including a mapping exercise. The follow-on step was a go-along interview, and these are now each discussed in turn below. There were several methods that I could have used which combine geo-spatial and qualitative approaches, to obtain insight into the lived experience of older people beyond the

home. Common examples within literature include using photovoice (for example van Hees et al., 2017; Mahmood et al., 2012), using mapping exercises (see Carpiano, 2009), and using go-along interviews or mobile methods (see Carroll et al., 2020; Finlay and Bowman, 2017; Gardner, 2011; Lager et al., 2019; Lager et al., 2015; van Cauwenberg et al., 2018; van Cauwenberg et al., 2012). However, I chose to carry out mapping exercises and go along interviews rather than use photovoice methods. Whilst I could also have asked participants to take photographs and it would have provided valuable data, I felt that this would be asking too much from my participants in addition to them carrying out a mapping exercise and go-along interviews, as it would have necessitated multiple visits and interviews. However, where appropriate and when participants agreed, I did take photographs of some of the places they showed me and the barriers that they experienced.

Another increasingly common method within mobility studies is the use of mixed methods approaches using accelerometer and GPS monitors and/or travel diaries to capture an individuals' activity space. This involves collecting information about how physically active an individual is, as well as the places they have visited over a set time (for examples of this work see Bell et al., 2015; Christensen et al., 2011; Mennis et al., 2013; Zenk et al., 2011). I decided not to use GPS or accelerometer data to capture an individuals' activity space, predominantly because I did not have access to this type of equipment. Typically, this type of research is carried out within larger teams with greater resources. One of the main benefits of using GPS data over travel diaries or other methods asking participants to identify places they have visited, is that is reduces the need for accurate participant recall, which studies have shown can be an issue (Milton et al., 2015). I considered the use of travel diaries but felt that go-along interviews and mapping exercises within an interview were more appropriate for my research questions and epistemological and ontological stance. Furthermore, I did not feel that participant recall was a significant problem given my research focus. This is because I was not trying to capture a complete picture of my participants' activity space including the more "mundane" trips that individuals may take for granted and overlook (van Hoven and Meijering, 2019, p.1). Instead, I was interested in capturing the places that were *most* important for their quality of life and those places that held most meaning to them. I felt that these were less forgettable.

Step 1: Interview and Mapping Exercise

For Step 1, a semi-structured interview including a mapping exercise was carried out. Interviews were chosen, because they are a useful and common method for exploring how experiences of ageing are shaped by the places that older people live in (Hand et al., 2017). During the interview, participants were asked how they interacted with their local environment, how important it was for them to get out and about, whether they felt limited by their health, and how they would define a good quality of life. For a full interview schedule, see Appendix 3.

Mapping exercises occurred during the interview. Participants were given an A3 map of their local neighbourhood. Prior to the interview, I printed several different maps of the study area and beyond, at different scales. Participants chose the map that was most appropriate for them and that reflected their activity space. In some instances, this involved using two maps at differing scales. Participants were asked to identify the places of most importance to them and explain their significance. A place of importance was not necessarily positively described, and this was often the case with green spaces. Places that were perceived negatively helped to identify more subjective barriers to getting out and about. Participants were also invited to draw regular routes they might take. All participants that took part in the interviews completed the mapping exercise in some form. Participants were encouraged to complete the mapping exercise themselves where possible, unless they were unwilling to, or physically unable to. In five instances, the researcher marked the routes and places whilst the participant described them, and in one instance a carer did. Common reasons that the mapping exercise was challenging for older participants, was because they were "not good with maps", they struggled to see the maps, or they struggled to draw on the maps. Some were also initially reluctant to draw on the maps because they didn't want to "ruin" them, but I reassured them it was fine to do so.

Mapping exercises complemented the interviews, because they provided a talking point "triggering thoughts and reactions" and helped to "set the stage" for the go-along interview which was carried out afterwards (Carpiano, 2009, p.270). Furthermore, it provided a useful resource and piece of data for analysing and

integrating the spatial and qualitative data later. A total of thirty-four participants took part in twenty-four interviews and mapping exercises.[2] The duration of the combined interview and mapping exercises ranged from 22 minutes in length to just over 2 hours. On average (both mean and median), interviews were approximately 1 hour and 8 minutes.

Step 2: Go-Along Interviews

Although interviews and mapping exercises offer possibilities of thinking spatially, the setting remains detached from the places mapped (Carpiano, 2009). The go-along method is a type of in-depth qualitative interview carried out in context (Kusenbach, 2003) and "on the move" (Finlay and Bowman, 2017). Go-along or "mobile interviews" are therefore in-situ and immersive and can provide additional insight beyond the traditional interview (Bell et al., 2015; Finlay and Bowman, 2017; Foley et al., 2020). Mobile interviews elucidate person-place interactions (Carpiano, 2009) and are increasingly used in research on ageing and environment to explore the everyday experiences of ageing (see Finlay and Bowman, 2017; Gardner, 2011; Lager et al., 2019; van Cauwenberg et al., 2018; van Cauwenberg et al., 2012).

Go-along interviews were optional, and participants were encouraged to only do what was within their capability, and the researcher kept pace (Foley et al., 2020). Participants chose where to go and what to show based on the following instructions: *"I would like you to show me some of the areas in your local environment that are important to you, or where there may be some issues or barriers that make everyday life more difficult".* There were no structured questions during the go-along interviews and participants acted like "tour guides", being the experts in their local area and somewhat redressing the traditional power imbalances that exist between researcher and participant (Carpiano, 2009, p.267; Finlay and Bowman, 2017). The route of the go-along interview was captured using the GPS software app *Endomondo.* Settings in Endomondo were modified to ensure that data captured was private. Fieldnotes were taken immediately after each interview and

[2] Some of these interviews were joint or group interviews – these were tailored to suit the wishes of the participant.

go-along interview to make a note of the places of interest identified during the interview, along with any observations I had during the fieldwork.

Using these methods, I was able to obtain an insight of individuals' subjectively meaningful "lifeworlds", rather than an objective map of everywhere they had visited in a set time frame. This allowed me to identify the "culturally defined spatiotemporal setting[s] or horizon[s] of everyday life" (Buttimer, 1976, p.277), recognising lived experience as the "orchestration of various time-space rhythms" of meaning to an individual (p.289). This approach allowed participants to consider places that were not currently visited but held meaning to them and to explore the reasons behind this. As with any of these qualitative and geo-spatial methods used, the data collected offers a snapshot of participants' worlds. However, it will always be a partial representation of their lived reality, influenced, indeed, by my role in eliciting it (Cope and Elwood, 2009).

4.4 Sampling, Recruitment and Study Setting

4.4.1 Sampling Strategy and Recruitment Procedures

Stage 1: Exploratory Focus Groups

For Stage 1, an opportunistic or convenience sample of older people living in their own homes was chosen. It was purposive in that I deliberately sought older people who attended community groups. To see more details about the social groups, including the types of activities that were carried out there, see Appendix 4. I contacted several community groups in the two research areas using information from newspapers and websites. When I had contacted the groups and they expressed an interest in taking part, I spent several weeks prior to the focus groups attending and participating in the activities to build rapport with the attendees. Prior to the focus groups, I provided those in attendance at the group with an Invitation Letter (see Appendix 5), along with an Information Sheet (Appendix 6), and a Consent Form (Appendix 7). We then arranged focus groups for a particular date, and those in attendance on the day who wanted to participate took part.

For Stage 2, a purposive sample of older people aged 70+ living in their own homes was sought. Of this "maximum variation" was pursued where possible. This is a type of purposeful sampling where the aim is to find heterogeneity (Teddlie and Yu, 2007). This form of sampling was sought to try to obtain a diverse perspective of what it meant to age well in place for older people with differing interests, as well as contrasting environmental and personal circumstances. This was not carried out in a systematic way, instead I asked myself throughout: who is likely to find it more challenging to participate in research; whose perspectives might be missing and how can I broaden my recruitment to capture a wider range of experiences? (Gilroy, 2021).

Participants were recruited through local gatekeepers and like Stage 1, this was primarily through a range of local community centres and social groups. I chose to recruit participants this way for two main reasons. The first was that the community groups and organisers served as gatekeepers in accessing older people and meant that I did not have to knock on older peoples' doors as a stranger. As a lone female researcher, I felt uncomfortable doing this, and I was conscious that older people may not open their door to someone they did not know (Russell et al., 1998). The second reason was that community groups offered a convenient and ready-made group from which I could then recruit multiple participants at once. Community groups were identified using local newspapers, internet web searches and word of mouth.

A limitation of recruiting participants through social and community groups, was that it resulted in the recruitment of individuals that were able access these groups. It was therefore likely to have excluded perspectives from those older people that were unable or unwilling to attend for a variety of reasons. Acknowledging this, a particular effort was made to recruit "harder to reach" participants who experienced health or mobility challenges, recognising that their experiences of ageing in place are often less well known or understood (Gilroy, 2021; Hockey et al., 2013). Within ageing research and from my experience engaging with local communities as a Planning Officer, it is commonly the more active retired and engaged older people that are recruited, usually because they have the fewest barriers to participating (Gilroy, 2021). As a result, I sought to recruit participants not just from *Active*

Retirement social groups but to also recruit from groups specifically designed to support older people who may find getting out and about more challenging. This included an Alzheimer's Day Centre, as well as a social group specifically designed for more socially isolated older people. For a summary table of all social groups that I recruited from during Stage 2, see Appendix 8.

When I met with a particular social group, I handed out Invitation Letters (see Appendix 9) and an Information Sheet (see Appendix 10). I placed A3 Invitation Letters in libraries and within the community centres and health centres. Interviews were conducted either in participants' homes or at the community groups that they had been recruited from, depending on individual preferences. One interview was carried out in a coffee shop. One of my participants was not technically recruited by a community group and was a more opportunistic recruit. I had been told by other participants about an assisted living complex in Study Area 2 that had a community centre within it, and I went there with the hope of recruiting some participants. Whilst there I spoke to one of the residents in the garden. I told him about my project, and he volunteered to take part. Whilst he lived in the assisted living complex, he didn't attend the community centre.

Table 4.1 provides an overview of participant characteristics recruited, including their age, gender, how they were recruited, their use of any mobility assistance devices, and whether they identified any health challenges that may limited their activities.

Table 4.1 Participant Characteristics

Characteristics	Details
Gender:	Male (n=6) Female (n=28)
Age Range (at time of interview and if known):	65–69 (n=1) 70–74 (n=12) 75–79 (n=4) 80–84 (n=4) 85–89 (n=2) 90–94 (n=1) Unknown (n=10)
Recruited through:	Local Community Centre / Social Group (n=30) Public Health Nurse (n=1) Dementia Day Care Centre (n=2) Home (Assisted Living) (n=1)
Use of mobility assistance:	Yes – walker (n=4) Yes – mobility scooter (n=1) No (n=29)
Health challenges identified in interview which influenced their ability to leave the house:	Yes (n=18) This included the following (some participants identified multiple): • Chronic Obstructive Pulmonary Disease (COPD) (n=3) (one participant used an oxygen tank) • Alzheimer's Disease (n=2) • Parkinson's Disease (n=1) • Bowel Conditions (n=2) • Visual Impairments (n=2) • Vertigo / Dizziness (n=2) • Joint-related mobility challenges or ongoing impact from previously broken bones (n=5) • General reduction in activities / restricted mobility identified but no specific health conditions mentioned (n=1) No (n=6) Not identified during interview (n=10)

In addition to recruiting participants from social groups, in the main study I broadened my search to try to capture harder to reach groups, particularly those older people who may have additional health challenges, who may find it more difficult to leave the home and could even be homebound. This included recruiting through Public Health Nurses, organisations such as Alone, 'Meals on Wheels' services[3] and Traveller community groups. My attempts to recruit a more diverse older adult sample yielded limited success. Just one participant across both study areas was recruited through a Public Health Nurse. Whilst I met with a gatekeeper at the Traveller community group and they expressed interest in the research, they felt that it was not possible to participate at that time.

I have included details of the organisations or individuals that I contacted but where I was unsuccessful in recruiting participants in Appendix 11. I believe it is important to be transparent about this, because contacting harder to reach groups is not without its challenges and they are harder to reach for a reason. Furthermore, the fact that I was unsuccessful provides valuable learning for future research and to ensure that we continue to carry out research with a wide range of older people. This includes recognising whose perspectives we may not be hearing from and learning from some of the challenges to recruiting these groups. It is important to note for context that Traveller groups in the Republic of Ireland face significant health challenges. On average, their life expectancy is on average 8 years lower they are also more likely to face severe limitations because of health challenges (29% compared to national average of 17%). This is particularly the case for males (36%) compared to females (23%) (European Union Agency for Fundamental Rights, 2020).

Sample Size

A social interactionist perspective will typically study much smaller numbers in geographically smaller areas, such as small communities or neighbourhoods (Gatrell and Elliott, 2015). As is common in qualitative research, where there is in-depth and rich data which can be time consuming to analyse, my sample size was relatively

[3] This is a service which delivers meals to individuals at home, usually because individuals are no longer able to cook or purchase meals themselves. Typically this service is for homebound older people.

small, and I aimed to capture perspectives of approximately 15 participants in each study area. I did not seek to obtain data saturation as it is often criticised amongst qualitative researchers (Braun and Clarke, 2013). Theoretically, if you subscribe to ontologies about the subjectivity of experience within quality of life and environment, data saturation will never be reached because everyone will experience their world in a different and unique way. When I applied for ethical approval, I had planned to carry out fieldwork in a third study area and to examine a more coastal suburban setting too. However, I decided not to carry out research in this area. This was partly due to time constraints, but also due to a shift in focus from area comparisons to lived experience approach, which required more in-depth analysis of data at an individual level.

4.4.2 Study Settings

For Stage 1, as this was an opportunistic sample, I chose the local university town where I studied and a nearby town to focus my enquiries. At that point, I had not finalised the locations of Stage 2, although I had some ideas. For the main study, I chose study areas that combined demographic and environmental characteristics I identified in Chapter 1 as being important within this thesis. I wanted to explore an area that was newly ageing within a suburban setting and with higher rates of health challenges. To help inform where I should carry out my research, I carried out Exploratory Spatial Data Analysis. This involved examining population data, such as age profiles by looking at Census 2011 and 2016 data. I also explored socio-economic characteristics from the HP Pobal Deprivation Index using All-Ireland Research Observatory Mapping and Data Visualisations (AIRO, 2016). Finally, I examined health mortality data from the Health Inequalities 2006–2011 Interactive Atlas (Centre for Health Geoinformatics, 2016; Rigby et al., 2017). This helped me to identify Study Area 1, where these factors combined. At a population level therefore, Study Area 1 has higher levels of deprivation and health challenges, compared with Study Area 2. Study Area 1 is also more newly ageing compared with Study Area 2.

To protect the identity of participants in this study, I have decided to not reveal the names of my study areas within this thesis and in published work. This is for both

methodological and ethical reasons. Within Chapter 7, I describe in-depth several participants everyday experiences and reveal their health and mobility challenges. I felt that combining this information with Study Area information could lead to the identification of my participants, particularly in a country with a relatively small population such as Ireland. Instead, I provide a summary of some of the key characteristics of the areas for background context.

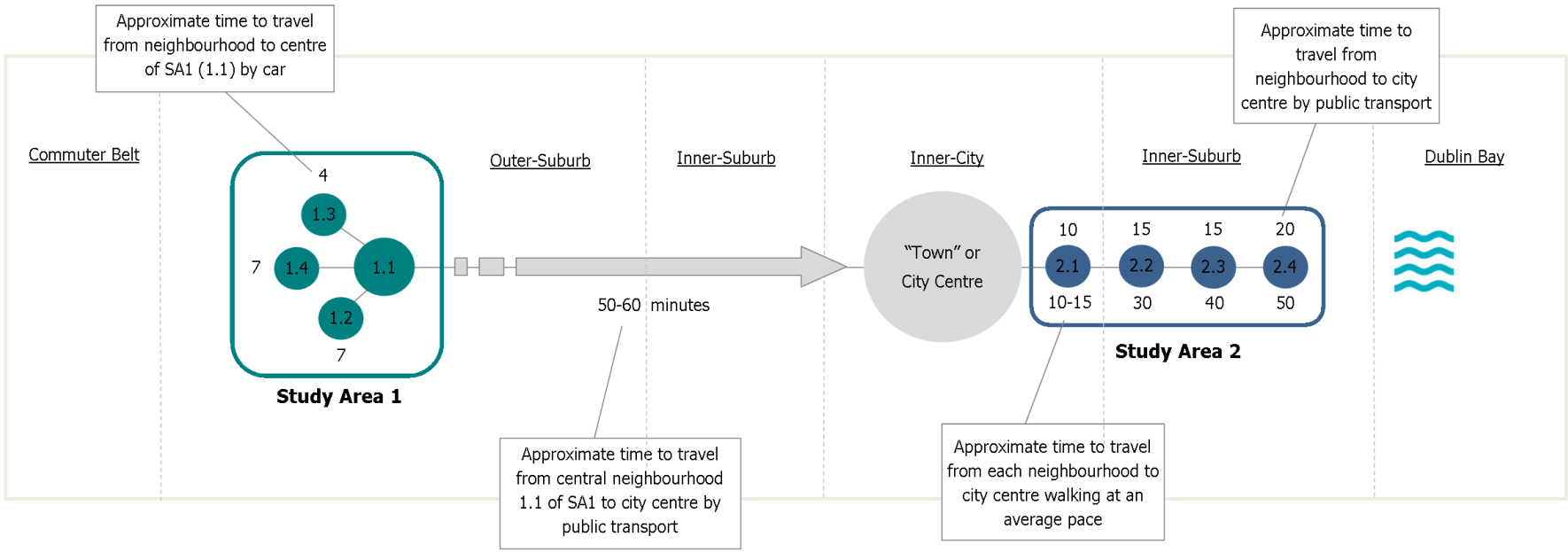
Study Area 1

Study Area 1 is a large working class new town located in outer suburban Dublin. Originally a village, it has experienced rapid suburbanisation and population growth since the 1970s, when many people moved to the area from inner-city Dublin. Many of these individuals have now reached or are reaching retirement age. The centre of Study Area 1 includes the former village and has a main high street. From here, there are good public transport links into the centre of Dublin, and this takes between 50 and 60 minutes. A variety of cultural and social assets and amenities have been built in recent years including a shopping centre, a theatre, and a library. Moving away from the centre, the study area becomes much more suburban in nature. These areas are more residential with fewer amenities, although some do have smaller shopping parades, health centres and community centres, including bus routes to the centre of Study Area 1. The more recently built neighbourhoods in Study Area 1 are the most geographically isolated and furthest from the centre of Study Area 1. They are also the most disadvantaged and where the number of residents that are older has grown dramatically quite recently. The outer suburban areas are the most car dependent and from them, it would take at least 20–30 minutes to walk to the centre of Study Area 1.

Study Area 2 is technically an inner-city location due to its proximity to Dublin city centre. However, much of the urban form is more suburban in nature and so I have classified it as inner-suburban overall. The density of Dublin is lower than most European cities. It is comprised of four distinct neighbourhoods within it. Of the four neighbourhoods within Study Area 2, one is an inner-city location working class neighbourhood, two are inner-suburban working-class neighbourhoods, and one is an inner-suburban more affluent neighbourhood. All areas are close to the coast. This

area has experienced significant urban change, gentrification, and high-rise office development. There are good public transport routes to the city centre, which takes between 10–20 minutes depending on the neighbourhood. It would be possible to walk to the city centre from between 10–50 minutes. Figure 4.2 diagrammatically represents the Study Areas and how they are located within the Greater Dublin Area.

Figure 4.2 Diagrammatic Representation of Study Area Settings within the Greater Dublin Area



4.5 Ethical Considerations: a flexible, inclusive, and care-full research approach

Ethical approval for Stage 1 was granted on 22nd February 2017 (Reference: SRESC-2017-017) (see Appendix 12 for Stage 1 ethical approval letter) and fieldwork was carried out in June 2017. Ethical approval for Stage 2 was awarded in November 2017 from the Social Research Ethics Subcommittee at Maynooth University (Reference: SRESC-2017-092) (see Appendix 13 for Stage 2 ethical approval letter). Fieldwork was carried out prior to Covid-19 in June 2017 for Stage 1 and from December 2017 to September 2018 for Stage 2. This research involved contact with more vulnerable sub-populations of older people, such as those with cognitive impairments or frailty. However, I also did not want to exclude them from participating in the research but instead provide the necessary accommodations to enable them to take part. To mitigate risks to participants, they were supported in a "care-full" way in all stages of the research to ensure they were enabled to participate (Foley et al., 2020). For example, two participants had Alzheimer's disease and were recruited through a dementia day-care centre.

In this instance, consent forms were adapted to make them more visual (see Appendix 14 for standard consent form and Appendix 15 for adapted consent form). Preliminary meetings were carried out and carers, family members and the participant themselves provided consent (Hubbard et al., 2003). As a result of discussion with carers, who were present during data collection, interviews were shortened to reduce demands on participants, but still focused on activities and places of importance, as well as how they defined a good quality of life.

Although I did not recruit any homebound participants, I did capture a broad range of older adult perspectives. Many participants were supported to participate in this research with varying health and mobility challenges. I believe that the flexible, inclusive, and care-full approach I have taken throughout this research has led to insights from participants who may have been prevented from participating without the adjustments that I made. It also meant that it more accurately reflected their existing experiences. An example of this is when I contacted a social group in Study Area 2, the group leader and attendees told me that they would prefer to carry out the

interview and mapping exercises together. Throughout the interview, I learnt that this group was specifically for older adults who were more socially isolated, and many participants did not feel confident enough to attend a larger social group and community centre nearby. Participants were much more comfortable doing the research together and I anticipated that many would have said no if I had asked them to take part individually. Carrying out a group interview was much more challenging from my perspective and meant that I was not always able to identify participants during the transcribing of this. However, adapting my research to be more flexible of participants' needs meant that I obtained access to harder to reach participants that I would likely not have recruited otherwise. Table 4.2 provides an overview of the variations in the interviews, mapping exercises, and how they were adapted to suit participant needs, abilities and wishes.

Table 4.2. Summary of adaptation of research methods

Interview Total (n=34)	<u>Format:</u> • Individual (n=18) • Accompanied by family member (n=1) • Joint (2 instances where 2 participants took part at the same time) (n=4) • Joint (2 participants also accompanied by carer) (n=2) • Group (one instance involving 9 participants) (n=9)
Mapping Exercise Total (n=34)	<u>Format:</u> • Participant completed this themselves (n=28) • Carer completed this (n=1) • Researcher completed this (n=5)
Go-along Interviews Total (n=20)	<u>Type of Go-Along interview:</u> • Driving (researcher drove) (n=6) • Driving (participant drove) (n=1) • Cycling (both researcher and participant cycled) (n=1) • Mobility scooter (n=1) • Walking (no assistance) (n= 8) • Walking (with use of walker) (n=2) • Visualisation at home (n=1) <u>Format:</u> • Accompanied with carer (n=2) • Accompanied with family member (n=1) • Joint go-along interview (n=2) <u>Distance:</u> Between 300m (walk) and 37km (drive) <u>Duration:</u> Between 7 minutes and 3 hours*

*This three-hour interview was unusually long and was a cycling interview with a former ultra-triathlete and his dog.

Another flexible adaptation that I made was in relation to age of participants. Whilst most participants were aged over 70, in one neighbourhood within Study Area 1 a participant aged 66 was included. Interestingly, this participant lived in the

neighbourhood with the fewest environmental supports, in an area that was newly aged, and they also identified significant health and mobility constraints. This contrasts with participants in Study Area 2, some of whom were aged in their 80s and far more active. This reinforces the need to recognise chronological age does not always reflect abilities, particularly when taking into consideration a lifecourse perspective of inequalities and wider determinants of health. Another ethical consideration during the go-along interview was whether to reveal that we were doing a go-along interview if we engaged with other people. I kept the audio device hidden from view in my pocket during go-along interviews to not draw attention to the participant and to make them feel more comfortable whilst out and about. This was particularly important when participants revealed fears about walking in their local environment during the interview, which did happen in some of the study areas (discussed further in Chapter 6). Participants decided if they wanted to reveal they were conducting a go-along interview when interacting with bystanders. The conversation data with bystanders was not used, as they did not provide consent to take part, but the interaction itself was noted.

4.6 Data Processing and Organisation

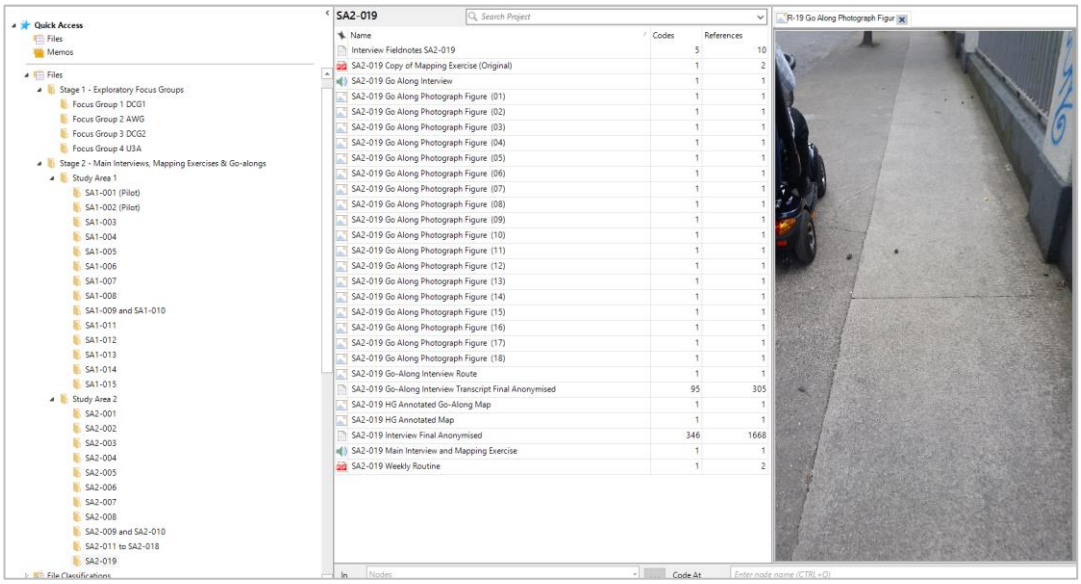
Focus groups, interviews and go-along interviews were audio-recorded and transcribed verbatim. Transcribing was partially completed by a professional transcribing service and partially by me. Interview transcripts, the completed map from the mapping exercise, fieldnotes, and any photographs taken during the go-along interview were imported into NVivo 12. Data from Endomondo was exported shortly after data collection to both table and spatial forms (as shapefiles) and images of the route and then imported. All imported data was assigned to a particular case ID. This referred to a particular focus group for Phase 1, or participant for the main study. Participants were given pseudonyms (see Table 4.3 for participant case IDs and the corresponding pseudonym).

Table 4.3. List of Participant Case IDs and Pseudonyms

Study Area 1		Study Area 2	
Case ID	**Pseudonym**	**Case ID**	**Pseudonym**
SA1-001	Jennifer	SA2-001	June
SA1-002	Moira	SA2-002	Michelle
SA1-003	Anne	SA2-003	Mairead
SA1-004	Edith	SA2-004	Dolores
SA1-005	Bridie	SA2-005	Shauna
SA1-006	Nuala	SA2-006	Áine
SA1-007	James	SA2-007	David
SA1-008	Noelle	SA2-008	Brenda
SA1-009	Niamh*	SA2-009	Margaret*
SA1-010	Méabh*	SA2-010	Nessa*
SA1-011	Darragh	SA2-011	Bríd**
SA1-012	Emer	SA2-012	Sinead**
SA1-013	Michael	SA2-013	Clodagh**
SA1-014	Eamon*	SA2-014	Sarah**
SA1-015	Louise*	SA2-015	Cara**
* = Joint Interviews		SA2-016	Francis**
** = Group Interview		SA2-017	Anita**
		SA2-018	Breeda**
		SA2-019	Jack

I chose to use NVivo as a CAQDAS (Computer Assisted Qualitative Database Analysis Software). The use of CAQDAS allowed me to a convenient way to manage my data, where I could arrange and organise multiple forms of data, code, query, and analyse my data in novel ways, as well as keep a clear audit trail of the analysis I had conducted (Bazeley, 2007; Silver and Lewins, 2014; van Hoven and Poelman, 2003). Data was stored on an encrypted laptop. Figure 4.3 provides a screenshot of my NVivo Database, with participant ID (cases are to the left, an example of the types of data recorded for each participant in the middle, and an example of a photograph taken to the right).

Figure 4.3. Screenshot of NVivo Database



I also had some hard copies of data such as the maps produced my participants in the mapping exercises, as well as my notes. These were labelled and kept in a folder by participant ID. Consent forms were kept in a locked drawer.

4.7 Data Analysis

To analyse my data, I used a range of spatial and qualitative techniques. My overarching goal within the data analysis stage was to make sense of what my participants had told me and to identify interesting qualitative and spatial patterns within their daily lives. Whilst there are many different approaches to qualitative analysis, a common thread is that they "seek to make sense of the data produced through categorisation and connection" (Kitchin and Tate, 2013, p.229). Qualitative data analysis is fundamentally about "searching for patterns" (Braun and Clarke, 2013, p.224). Continuing with the flexible approach I have taken throughout my thesis, I chose to use the thematic analysis approach developed by Braun and Clarke (2006) and more recently updated as "reflexive thematic analysis" (see Braun and Clarke 2019), to guide my analysis of the qualitative data. Thematic analysis provides a flexible structure to qualitative data analysis, which involves categorising text first into codes, and then grouping these codes into themes (or categories) (Braun and Clarke, 2013; Bryman, 2016). I chose thematic analysis because much of

this work was exploratory, and I intended to use different approaches to coding and categorising depending on the research question I was answering. I did not want to be bound by a particular analytical approach; instead, I wanted to be flexible and intuitive to respond to what my participants were telling me. Typically, thematic analysis involves 5 key overlapping phases, beginning by familiarising oneself with the data (Phase 1), generating initial codes (Phase 2), searching for themes (Phase 3), reviewing themes (Phase 4), defining and naming themes (Phase 5) and writing up a report (Phase 6) (Braun and Clarke, 2006, p.87). Where I carried out more traditional thematic analysis approaches, I followed these phases. Throughout the analysis, I carried out multiple rounds of coding, categorising, and writing.

During Phase 1, I transcribed and organised the data (as described above), carrying out repeated readings. I took notes, drew diagrams, and wrote annotated memos during this phase to generate ideas and make sense of my data. The most important and essential part of this analysis was Phase 2, where I completed extensive rounds of coding for different purposes, depending on the chapter I was working on. A key component of most qualitative research is coding, which are the building blocks of analysis from which it is then possible to find patterns and meaning within the data (Saldaña et al., 2011). As is common within qualitative research, I began the analysis with a broader research question, which were then refined over time, as I found something I wanted to explore further that could only have been revealed through coding and familiarisation of the data. When I had an idea of a topic area that I wanted to explore in more detail, I would carry out deep dives of the data. This is where I coded the entire dataset to produce an extracted data set focusing on a particular topic area (e.g., how participants defined a good quality of life). I included data from both Stage 1 and Stage 2 within these data sets. Sometimes this involved looking at the relevant question asked during the interview, but also looking across the entire dataset, in case it was discussed outside of this question. Here I also made use of *text search queries* within NVivo, to identify words that may be connected, and this provided an extra layer of accountability to ensure that I did not miss anything important. This phase of coding typically generated more broad-brush coding of entire paragraphs or sections. It was also deductive and primarily about "reducing" the dataset to make it more manageable to work with (Saldaña et al., 2011).

Once I had an extracted data set of a particular topic area, I printed this out. Although I used NVivo as a database, I preferred to use more of a hybrid approach when it came to analysis, where I printed and inductively coded smaller extracts of data by hand (Maher et al., 2018). Coding of interview transcripts was carried out with another PhD student on a sample of four interview transcripts, to discuss levels agreement about the codes identified, as well as my interpretations. In Chapter 5, the thematic analysis I carried out was inductive, where I was seeking to generate empirically grounded concepts (Braun and Clarke, 2013). For Chapter 6, I undertook a thematic analysis which drew from content analysis, where I was trying to code and categorise places and activities and was interested in how many participants identified these. I framed my categories by a particular theory and so this was more deductive. In Chapter 7, my analysis followed a narrative (or geo-narrative) approach. For this analysis, instead of cutting and combining everything said about a topic area, I would look at everything an individual said and produce a narrative of this (Saldaña et al., 2011). I now provide more details for the approach taken for each empirical chapter.

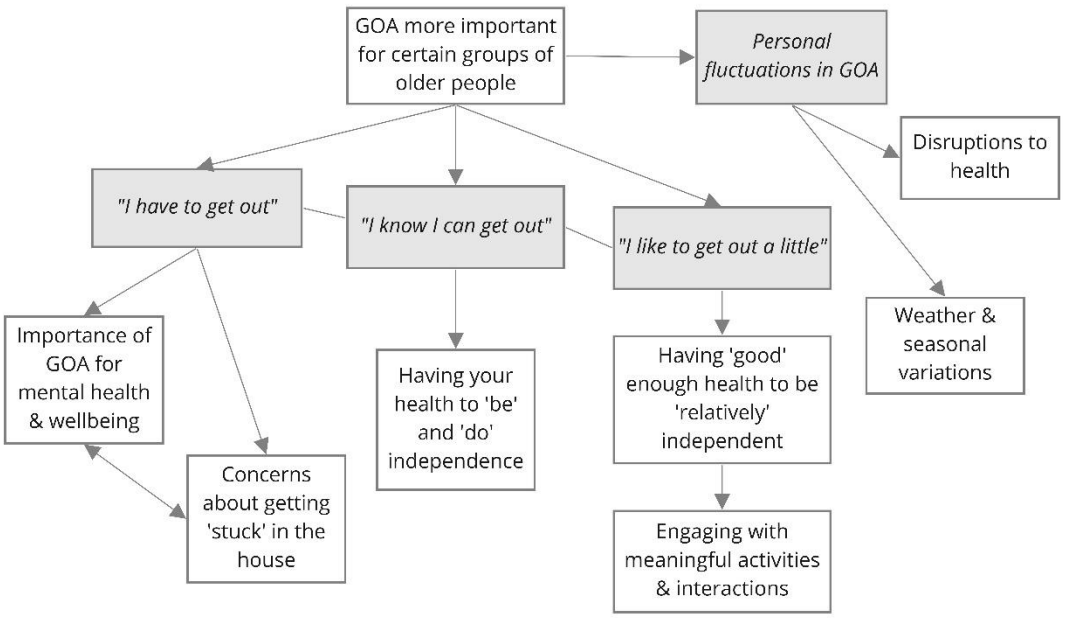
4.7.1 Data Analysis for Chapter 5. Conceptualising Ageing Well in Place: Getting out and about for a good quality of life

Within Chapter 5, I carried out a thematic analysis to explore how my participants defined a good quality of life and to examine how important getting out and about was to them. I had two key extracted data sets for this: everything my participants said about a good quality of life and everything they said about getting out and about (both positive and negative). Within the initial coding phase (Phase 2) for Chapter 5, I produced 68 codes that referred to how my participants defined a good quality of life and 21 codes that related to the importance of getting out and about. The next step was to generate themes (Phase 3) and then review themes (Phase 4). I did this by hand initially and then inputted this back into NVivo.

I categorised my codes relating to quality of life into four themes. I produced a series of diagrams at this stage to think through how the codes related to each other. Some of these were drawn by hand and others were produced using Miro (see Appendix 16 for an example). These themes inform my conceptual contribution of ageing well in

place, which is presented at the beginning of Chapter 5 and referred to throughout the remainder of this thesis. However, these themes only told part of the story – what mattered for ageing well; it was missing the spatial element. Alongside this piece of coding, I identified four themes related to getting out and about and these have been used to structure the sections of Chapter 5. Through writing and revisiting codes (Phase 5 and 6), I realised the importance of getting out and about for a good quality of life, how participants varied in the amount that they *needed* to get out, and how this was intrinsically linked to their quality of life through their health, mobility, and independence. Initially my codes and themes related to getting out and about and quality of life were distinct, but during this phase I began to integrate these and focus on those aspects of quality of life that were related to getting out and about. The final themes solidified as I wrote the empirical chapter, recognising the iterative nature of qualitative data analysis and thematic analysis. Figure 4.4 provides a coding tree of the final themes that I used to structure my chapter.

Figure 4.4. Coding Tree showing the variation in participants' ability and 'need' to get out and about (GOA)



4.7.2 Data Analysis for Chapter 6. Getting Out and About to Connect with Others

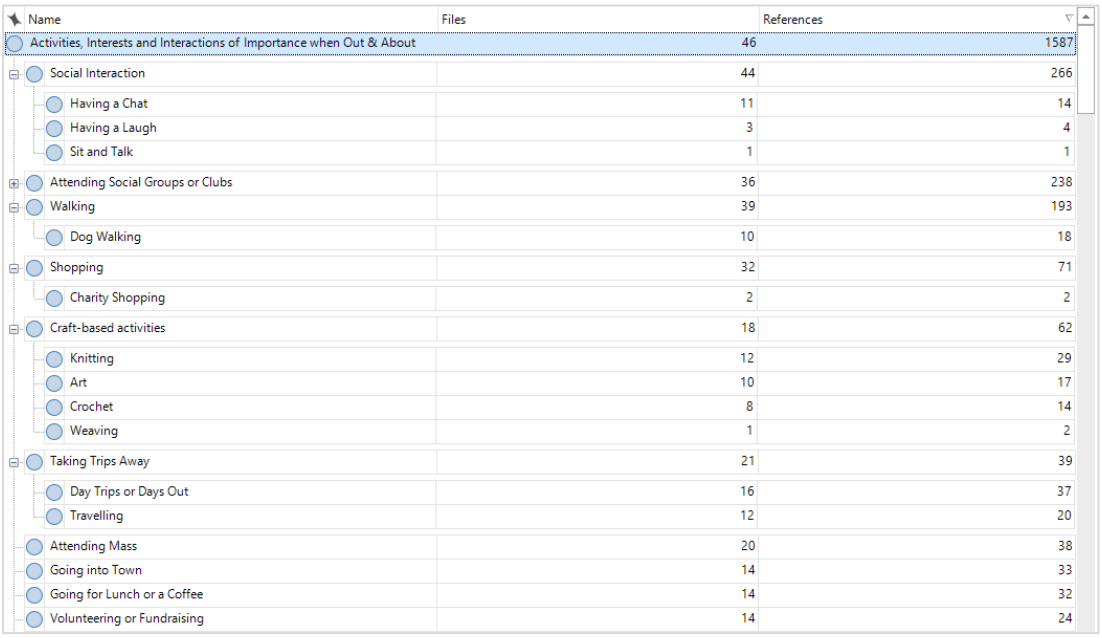
For Chapter 6, I had a different set of guiding research questions and coding was adapted as a result. Initially, I coded all places mentioned by my participants to create a database of places. There were over 640 codes for this phase. I have shown aggregated summaries of these in the screenshots (Figure 4.5) to not reveal the locations.

Figure 4.5. Screenshot of Initial Coding of Places of Importance

Name	Files	References
Places of Importance	47	2923
Study Area 2	25	1115
Study Area 1	36	1113
Outside Study Areas	43	604
Previously Lived	25	46
Home	19	28
Hospitals (not specific)	8	12
Nursing Homes (not specific)	1	2
Car	1	1

For each place, I could easily find out how many participants identified this place, how many times they referenced the place. I could also retrieve data about everything that was said about each place. This allowed me to consider places in turn and compare what my participants said about these places. By carrying out cross-matrix analyses, I crossed individual cases (participants) by places to see the number of places mentioned by each participant. I identified the coordinates of these places wherever possible so that they were spatially referenced. In addition to places of importance, I coded activities that were mentioned by my participants, so that I could get a sense of what participants did in the places of importance to them. There were 222 codes generated for activities during the initial coding phase (see Figure 4.6 for most highly referenced activities).

Figure 4.6. Screenshot of Initial Coding Activities of Importance



Name	Files	References
Activities, Interests and Interactions of Importance when Out & About	46	1587
Social Interaction	44	266
Having a Chat	11	14
Having a Laugh	3	4
Sit and Talk	1	1
Attending Social Groups or Clubs	36	238
Walking	39	193
Dog Walking	10	18
Shopping	32	71
Charity Shopping	2	2
Craft-based activities	18	62
Knitting	12	29
Art	10	17
Crochet	8	14
Weaving	1	2
Taking Trips Away	21	39
Day Trips or Days Out	16	37
Travelling	12	20
Attending Mass	20	38
Going into Town	14	33
Going for Lunch or a Coffee	14	32
Volunteering or Fundraising	14	24

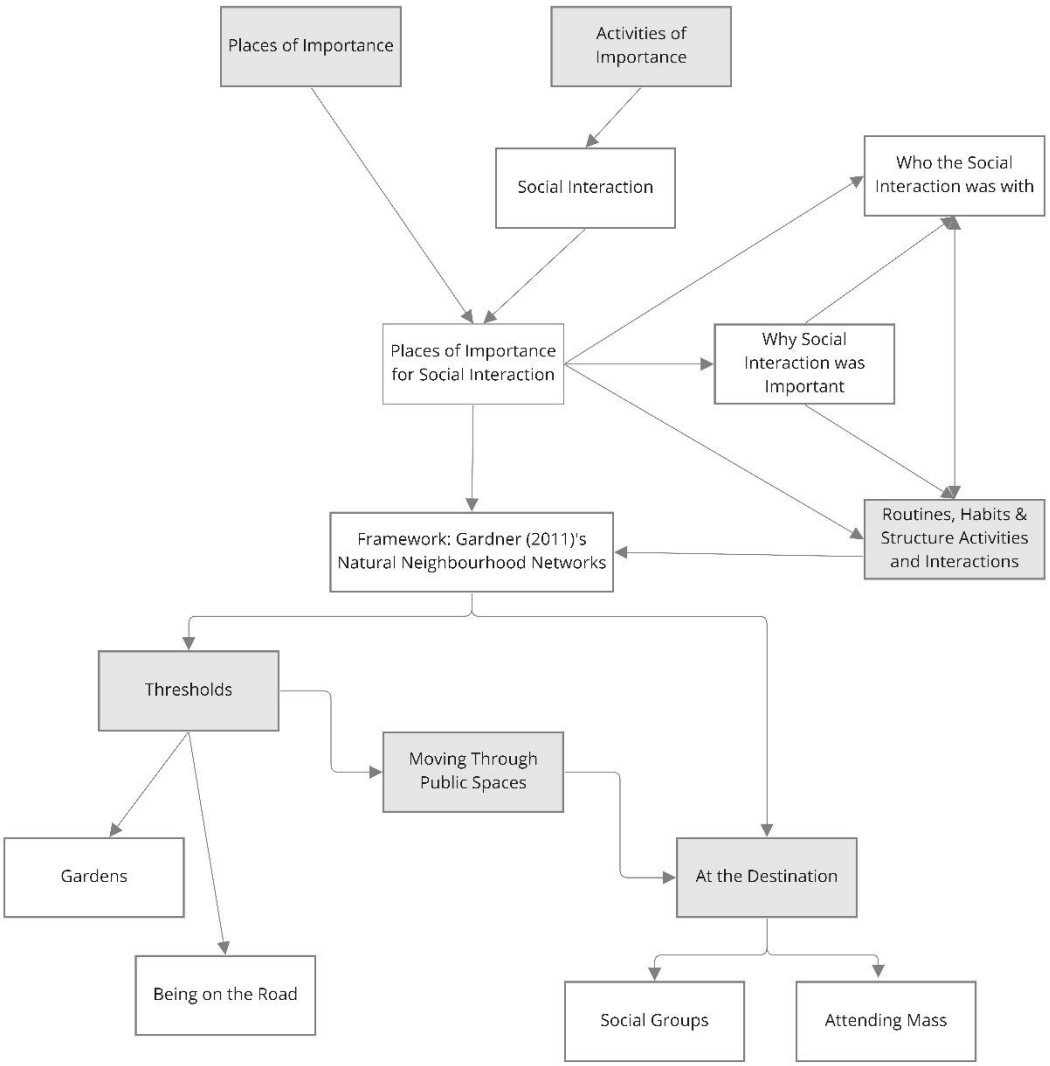
As with Chapter 5, the scope of Chapter 6 refined and narrowed over time. The most highly referenced activity was *social interaction*, and I began to explore the places where social interaction occurred (or did not occur) whilst out and about, focusing on places that might be considered "Social Infrastructure" (Klinenberg, 2018). Within Chapter 6, I do not focus on all places of importance to my participants, but instead those places identified as important for social interaction. As I had this initial coding already completed, I was able to extract all the codes for social interaction as a data set and carry out inductive coding for this, as I had done for Chapter 5. I also produced a refined list of Social Infrastructure places and categorised these into similar groups of places. For a summary table of these categories, the number of places within these, as well as the total number of references see Table 4.4. For a more detailed table, which breaks this down by Study Area and case (participant), see Appendix 17. Carrying out this type of analysis allowed me to consider what was it about certain places that made them useful to older people for social interaction. Focusing on social interaction and Social Infrastructure as a topic area for this chapter led me to examine Gardner's (2011) work on the "sites of significance" for social interaction (p.268). I applied Gardner's (2011) categories of place (thresholds, transitory zones and third places) as a framework to think about the importance of

these places and used this to structure Chapter 6. In Figure 4.7 I have provided a flow diagram to summarise the development of this thinking and analysis over time.

Table 4.4. Summary of Categories of Social Infrastructure Places

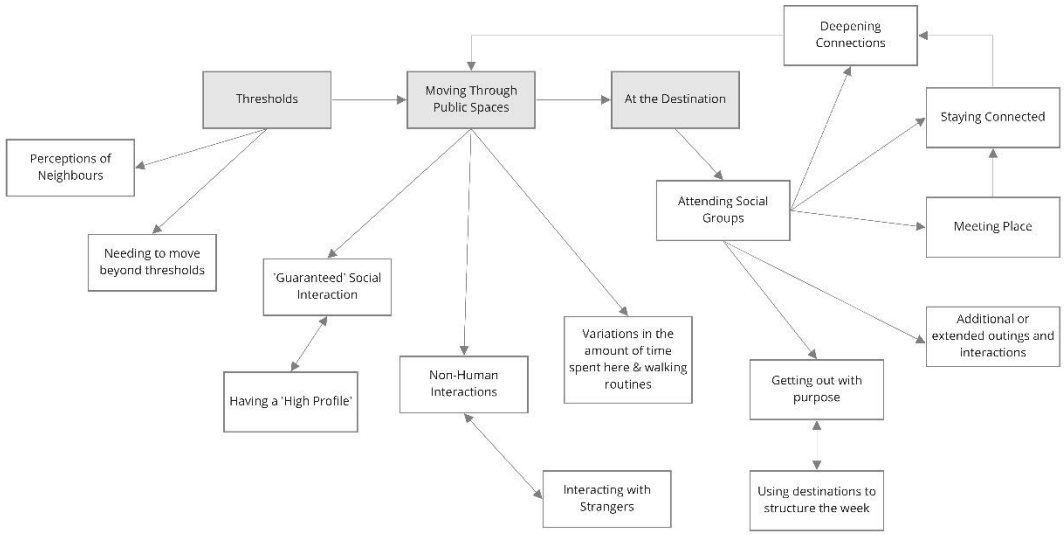
	Category of Places	Code	Number of Places in Each Category					Number of References						
			SA1	SA2	OSA	All	Rank	SA1	SA2	OSA	All	Rank	All	Rank
1	Main Community Centres	MCC	5	4	0	9	*9*	135	77	0	212	*3*	298	*3*
2	Other Community Centres	OCC	10	5	3	18	*5*	53	23	10	86	*5*		
3	Shops	SHO	15	12	18	45	*1*	171	40	90	301	*2*	301	*2*
4	Post Offices	POF	4	4	0	8	*10*	14	9	0	23	*11*	23	*10*
5	Banks & Credit Unions	BCU	1	2	2	5	*11*	4	3	3	10	*12*	10	*11*
6	Hairdressers	HAI	3	1	0	4	*12*	3	1	0	4	*13*	4	*12*
7	Health-Related	HRE	10	3	4	17	*6*	58	5	17	80	*6*	80	*5*
8	Green & Blue Spaces	GBS	8	16	9	3	*2*	74	207	72	353	*1*	361	*1*
9	Trip Destinations	TRI	0	0	21	21	*4*	0	0	61	61	*8*	61	*7*
10	Eating & Drinking Places	EDP	8	11	4	23	*3*	24	19	5	48	*9*	48	*8*
11	Cultural Buildings	CUB	4	2	10	16	*7*	22	4	39	65	*7*	65	*6*
12	Churches	CHU	8	4	2	14	*8*	45	25	19	89	*4*	89	*4*
13	Libraries	LIB	2	1	0	3	*13*	13	13	0	26	*10*	26	*9*
14	Miscellaneous - Recycling Point	MIS	0	1	0	1	*14*	0	2	0	2	*14*	2	*13*
		Totals =	**78**	**66**	**73**	**187**		**616**	**428**	**316**	**1360**		**1368**	

Figure 4.7. Flow Diagram of the Development of Data Analysis for Chapter 6



In addition to identifying the places and activities that participants valued whilst out and about, I wanted to explore the temporality and rhythms of this, recognising that all activities happen in a particular time and place. I was able to explore the temporal analysis aspect of these places and activities by using a weekly routine template, which I completed for participants to map out what they had told me during the interview. This was something I added later in the analysis and if I were to conduct the research again, I would ask participants to complete this themselves or complete it with them. Nonetheless, I found this a useful exercise within the analysis, as I began to see patterns of routine and activity that I might otherwise have missed. This led me to consider the planned and scheduled nature of social interaction within each of Gardner's (2011) different place categories within Chapter 6. Figure 4.8 below shows a thematic coding tree, where I show the key themes identified within each of the three categories of places for social interaction.

Figure 4.8. Coding Tree for Chapter 6



As is common within qualitative research, which is more of an iterative process, the scope of this research narrowed over time (Agee, 2009). Initially the scope of this chapter was to focus on RQ2: What places, routes, routines, and interactions outside of the home are most valued by participants? However, to narrow down the focus of inquiry for this chapter, I revised my research questions over time and identified some additional sub-research questions. This included:

- RQ2.1: Where did participants connect to others whilst out and about?
- RQ2.2: What types of social interaction occurred within these different places and who were they with?
- RQ2.3: How important were these interactions to participants and why?
- RQ2.4: To what extent were the engagements with these people within these meeting places planned and how frequent were they?

4.7.3 Data Analysis for Chapter 7. Ageing - as well as you can - in place with health and mobility challenges

Chapter 7 builds on the findings of Chapters 5 and 6 but instead of looking across and comparing the experiences and perspectives of all participants, I focus in-depth on four individuals with differing health and mobility challenges. The coding and analysis carried out for the previous chapters assisted with the data analysis for this chapter, but I did not carry out a specific form of thematic analysis for this. Instead, the extracted data set was at an individual or case level and I looked at this using a narrative approach. Findings within this chapter were analysed and presented as a "geo-narrative" (Bell et al., 2015; Bell et al., 2017; Kwan and Ding, 2008), that is as spatially referenced narratives or experiences (Yuan 2020), which typically involves the use of "visual or cartographic means (maps, GIS, and GPS) to generate rich interpretive accounts of people's experiences of certain aspects of the urban environment" (Kwan, 2021). In this instance, I was interested in narrating and representing individuals' geographically grounded lifeworlds (Seamon, 2018). This included an individuals' meaningful activity space, including their everyday experience, their activities, and their social contacts that happen whilst out and about, as well as barriers and risks as they navigate this with health and mobility challenges.

One of the most powerful tools in geography is the ability to visualise data using maps. Qualitative GIS and mapping can therefore hold "ontological power" (p.6), where "counter-mapping" non-dominant or missing perspectives can "construct new imaginaries of place and space that can contribute to inclusive citizenship" (Pavlovskaya, 2017, p.9). The perspectives of individuals with health and mobility challenges are an under-represented population of older adults. Whilst I have used

databases to collect and hold both spatial and qualitative data, I have not integrated or analysed the data in ways that are more common with Qualitative GIS approaches which have used computational technologies (using approaches such as Matthews et al., 2005; Knigge and Cope, 2006; Kwan and Ding, 2008 for example). Instead, I have integrated the qualitative and spatial components using annotated mapping (such as Bell et al., 2015). However, a key difference is that I have carried out mapping at an individual level through person-centred mapping, representing their lifeworld, rather than in a collective way (as would be more common in participatory approaches involving communities). This fitted in with what I was trying to show through the maps, which was how my participants conceptualised a good quality of life for them, as well as how they navigated ageing in place based on their existing personal and environmental contexts.

The geo-narrative had two parts to it: it had the story of the experience focusing on the research questions and the accompanying annotated maps. From the interviews, I learnt what mattered most to each participant, and this was clarified with participants during the interview, mapping exercise and go-along interviews. For each participant I examined all research questions, by first considering what was most important to them for a good quality of life and to age well (RQ1), as well as the places, routes, routines, and interactions that were most valued (RQ2). I then considered their person-environment fit, exploring the factors that made it easier or more challenging to get out and about in ways that are meaningful to them (RQ3).

To produce the maps, I took notes by hand of each participant and the places they identified. I then combined the results from the interview, mapping exercise and go-along interview and produced my own annotated map, as well as a weekly routine log. To produce the maps digitally, I produced base maps in ArcMap 10.2.2 using Open Streetview layers but I modified them, so they did not have labels of streets or buildings. I kept some aspects of the built form of the neighbourhood but removed street patterns so that the local environments were not identifiable. I also rotated the map so that locations were less easily identifiable. Only approximate locations of home addresses were provided for finalised maps, and I created buffers to obscure their exact address and to show Euclidean distances from participants' homes. I then exported these base maps, before digitising the annotated parts relevant to the

individual participant. I produced these in Microsoft Publisher, because I found it more user friendly to carry out annotations in this software compared with ArcMap 10.2.2. I made several decisions about the style of the maps (detailed in the map key within Chapter 7), to add qualitative dimensions of meaning and emotion to them. This included using stars for places of importance, where the larger the star the greater the importance to the participant. I also used colour coding to show where the places had positive meaning to the participant (green), mixed feelings (amber), negative feelings (red), and finally, where they were valued but the participant was no longer able to access them (grey).

4.8 Conclusion

To summarise, this thesis has followed a pragmatic, flexible, care-full, and inclusive methodological approach to explore the lived experiences of older adults and how they conceptualise and navigate ageing well in place. I have combined qualitative and spatial research methods and analysis to explore this topic and to identify patterns in experience, behaviour and meaning. Now that I have outlined what I did for this research project, the next three chapters present the empirical findings for this thesis.

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Chapter 5. Exploring the importance of getting out and about for a good quality of life

> I don't want to be the granny sitting in the corner with a shawl around her shoulders and a blanket around her knees, I want to be able to get up and go. (Edith)

5.1 Introduction

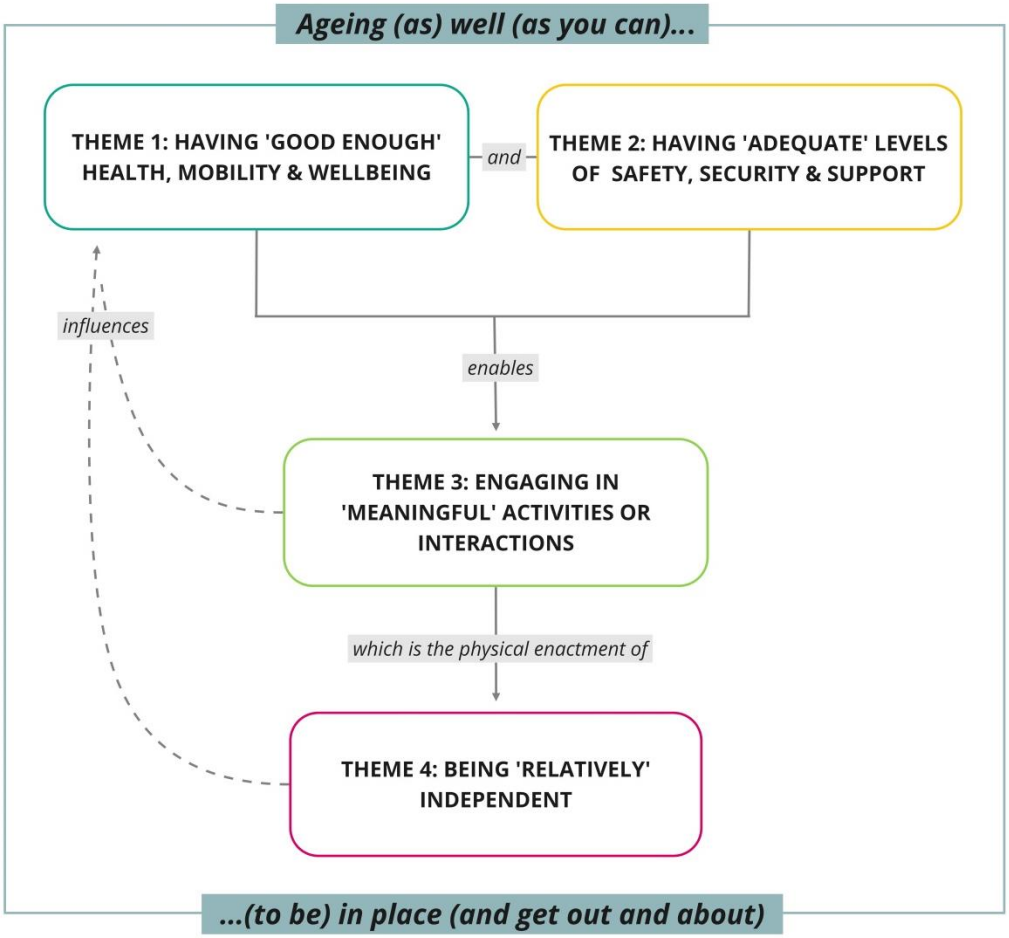
As demonstrated in Chapter 3, leaving the home can provide a range of wellbeing benefits. As a result, older people usually have some want or need to leave their house to get out and about (Holland et al., 2005). Within this first empirical chapter, I set the scene for the entirety of this thesis' empirical work, by examining the importance of getting out and about to my participants and how this relates to their quality of life and ability to age well in place. To begin, I introduce my empirically grounded conceptual model of ageing – *as well as you can* – in place (see Figure 5.1), which I continue to use throughout the remainder of this thesis. Within this model, I argue that a key component of a good quality of life in old age is being able to get out and about, to engage in activities and interactions of most importance to an individual. The four themes important to my participants for a good quality of life and included in this model are:

1. Having 'good enough' health, wellbeing and mobility
2. Having 'adequate' levels of safety, security and support
3. Engaging in 'meaningful' activities and interactions
4. Being 'relatively' independent

All the words in apostrophes emphasise that they are subjectively defined. As I will demonstrate throughout this chapter, each of these four inter-connected themes is related to getting out and about in some way. The figure below illustrates the ways that each of these themes relate to each other and how they contribute to a good quality of life and ageing well in place.

5.1.1 Integrating Quality of Life and Getting Out and About

Figure 5.1 Empirically Grounded Conceptual Model of Ageing – as well as you can – in Place



Having 'good enough' health, mobility and wellbeing is connected to more subjective interpretations of types of ageing well, discussed in Chapter 2. However I have amended this to 'ageing as well as you can', to reflect the more realistic views of health that participants had. As I will show later on in this chapter, 'having your health' was very important to my participants for a good quality of life and was one of the most highly referenced codes. However, when this was examined further, the way that participants defined health revealed that health was highly valued, because it *enabled* participants to get out and about. Furthermore, for some participants with health and mobility challenges, they were still *supported* to get out and about and felt safe and secure doing so, which is why Themes 1 and 2 are so inter-connected.

As I will demonstrate in Chapters 6, which explores how getting out and about can be important for social interaction and Chapter 7, which focuses in-depth on four participant lifeworlds, getting out and about was much easier for some than others. The nature of the risks faced by individuals, as well as how these risks impacted the ability to get out, varied considerably. In this way, participants had to negotiate and navigate their existing capacities within the environmental context they found themselves, to age as well as they could. *Having 'good enough' health, mobility and wellbeing,* combined with *Having 'adequate' levels of safety security and support*, were therefore necessary in order to get out and about. *Engaging in 'meaningful' activities or interactions* and *Being 'relatively' independent* are connected to being in place, or getting out and about directly. In order to participate and engage in 'meaningful' activities or interactions, getting out and about in some form was usually necessary. Furthermore the way participants conceptualised *Being 'relatively' independent* was connected to getting out and about, because this was the physical enactment or embodiment of being independent.

I now dedicate the remainder of this chapter to participants' accounts of how important it was to them to get out and about. Whilst getting out and about was consistently valued amongst participants, there was considerable variation in the way participants answered the question: *How important is it for you to get out and about?* Broadly, I was able to group my participants into three groups. The first group included those participants that spoke urgently and strongly about getting out and about and described it as something they *must* do and these experiences are summarised in Section 5.2. This group typically spent a greater amount of time out and about. I begin this section with a vignette from one participant in particular that I use as a case throughout Chapters 5 and 6, who demonstrates the importance of getting out and about for a good quality of life particularly well. The second group included those participants that were reassured by *knowing they can* get out, but did not necessarily have to be out all of the time and these are described in Section 5.3. Finally, the third group included participants that were more limited in their ability to get out, but still valued getting out *some of the time* and these are outlined in Section 5.4.

In addition to variations in the importance of getting out and about between individuals, there were considerable individual variations or fluctuations in how often they got out. These variations reflected different personal circumstances such as health circumstances, as well as differing environmental contexts, including seasonal and weather variations or time of day. Section 5.5 of this chapter considers some of these variations. Throughout all sections I have woven participant accounts of the importance of getting out and about with the themes for a good quality of life, highlighting the inter-connectedness of these two concepts.

5.2 "I have to get out"

5.2.1 Introducing Bridie

Bridie, aged 72 at the time of her interview, had lived in the same house in her neighbourhood within Study Area 1 for the past 43 years, and was originally from an inner-suburb of Dublin. Bridie had lived alone in her house for the past fourteen years, as her husband had to move into a nursing home; she has been widowed for the past five years. Like many participants, Bridie conceptualised a good quality of life as having her health and being able to get out. For Bridie, having health was defined as being as free from pain as possible and being able to get out and walk:

> Well health, once you have your health and you are able to get out, and free from pain as possible that you can get out and walk. I think it is what you make of it yourself really and truly. (Bridie)

When I asked Bridie specifically how important it was for her to get out of the house, she replied:

> It is very important, definitely very important. After the last week [unprecedented snow weather event], I really sympathise with anyone who can't get out. If I couldn't get out of the house, I don't know what I would do, because it is important to get out to meet people - for your own sanity - get out and meet people. I enjoy it. (Bridie)

During data collection in Study Area 1, an exceptional snow weather event took place in Ireland from Wednesday 28th February to Sunday 4th March 2018. It was described by Met Éireann as one of the "most significant snowfall events of recent

years" (Met Éireann, n.d.), with an estimated 40cm of snow falling in some parts of the country overnight on Thursday 1st March. This unprecedented snowfall in Ireland was caused by the combination of two weather systems, a cold air mass from Siberia, informally known as the *Beast from the East*, and a depression named *Storm Emma.* As a result of infrequent occurrences of heavy snowstorms in Ireland, events such as these cause more disruption than would be the case in countries where snowfall is more frequent and planned for. Status red weather warnings were issued and people were advised to stay indoors throughout the event. Public transport ceased and the country came to a standstill (Met Éireann, 2019).

Bridie discussed how important family and friends were to her, and how they were also very important to her for a good quality of life. She commented that her grandchildren helped her health wise, because they kept her active. Bridie has cared for others for most of her life. Before her husband died, she spent a great deal of her time either travelling to the nursing home or visiting him. When he died, she explained that initially, she didn't know how to fill her time:

> I found I was at a loss for the time, I just didn't know what to do. (Bridie)

> Yes, I had so much time. Where [before] I had no time to spare… but I did find when he passed, I couldn't get used to having so much time then… I was able to go to all my clubs and that. But it was grand then after a while, you'd get used to it. (Bridie)

She described that "after a while" she adapted and began attending various social groups and clubs because she was suddenly able to, and gradually she began to get used to this change in her life. One of the reasons that getting out and about was so important to Bridie, was because it provided the opportunity to meet other people, as well as fill some of the time that she suddenly had available to her when her husband died. Bridie's overarching valued functioning could be described as connecting with others whilst getting out and about. In addition, it was important to her not to spend too much time at home on her own, because this made her feel as though she had too much time on her hands. I return to Bridie in more detail in Chapter 6, when I consider her daily routines, places and activities of importance.

5.2.2 The importance of getting out and about for mental health and wellbeing

Bridie was someone that had a very strong motivation to get out and about. It was very important to her for her mental health, wellbeing and her quality of life and she admitted that she would not know what to do if she couldn't. Other participants also described how they *needed* to get out and spoke about the detrimental impact it would have on their physical and mental health if they couldn't. Shauna felt very strongly about the importance of getting out so that she could talk with others. She stated during her interview that she would "crack up" if she couldn't get out and would need to be "committed" and how getting out was her "therapy":

> 100% yes, if I couldn't get outside the house, they could commit me. I told the daughter that. (Shauna)

> I think my therapy, everyone is different, keep out and meeting people. It is better than a tonic. I am never sitting. (Shauna)

In Margaret and Nessa's joint interview, they discussed how if they had to stay within their house "for any length" of time, they would "nearly go mad":

> But also, it could be the difference of living longer because I personally, and Nessa I think is the same, if we are in the house for any length, through no fault of our own, we nearly go mad. (Margaret)

Getting out and about was also identified as a must for David:

> No, I *have* to get out… I wake up every single day, can't wait to get out and much to the annoyance of my missus. (David)

Whilst David enjoyed interacting with others whilst out and about (shown more in Chapter 6), his primary motivation for getting out was different to the previous participants. He felt that getting out and about was important for his mental health, but emphasised different pathways to this. In particular, it was being physically active and carrying out regular cycling routines, as well as connecting to nature, that provided him with health and wellbeing benefits. David was quite unusual amongst my participants and was by far the most active, as he was a former ultra-triathlete. David's routines beyond the home are described in more detail in Chapter 6, but included cycling long distances with his dog. Here I summarise why David felt so

strongly about getting out in the first instance. David felt that getting out and about was "key" to his mental health. In particular, he felt that his routines ensured that he never felt lonely or depressed:

> The key to good health in terms of mental health and all is being out and about, and I never look on myself, I could never see myself being lonely. (David)

During his interview, David discussed the prevalence of depression that he observed at a societal level. He speculated whether people would feel depressed if they engaged and connected more with nature, something he particularly valued. David provided examples of activities that he felt would be beneficial to people, which were activities he obtained "pure enjoyment" from. This included watching waves during a storm, seeing cygnets on a nearby river, and feeding two robins outside his house that he had named "Cheeky" and "Nervous":

> There is too much depression. How many people really suffer from depression? How many people will get rid of feeling depressed if they went out for a walk in a storm and watched the waves beating up over a wall 25 foot high? Exhilarating stuff... And getting out… Like I go down [name of nearby river] every day, there's five beautiful little cygnets are growing at a great rate down there, and all that kind of stuff. It does your heart good. We have two little robins that fly into the hall here, we feed them with cheese. My friend's kids come down especially to see Cheeky and Nervous. And they whistle from 2am. They are fantastic. It is pure enjoyment here at times with just nature. (David)

5.2.3 Concerns about getting "stuck" at home

For some participants, it was clearer to obtain a sense of what was *not* a good quality of life, rather than what was. Edith, Shauna and Bridie all expressed concerns that about spending too long at home. For these participants, there appeared to be an unnacceptable line that would constitute a poor quality of life. This included not being able to get out, not moving and not interacting in any way, to the extent that you would effectively "vegetate". In this way, *not* having a good quality of life was conceptualised as having a completely passive existence both physically and mentally and having no meaningful activities or interactions to look forward to:

> I don't want to become a vegetable sitting in the corner. Life is for living and for whatever bit I have left I want to live it. (Edith)

> You either sit in the chair at home and just veg out, or you get out. (Shauna)

> I know there are some people who don't like going out and stay in all the time, but I think you would just vegetate if you didn't get out. (Bridie)

This has been identified as a common concern among older people within lay person definitions of quality of life (see Aberg et al., 2005, Borglin et al., 2005, Bowling and Gabriel, 2007, Holland et al., 2005). Connected to fears about spending too long at home, several participants raised concerns about being "stuck" in their homes and not being able to leave. When I asked Jack how important it was to get out, he responded:

> Oh it's, yeah, yeah, yeah, I would hate to be stuck in all the time. (Jack)

Getting "stuck" included both physically being unable to leave or mentally unable to, where the perceived barriers become too difficult, or when an individual gets out of the habit of doing so. In the group interview, there was a discussion about people who might be stuck in the house for various reasons, and how it could be very difficult to overcome this:

> I think once you get out it becomes a habit and then you can't get stuck in the house. (Clodagh)

James described how he would feel it he could not get out and felt as though he would effectively be imprisoned:

> Oh, that is very important, you don't want to imprison me, you don't want to put me in jail in the… now, at the same time, I probably mellowed a bit in recent years. In that, I can sit in a lot longer and go on the laptop and do something or read a book or something like that, but I still like to get out, fairly often. (James)

What is interesting here is that James also discussed how he has "mellowed" over time, suggesting that his expectations about getting out, and the perceived need to be out has changed as he has aged. Being a prisoner within your own home was also identified in Focus Group 2:

> Yes, I think it is important people get out though, don't make a prisoner of their home, and you can be a prisoner to your own home. And if you start tidying and cleaning, it is endless and nobody sees it, only yourself. (Participant from Focus Group 2)

When Michelle described her weekly routine, she talked about how she was not "locked in", because she could still get out and about:

> I don't stay in the house too long, weekends, maybe a bit, but my sister comes down on Sunday mornings and she has a bit of lunch and then she goes off home. Because she is 84 and she drives, she lives out in Shankill, but she comes on Sundays so I am not, like you would say, locked in, no. (Michelle)

The strong emotive language used within these accounts, to describe being at home for too long, was particularly striking. Older people feeling as though they were imprisoned, has been identified in research for individuals living in both nursing homes (Falk et al., 2013) and at home (Smith, 2012). Furthermore, within research exploring community mobility and the important role of social engagement in maintaining identity for older people, Gardner (2014) found that the home environment was "frequently referred to as a prison from which escape was necessary" (p.1252). Existing literature has described the "bodily imprisonment" experienced when difficulties arise with carrying out desired everyday tasks (Falk et al., 2013, p.1005) and particular challenges have been identified for individuals with health conditions such as dementia (Heggestad et al., 2013) and Parkinson's disease (Bramley and Eatough, 2005).

For many participants, the length of time spent at home influenced whether being at home was perceived positively or negatively. For example, in the quotation above, Margaret stated that if she stayed in the house and didn't get out for "any length of time", as in an extended period of time, she would "nearly go mad". Participants described frames of reference that they felt were acceptable amounts of time that they could *cope* with being at home. However, if this was exceeded, it went from being something enjoyable, to something that had to be endured and their mental health deteriorated. In a joint interview with Niamh and Méabh, they both expressed concern that their days would be "endless" if they stayed indoors all the time:

> Méabh: I'd go mad always sitting… endless days like this, just sitting.

> Niamh: They would be endless.

Méabh and Niamh demonstrated how they would perceive time differently if they were at home, because they would not have as many different activities to carry out and would spend more time just sitting. Again, Méabh referenced how she would "go mad" if this was the case. This example highlights variations in perceptions of time and the importance of recognising subjective perceptions of time, or "experiential time" when considering why getting out and about is so valued (Dodgshon, 2008). This example shows how this is linked to the types of activities carried out by individuals, in particular, how certain activities or occupations typically carried out at home or beyond the home can positively or negatively influence perceptions of time. A common account by participants was that if they stayed in all day, they often felt that the day was too long, but if they left the house, even for a short period, it helped to break up the day. This was the case for Nuala. Nuala described instances when she might be in for the whole day, her perception of time would change. This could be during winter time or when her daughter that she lives with is out, as she usually goes out with company:

> I do like to get out, if it is only for an hour. It breaks the day. Sometime in the winter days I probably wouldn't go out, my daughter may be out, and I wouldn't go out if it is raining or what have you and the day is endless. (Nuala)

June described how when she stayed at home all day, it became a "very long day":

> When you stay in all day it is a very long day. I did recently over the holiday weekend I stayed in all day and that night you are saying, God I have been in this house all day. Not that there is anything wrong with the house, but it is better to get out for an hour, even walking the dog gets you out and you meet people. (June)

Both participants felt that getting out for an hour was enough to help minimise the day feeling too long. Shauna described how she preferred to go out in the afternoon, because it "shortens the nights". Going out in the afternoon was then a strategic action by her to ensure that the length of time inside the house was not too long and that going out at a particular time helped with this. I return to the topic of routines and structuring the day by getting out and about in Chapter 6, but these examples

highlight that there was an acceptable level of time to be outside for participants, in order to make being inside more easily coped with and enjoyable.

The amount of time needed out of the house varied amongst participants. Bríd, the leader of the community centre that took part in the group interview, recognised the importance and benefit of being involved in a structured activity once a week and explained what a big deal it was for some of her members to achieve this:

> So it is very important to be able to get out and to join a club or become involved in something even if it is only once a week. (Bríd)

The participants that took part in this group interview described the purpose of their social group, which was to help older people within the locality that were not yet ready to attend the bigger social groups for older people in their area. It was deliberately a much smaller social group, designed to support people that had become isolated to re-engage with their communities:

> We are providing an outlet for people that are isolated and in isolated areas and don't really want to go to big centres, are not ready to go to big centres. (Bríd)

For older people who have not been used to leaving the house regularly, attending an organised activity once a week would be quite an achievement, particularly when they may be rebuilding their confidence about leaving the house.

Variations in perception of time, depending on whether participants were at home or beyond their homes, can be partially explained by literature on "flow state", a concept originally developed by Csikszentmihalyi (1975), defined as the positive "experiential state that occurs as one approaches optimal engagement with a task" (Payne et al., 2011, p.738). In these examples, getting out and about was perceived to make time move more quickly, which is an important component of being in flow state, where an individual loses track of time (Csikszentmihalyi, 1975). When time was mentioned by participants, moving quickly was preferred, as has been found in literature exploring the rhythms and time-spaces of older people (Lager et al., 2016). Faster perceptions of time are also associated with better psychological functioning, improved wellbeing amongst older people, particularly with regards to sense of purpose and control (Baum et al., 1984). That is not to say that being at home cannot

also produce flow state; indeed one study found that participants were more likely to enter flow state at home, rather than beyond the home and found gendered components of this (Heo et al., 2010). What matters though, is the quality of the experience, the type of activities carried out and how occupied the person is. It is also important to recognise that the feelings associated with getting out and about, can extend beyond the event itself. In particular, getting out and about can influence how participants feel when they come home, as well as how they feel about home.

5.2.4 Getting out and about is more important when you live alone or are widowed

An important factor that influenced how important it was for people to leave the home, as well as how long they left the home for, was whether or not they lived alone. Many of the participants that felt very strongly about the importance of getting out either lived alone, were widowed, or both. Arguably, they valued getting out and about even more because of this. Michelle lived alone and reflected that because of this, she spent a greater amount of time out of the house:

> I spend quite a bit outside; I don't stay in the house because I live on my own. (Michelle)

Brenda lived alone in sheltered housing but spent much of her time visiting family members throughout the week. She described how she was "willing to go anywhere" to have company and to enjoy herself. Living alone gave her extra motivation to get out and about, even though she found getting out challenging due to health issues:

> I am willing to go anywhere just to enjoy myself, company. Because it is very lonely when you are on your own, so you need company. (Brenda)

From the most recent Irish census (2016), among those aged 65 and over, 12.1% of males were widowed, compared to 35.0% of females (CSO, 2021a), while 21.3% of males lived alone, compared to 31.5% of women (CSO, 2021b). It is well documented in literature on ageing and social isolation that living alone increases with age and that women are more likely to experience living alone in Ireland (Kamiya and Sofroniou, 2011). This is partly due to the increased likelihood of being widowed. In general, living alone (Wenger et al., 1996; Finlay and Kobayashi, 2018;

Kearns and Tannahill, 2015; Klinenberg, 2016) and widowhood (Utz et al., 2014) are associated with a greater risk of loneliness. Bridie, in particular, showed remarkable resilience and agency in developing strategies for managing loneliness after widowhood and these are discussed further in Chapter 6. This has been found elsewhere, where widowhood initially led to an intense experience of loneliness, but like Bridie, some individuals develop strategies to cope with this transition (Davies et al., 2016). This included getting out and about to connect with others, developing routines and keeping busy (Bennett et al., 2005; Davies et al., 2016). This finding highlights the importance of the social environment in supporting individuals to manage this transition (Zebhauser et al., 2015; Pinquart and Sorensen, 2001).

5.2.5 Summary

This first group of participants felt very strongly about the need to get out and as shown by Bridie, it was an important component of how a good quality of life was defined. As shown throughout this section, getting out and about was perceived to have a variety of benefits to mental health and wellbeing. These benefits arose from connecting to others, engaging with nature and being physically active, as has been found elsewhere within the literature (Alves and Sugiyama, 2006; Sugiyama and Ward-Thompson, 2007). However, these findings also highlight that the relative importance of each of these varied between participants. Participants raised concerns about the deterioration of their mental health if they were unable to get out. In particular, they feared getting “stuck”, “vegetating” at home and effectively being “imprisoned” in their homes. An important factor in how positively being at home was perceived was the length of time they were at home versus out and about. Participants demonstrated good awareness as to an acceptable length of time for them and if this was exceeded, they would feel more negatively about being at home. This was partially because their perceptions of time changed and appeared to slow down.

Getting out and about was particularly important for participants who lived alone and were widowed and this was due to the need to connect with others outside of the home. I return to the topic of getting out and about to connect with others in more detail in Chapter 6. These findings have important implications for the Covid-19

pandemic, when older people were told to 'cocoon' at home and were unable to participate in valued activities beyond the home. However, as this fieldwork was not carried out during Covid-19, I do not discuss this within the findings chapters, but instead consider what these findings mean for the global pandemic in Chapter 8.

5.3 "I know I can get out"

For participants such as Mairead, it was a comfort to know that she *could* get out, but she didn't feel the need to physically get out all the time. Mairead described herself as a "stay at home kind of a person", and identified a number of activities at home that she enjoyed, including reading. She explained that getting out and about "doesn't bother" her, because she knew she could:

> It is just that is the way I am, it doesn't bother me [getting out]. I know I can go out. (Mairead)

Mairead's response suggests that there could be wellbeing benefits simply from knowing you can get out, even if you do not actually get out. This has been found within therapeutic landscapes literature, where more passive experiences of nature and green spaces, such as viewing these from a window, can still produce (some) restorative and therapeutic benefits (Elsadek et al., 2020; Orr et al., 2016; Pearson and Craig, 2014; Taylor et al., 2002; Ulrich, 1984). This has implications for mobility research, particularly literature that focuses on measuring and defining individuals' activity spaces, which explores where people physically travel to and from. A limitation of these approaches is that they do not capture imaginative mobilities and the potential wellbeing that comes from the potential, possibility and availability of getting out and about (Curl and Musselwhite, 2018; Metz, 2000; Parkhurst et al., 2014; Ziegler and Schwanen, 2011).

Mairead was someone that got out most days and had routines that were very important to her (discussed more in Chapter 6). Whilst Mairead appeared to show disinterest in getting out, she mentioned several times during her interview that she "should" get out more to walk and that she often felt stiff because she was not as active as she could be. What was not clear from Mairead's account, was whether she appeared to be disinterested in getting out because she was genuinely not interested,

or whether she downplayed its importance because she had begun to find it more challenging and it was easier for her to stay at home.

Variations in the need to get out reflected the activities, interests and reasons participants had to get out for, as well as the habits, routines, narratives, identities and beliefs about themselves, that had built over a lifetime. For example, although Mairead did get out, she saw herself as a bit of a homebody. Mairead's example suggests that there may be gendered components to expectations of getting out and about, particularly for those generations where women were expected to stay at home. This has been found elsewhere with regards to driving patterns but not with regard to expectations about getting out (Davey, 2007).

Another way that participants responded to the question about getting out and about, was by highlighting the importance of having the choice and freedom to be able to do so. Michael described how much he valued having the choice either to get out or stay at home and how retirement gave him the freedom to do what he wanted:

> More than I have the right to do when I want to, that I am able to do it, whether I want to, I like that choice, and if I don't want to do it... the one thing I realised about retirement was that I could do what I wanted when I wanted and that is what I have been doing. But it is important to be able to get out of the house. But it is also equally important that I can stay in the house when I want. (Michael)

Here Michael acknowledged both the importance of getting out but also the importance of staying in if he chooses. This was emphasised by Darragh, who explained the important distinction he made between *having* to do something and *wanting* to do something:

> I don't feel the need to have to get out the house, you know? If something requires me to get… I have a policy in life, don't do something 'cause you have to do it, do it because you want to. (Darragh)

Darragh did not feel that he *had* to get out and about, instead he *chose* when to engage in activities that he valued. Throughout a typical week, Darragh had many instances where he wanted to get out and did get out, to the extent that he needed a diary to keep track of everything:

> I'm occupied … one hundred percent of the day, meeting people like yourself, Hannah … getting involved in different projects. I have to say I have a diary, and I need a diary, because of all the activities I'm involved in. (Darragh)

This highlights the importance of what participants do when they are out and about and how this can influence whether the experience contributes to wellbeing. In particular, this will depend on how important it is to them, and how much they *want to* carry out activities, versus *have to*.

Emer described how being at home as an activity in itself was something that she valued on occasion. She talked about the comfort of a "lazy day" at home:

> Yes, sometimes I would like a day in. If I looked out and saw it was lashing down raining and I would feel, oh gosh this is a great day for staying in and doing as little as possible or maybe catching up on something you have to do. But a lazy day, yeah, I like that too, definitely. (Emer)

As an activity carried out once in a while, having a "lazy day" in the house was a very positive and comforting experience for Emer, but this was something that was chosen in response to a particular weather condition. However, it would likely be a very different reaction if it was the only option available to her and she had no choice in the matter.

5.3.1 Having your health to 'be' independent and 'do' independence

Having choice and control about when to get out, as well as physically being able to do so, was an important factor for participants and was influenced by both personal and environmental characteristics. I return to this idea in subsequent empirical chapters, but in this section I outline the ways that health, independence and getting out and about interacted to influence the quality of life of this group of participants. For many of them, getting out and about was the physical embodiment or enactment of independence and helped them to feel good about themselves. This was discussed at several points during Focus Group 2:

> It is important to do things on your own because you feel stronger for it, rather than depending on people to go places. (Participant from Focus Group 2)

> It is important when you get to our stage in life that each individual person is able to do their own banking, pay bills, things like that are very important as well. (Participant from Focus Group 2)

As discussed in Chapter 3, existing research has demonstrated the vital and overarching role independence, freedom and autonomy play in the quality of life of older adults (Gilroy, 2006; Borglin et al., 2005; Meijering et al., 2019). Literature has also identified important overlaps between mobility, freedom and independence (Curl and Musselwhite, 2018), where mobility is seen as "an expression of personal autonomy and freedom" (Mollenkopf et al., 2011, p.788) and the act of moving independently brings about wellbeing benefits (Ziegler and Schwanen, 2011; Schwanen et al., 2012; Schwanen and Ziegler, 2011). This is often discussed in relation to older people driving and the negative impacts experienced when an individual is forced to give up driving, particularly on identity and sense of self (Alidoust et al., 2019; Davey, 2007; Ziegler and Schwanen, 2011), but also related to carrying out everyday activities outside of the home (Franke et al., 2019). Accomplishing daily tasks and being mobile has been shown to influence wellbeing in a variety of ways, but important factors include the sense of accomplishment, fulfillment and confidence that comes from achieving this (Curl and Musselwhite, 2018; Ziegler and Schwanen, 2011).

Another important component of a good quality of life identified by participants, which was very inter-related with independence, was health. This was one of the highest referenced codes for quality of life (see Appendix 16):

> To me good health is very important, to be able to get up and do things every day. (Nessa)

One of the reasons that "having your health", as it was commonly described by participants, was so important to participants was that it was seen as a form of wealth. The phrase "health is wealth" was mentioned several times by participants. Having health was valued so highly because it enabled participants to 'be' independent but also 'do' independence, i.e., to be able to get out and to engage with people and places that were important to them. This was illustrated by both Áine and Nessa:

> Health is very important, most important because if you haven't got your health, you can't do and be independent. And my independence is very important to me. I don't want to have to rely on anybody, but I would like to think and know that I can and that is important to everybody. That you can ask for assistance if you need it but don't become a burden on anybody, try and always keep your independence around you and strive to be of good character. (Áine)

> Well, the fact that I am able to get up every morning, look after myself, I clean my own house. I don't depend on anybody for anything, but they are there if I need them but thank God, I am very independent and that is how I would define it [a good quality of life] and I have the good health to be independent. (Nessa)

Áine and Nessa's descriptions of a good quality of life highlight the delicate balance of being independent versus dependent and not wanting to be a burden, as well as the importance of reciprocal relationships, which have been identified in existing research (Borglin et al., 2005).

5.3.2 Summary

For this group of participants, wellbeing arose from knowing that getting out and about was an option for them. This highlights the importance of independence and having the choice and freedom to be able to get out in the first instance and the important distinction between having to get out and wanting to get out. This section has demonstrated how participants enact their independence through getting out and about and how this is both influenced by, and influences their health. However, looking at all participants, whilst both independence and health were commonly valued by participants, they were interpreted and defined differently across participants and this was usually related to existing abilities or contexts. In this final group of participants, I consider some of the variation in how participants defined health and independence, developing the conceptual framework of ageing – *as well as you can* – in place, and emphasising the importance of being 'relatively' independent and having 'good enough' health.

5.4 "I like to get out a little"

While getting out and about in some form was consistently valued, the ability to get out, as well as how often individuals got, out varied considerably across participants. Aged 89, Nuala was one of my oldest participants. Her description of the amount she got out was quite different to most participants, in that she stated she liked to get out "a little":

> I like to get out a little. I used to go out to visit but unfortunately most of my friends are gone as well, all I can do is visit their graves, which is the sad part about it. But I used to go out quite a lot. (Nuala)

Nuala often described getting out in the past tense during her interview, recognising that it used to be something she did more of. This reflected her changing capacity to get out but also the opportunities or reasons she had to get out (this is discussed more in Chapter 6). Nuala appeared to have accepted getting out less frequently and had changed her expectations as a result. Nuala acknowledged that she did not get out very often, she did still like to get out for short periods of time, identifying a specific amount of time that she preferred to get out for, which was an hour (see Nuala's quotation in previous section). Nuala's example shows how both the extent older people get out can vary over time but also how expectations about getting out can change. Whilst it may be less than previously had been the case, some form of getting out and about was still desirable.

5.4.1 Having 'good enough' health to be 'relatively' independent

Nuala referred to the importance of being independent during her interview. Like her desire (and ability) to get out, the level of independence she desired (and required) had also shifted. Nuala recognised that she needed more help than she used to but still liked to have "a little bit of independence":

> Nuala: I just think I get up in the morning and I am able to do my own things, a little bit of independence. Now a lot of things I need to have help with I know, but I think independence.
>
> Hannah (Interviewer): [Independence] is very important to you?

> Nuala: Yes, I like to be. Now a lot of things I have to get help with, but I like being independent.

For Nuala, some support was required to ensure that she could still get out and participate. Nuala had support from her niece, who accompanied her at social groups and was present during her interview and go-along interview. This support from her family members ensured that she was "never really stuck" at home. Nuala appeared to be willing to accept this help, because she was still able to have some independence, was able to stay in her own home and was still able to get out.

Nuala's example demonstrates that participants' conceptualisations of independence was not uniform, recognising the "fluid" and "fuzzy" ways that it can be defined by older people (Allam, 2015; Schwanen et al., 2012, p.1313). I return to this idea later in Chapter 8. Nuala's account also highlights the importance of having the opportunity to identify what independence means to her and the capability to choose which aspects of independence she may be willing to re-negotiate over time. By having this freedom, losing some independence may be less damaging to an individual. To recognise that some revisions may be necessary for individuals, I revised Theme 3 related to independence to being *relatively* independent.

Moving on to health, whilst health or "having your health" was commonly identified as being important, it was not as easily or uniformly defined by participants. Participants often had frames of reference that they felt constituted having good health, which would not necessarily align with a definition of complete health, such as that defined by the World Health Organization (1946, p.1). Instead, participant definitions of health varied and in most instances, reflected what the participant themselves was able to attain, ensuring they could frame themselves as having good health in some way. This is closer to Norman Daniels' (1985, p.28) description of a right to health consistent with "normal species functioning", which recognises that this will vary with age.

Returning to Bridie, introduced at the beginning of this chapter, having her health meant being relatively free from pain, as well as being able to do things such as get out of the house and go for a walk. These were criterion and activities that she was able to achieve whilst living with Chronic Obstructive Pulmonary Disease (COPD).

Adapting her definition of good health, meant that she could self-identify as having her health. Niamh considered herself lucky to "have [her] health" because she did not have "sickness", was not taking any medication, and was able to keep busy:

> I'm at this state now I'm going wherever I can. I'm lucky, I'm not on any medication and I'm not, I don't have sickness, thank God, you know, while I have my health, I'm busy. (Niamh)

Darragh, meanwhile, explained that he was told by his doctor that he had great health. When I asked him whether he was ever restricted in his activity due to his health, he described his experience of being a bus mechanic and how he had always found ways to adapt and compensate, such as "to increase the leverage" when using a spanner to loosen wheel nuts, when he was not as strong as some of his other colleagues. As a natural problem solver, he did not feel limited by his health but instead made small adjustments, asking "is there a better way of doing this?". Whilst he did take some medication, it was only for preventative purposes and because it was preventative, he felt he had good health:

> So, yes, my life is very positive, thanks be to God, I have great health, my doctor will say to me, [participant's name] keep doing what you're doing, it's working for you. OK, the only medication I'm on is cholesterol tablets, not because I have cholesterol, but… because of my age. It's a protective, it's a preventative medicine, rather than some … you know? (Darragh)

Participants using more flexible or "pragmatic" definitions of health over time has been identified elsewhere in the work of Gilroy (2006), who found that participants chose accounts of health that aligned more with subjective wellbeing, rather than objective health and emphasised the importance of engaging in enjoyable activities. Furthermore, this finding aligns with Huber et al. (2011), who argue that the traditional World Health Organization's definition of health is no longer "fit for purpose", owing to the prevalence of chronic health conditions. Instead, they have proposed an alternative definition of health, which is the "ability to adapt and self manage in the face of social, physical, and emotional challenges" (p.1). This definition emphasises the subjectivity of defining health and how this may need to be adjusted over time, and places a greater emphasis on wellbeing and quality of life (Borglin et al., 2005).

5.4.2 Engaging with 'meaningful' activities or interactions

Participants tended to align more with alternative or pragmatic definitions of health, particularly those who had existing health and mobility challenges. Most participants with health and mobility challenges still felt that they had a good quality of life. This was in large part, because they were still able to get out and about and find meaning in their lives (Theme 3). Whilst optimal health and mobility were desired and preferred, reductions in either were more readily accepted and coped with if participants were still able to participate in meaningful activities, many of which occurred beyond the home:

> I used to do set dancing, but I don't do it anymore 'cause I wouldn't be able … it's my age as well as my … I won't call it my illness, but like, my age… I do have a kind of problem with my hips … I do have a bit of a problem with my bones, like, you know, I've arthritis and that, but … it's not stopping me from getting out, and I'm quite happy what I'm doing. (Niamh)

Some re-negotiations were sometimes necessary, as shown by Niamh, where certain activities were no longer possible, but participants still needed to get out and about in some form.

Anne was the only participant to state a direct "No" to the question of whether getting out and about was important to her. She described how she was quite happy to stay in, and was not a person that had to be out all the time. When I asked her how important it was for her to get outside the house, she responded:

> No, not really, no... I'm quite happy in my own, you know, my own little... I wouldn't be one of these people that had to be out all the time. Now in the night, I'm like a vampire… going to bingo… I like to get out and walk, but I wouldn't have to be out, out, all the time, do you know what I'm saying? I can sit in my home, I enjoy sitting in my home. (Anne)

Anne's response was interesting, because she began by saying how getting out and about was not that important to her. However, she then clarified that she was not someone that had to be out *all the time*. Yet, when I examined her valued routes and routines through the mapping exercise, she was someone that was out quite frequently, regularly walking relatively long distances, shopping, attending social

groups and playing bingo. These accounts did not appear match up, in that she stated it wasn't that important to her and yet her actions contradicted this. To Anne, someone that valued getting out and about spent more time than she did out of the home. However, because she enjoyed being at home, it is possible that she did not recognise the importance of getting out in smaller amounts and may even have taken it for granted.

Anne described how she would spend "the best part of the day in the house". In this instance, she differentiated between people who were out of their house for extended periods of time, whereas she enjoyed being at home. Unusually amongst the women in my study, she was often out at night playing bingo. Many of the activities that were important to her were home-based. When reflecting on how she would define a good quality of life, being able to carry out home-based activities was very important to her:

> I like decorating and doing things... so far so good, I can still do my bit of painting and do things. And the day that I can't do that I'd really and truly find it very, very hard. That's one thing that would have a... I'd know then that... I'm getting old. I know I'm old, but you know what I mean? If it started interfering with me that way, that would be a big, big deal of my life. 'Cause I like to just get up and do things and not hang around. (Anne)

One of the activities she valued most was decorating and doing home improvements. These were activities that necessitated being at home more, however, they still required some engagement with outside the home to obtain relevant materials. Anne differentiated between an older person who was still able to do things of importance to them, with an older person unable to do things that they valued. If at a point in the future, Anne was no longer able to carry out these valued activities, she felt that a line would have been crossed, where she would know that she was "getting old". She would also find this very difficult to accept.

Anne's account aligns with a definition of quality of life that is about being able to do the things that are most important to her, whether that is inside the home or outside of the home. This fits with a capability approach to a good quality of life and ageing well – achieving valued functionings, or life's beings and doings (Gilroy, 2006; Meijering et al., 2019). In Anne's instance, this involved carrying out activities

in the home but also getting out and about and engaging beyond the home in some form. Whilst Anne identified a number of activities and hobbies that were important to her, some were rated more highly than others and would have resulted in more negative consequences if they were no longer possible. This highlights the subjectivity of both a quality of life and valued functionings.

5.4.3 Summary

Health was important to individuals to an extent, because it enabled people to get up, be mobile, engage with meaningful activities and get out and about. For those that had challenges, was still possible to have a good quality of life, as long as they can still do those things that are of *most* importance to them. Health challenges were more readily accepted and coped with by participants if their challenges did not prevent individuals from getting out and they had suitable alternatives to replace more vigorous activities that they may no longer be able to carry out. In this way health amongst participants did not have to be perfect to have a good quality of life, it just had to be 'good enough' to be able to participate and engage in meaningful ways. This was the motivation behind the modification of ageing well to "ageing as well you can" and this conceptualisation is further developed in Chapter 8.

5.5 Temporary fluctuations in getting out and about

So far within chapter, I have focused on highlighting the variation in the extent that participants felt they *needed* to get out and about. In this section, I consider the ways that individuals themselves fluctuated with regards to getting out. Several participants have already shown that expectations about getting out changed over time, for example, James and Nuala. I now discuss two ways that participants demonstrated their appreciation of getting out and about and its importance to them, by reflecting on a time in the past when they had been unable to get out and were confined to their homes. The first was due to disruptions to health and the second was due to seasonal and weather variations.

5.5.1 Disruptions to health

One way that participants had been confined was due to temporary disruptions in their health, as was the case for Shauna, David and Michelle. Shauna and David had both broken their legs in the past, which meant that they needed a crutch to walk and were limited in their mobility for a period of time; two years and a month respectively. Shauna and David differed considerably in their recovery and how this influenced their independence. For Shauna, she admitted that there were two "bad years" but she now had home help to assist with cleaning which was a big help to her. David's account was particularly striking, because of how he pushed himself to recover more quickly. This was due to the importance of cycling to him:

> I broke my leg two years' ago, my femur, three places, and in a month I was on my bike doing a time trial up on the quays, a month ahead of schedule. And the doctor [was] screaming at me to give up cycling. If I had listened to them, I'd have been nobody. The bicycles and the trike puts me in touch with everything. I am completely independent. I get my groceries in my rucksack, and I exercise the dog 10 miles a day, he needs big mileage. Not for him, me walking around on the lead with him, he runs, and he is part of my life. I have had dogs all my life, but we were told we were getting too old for a dog. No way, he has given me back, I never lost it anyway, independence and keeping an eye out to what is going on. (David)

David's account is revealing when he stated that the doctor told him to give up cycling, but if he had done that he would have been "nobody" because it was his cycling that kept him connected. He spoke of the cycling routine he carried out with his dog and reflected on his decision to get another dog. He started to describe how the dog gave him back his independence, before quickly revising this to state that he "never lost it anyway". This example provides an insight into the sheer determination and motivation David had to get out. This was unusual amongst my participants, even for those that highly valued it. David's answer to the question of whether he ever felt limited by his health was particularly striking and highlighted well the heterogeneity of the older adult experience. His answer was categorised as yes in Table 4.1 in Chapter 4, and yet as a former triathlete, he queried the fairness of such a question:

> Well, I can never run a 3 hour 15 minute marathon, which I have done. I can no longer finish an Iron Man, which is a 2½ mile swim, 114 mile cycle and the marathon. I am no longer capable of doing them in 11½ hours. So that is not a fair question to ask a 75 year old guy who eats his heart out when he looks up at the mountains to say, I have run them a million times and I can name every one of them from one end to the other. And I challenge Wicklow men to run the mountains I run in Wicklow. So I am badly curtailed… But looking at myself again 75, I cover 10 miles a day at the very least with the dog and then I am on my other bike then. I can go into town and back in 25 minutes, especially to get bread. (David)

Looking at general trends for older people he would not seem particularly "curtailed" for a 75 year old, but according to his own previous standards he felt he was. This highlights the "discontinuity" between his past self and current self and how he was coming to terms with this (Lager et al., 2016, p.1574).

Michelle described how she nearly lost her sight as a result of being Type 1 diabetic. As a result of medical treatment and injections, much of her sight had been restored and she was very grateful that she was able to read again:

> I can see, I am reading my books, the thing I love mostly. (Michelle)

She had recently joined a book club and spoke very enthusiastically about this, as well as how lucky she felt that she could still get out:

> But it is great, I am lucky, and I can go out. But yeah, I get out, I definitely do, I am always doing something, I am always busy. (Michelle)

Whilst some of her sight had been restored, she still struggled with her sight, particularly when out walking. She was able to get out, but admitted she had not been walking as much recently, particularly at night. Shauna, David and Michelle were all participants that *had* to get out and possibly this was partially because they had experienced a time when they couldn't and appreciated it all the more when they could as a result.

As well as describing direct experiences, other participants such as Noelle described the experiences of friends or family who had not been able to get out and how difficult it was for them. By comparing her situation with theirs, she was able to

reflect on why getting out and about was so important to her. Noelle discussed how her husband had been unable to walk for some time after he had a heart attack and how he missed getting out to his community centre:

> I know all he longed for was to get back on his feet. He lost his walk at one stage, all he longed for was to get back on his feet to go [to attend his local community centre] … it was the first thing that he went to when he got back on his feet again… I mean he goes every day since, so it's so good for him to get out of the house. (Noelle)

When I asked Noelle how important it was for her to get out, she described a friend who was unable to leave the house, because of caring responsibilities to her husband. Initially, she had to travel to the hospital every day and now she recently she had to stay at home to look after him:

> Oh, very important to anybody, I think. I think it's just not me, it's everybody … I see my friend now that used to do the bingo with me. And … my heart goes out to her, because I know what she must be going through because she loved coming to bingo to meet the other women … But this woman doesn't get to bingo, she doesn't get out anywhere … must be I'd say a good five months every day going to the hospital, and he came home last week and now she's kind of confined to the house, she can't leave him … She lives on her own with him so she can't leave him … I kind of find, how it must be to her, that she doesn't get … And … with somebody like that, sick as well, you're not inclined to have friends coming in, because her whole time is taken up with him as well … That to me is … why it's so important to be able to go out. (Noelle)

Noelle mentioned how her daughters made sure that she still attended her favourite activity of bingo whilst her husband was in hospital and that her sister would come up to stay with her, and she admitted "that's how important these things are to you". In this instance, Noelle's friend was hindered by caring responsibilities but Noelle herself, through respite and the care received from her daughters, was enabled to continue attending her social group. This emphasises the relational aspects of being able to be mobile and how it can also be a caring act (Croucher et al., 2020). These findings also highlight that caring responsibilities for others can potentially impede attendance in social groups, which may contribute to the social isolation of informal older carers (see Greenwood et al., 2019).

5.5.2 Weather and seasonal variations

Another way that several participants reflected on a short period of confinement to their homes, was during the unprecedented snow event that Bridie referred to at the beginning of this chapter. Several interviews with participants took place immediately after this event. For Bridie and Edith, there was still snow on the ground. During this weather event, many of my participants had been housebound for several days and some reflected on the experience during their interviews. This was mainly those that had been interviewed immediately after the event, but there were some mentions of it amongst those interviewed several months later. Bridie spoke about the "cabin fever" she had experienced during this time:

> Hannah (Interviewer): How have you found the last few days?
>
> Bridie: Cabin fever, certainly cabin fever. It was desperate, but we got through. The neighbours were great, calling in making sure I had everything, they were very good. Everything was fine, thank God.

Bridie recognised how easy it could be to "get into a rut" and how this was particularly the case during the winter months:

> It is very easy to get into a rut and it is very hard then to break the habit to get out, especially during the winter, it is very hard when you are sitting here to get a coat on and walk down, very, very hard. But once you get down there you enjoy it, and you are glad then when you come back that you have done it. So it is very easy to not go out. (Bridie)

She described a neighbour that struggled with getting out and how hard she found it to "break the habit" and get out:

> And God love her she died on her own. She only died there in December, and she never done it, she was a lonely, lonely woman. She just wouldn't break the habit of [not] going out. (Bridie)

She spoke about how she tried to encourage her to attend social groups but she would not attend. She reflected how she would "hate" for that to happen to her:

> I would hate that to happen to me, I really would. That is how I spend the time, I would hate to be stuck in the house, it is important for me to get out, it definitely is. (Bridie)

Brenda was interviewed in July 2018, approximately 5 months after the event but described how she had struggled during the previous "bad winter" and how lonely she had felt:

> Sure, the house, the bad winter there, holy God there was many a time I had to miss the knitting and all, it was so lonely because everybody's door was closed. (Brenda)

James, described how he had coped reasonably well during the snow and was able to adjust in the short term, but revealed the relief he and his wife felt when the snow had cleared enough to be able to walk to the shops:

> James: I managed alright during the snowy days. When it came to the point where it was nearly good enough to go out for a walk or go down to the shops, I was glad. Even herself [James' wife] was the same. She said "I haven't been out in one ah…" …we went down to the shops even when there was nothing in it.
>
> Hannah (Interviewer): Just for the walk? *[laughs]*.
>
> James: Just for the walk yea. So, so it is important to get out, but I can adjust myself if need be, but I wouldn't like to be confined to it yea.

James' account contrasted with Bridie's and Brenda's in that he "managed alright" during the days that he couldn't get out. He felt that he was able to "adjust" himself if needed but that he wouldn't like to be "confined" all the time. Brenda and Bridie found the experience much more challenging, due to the strength with which they usually *needed* to get out, owing to them both living alone and being widowed, and the subsequent need to get out to engage with other people.

5.5.3 Summary

This final section provides accounts of temporary disruptions to getting out and about, as a result of health challenges, as well as seasonal and weather variations. Weather and seasons have been identified as important environmental factors which

influences the extent and ease with which older people get out and about (see Böcker et al., 2017; Finlay, 2018; Franke et al., 2013; Hjorthol, 2013; Holland et al., 2005; Ludwig, 1997; Tanner, 2010). Existing research has also highlighted the "seasonal rhythms" that occur amongst older people (Lager et al., 2016, p.1573) and how for some this can lead to a "dependence on the weather" (Lager, 2015, p.104). What was notable about these accounts was not that fluctuations existed, but the variation in the extent that participants felt that health challenges, weather and seasons *influenced* their ability to get out. This highlights the heterogeneity within the older adult experience. These examples demonstrate that for some participants who have either experienced a time when getting out and about was more challenging, or known someone else that had, were more appreciative of being able to get out when they could. As a result, getting out and about is often more highly valued when it is threatened, or at least its importance is most acknowledged when at risk. Experiences such as these highlight how difficult many participants found spending several days at home, as well as variations in how adaptable they were to these changing circumstances. These findings have implications for the recent Covid-19 lockdowns and pandemic, which I will discuss further in Chapter 8.

5.6 Conclusion

This chapter has set the foundations for the remainder of the empirical work. Within this chapter, I have not explored in detail the ways that participants got out and about to engage in meaningful activities and interactions (Theme 3). In Chapter 6, I provide an overview of this and focus in detail on how participants got out and about to connect with others. I have begun to demonstrate how getting out and about can be easier for some of my participants than others and how this is linked to their complex and dynamic person-environment interactions, as well as having adequate levels of safety, security and support (Theme 2). I explore this theme in more detail within both Chapters 6 and 7.

There were marked differences with regards to how getting out and about was valued and how much participants felt they *needed* to get out. Some participants commented that it was vital to their wellbeing and had a strong urge to get out; for others it was nice to know they could but stated that they didn't have to get out all the time.

Others, particularly those who were more constrained, liked to get out a little. Some participants took getting out and about for granted and those that had experienced a time when they were homebound in the past, valued it more highly, because they had experienced life without it. Getting out and about is an everyday, lay term and is often assumed to be uniformly important to older people Whilst there is a wealth of literature that examines the importance of older people getting outdoors, leaving the home, or being mobile, as demonstrated in Chapter 3, there is a lack of research that has looked specifically at the importance of getting out and about as a concept and why this is important to older people themselves. However, this research has highlighted some of the subtleties in terms of its meaning to participants.

This chapter has provided an overview of how important getting out and about was to my participants. To illustrate the variation between individuals I grouped participants into those that *had* to get out, those that *knew they could* get out and those that were more restricted but liked to get out *a little*. For those that had to get out, I began with Bridie, whose account highlighted how getting out and about was vital for her quality of life. Within this section, I emphasised the ways that getting out and about was important for mental health in particular. I also identified concerns that participants rose about getting stuck at home and showed that getting out was particularly important for participants living alone and who are widowed. This research has shown that the *amount* that participants get out does not necessarily align with its *importance* to an individual.

For those that knew they could get out, this provided comfort and wellbeing benefits because they were still able to attain it. This section highlighted the importance of freedom and choice in how to get out, as well as the important role that health plays in enabling the independence to get out. The final group valued getting out in some form, but due to varying preferences and in some instances reduced abilities, they liked to get out a little. This group had reduced expectations and had to make some adjustments, for example, being relatively independent or defining health more pragmatically or alternatively. Yet, because they were still able to get out in some form to engage in meaningful activities, they were able to insist that they had a good quality of life. For example, Anne would know that she was old when she was no longer able to do what mattered most to her. This aligns with a capability approach

to ageing well, emphasising the valued functionings of older people (Gilroy, 2006; Meijering et al., 2019). This is the theoretical lens for the conceptual model of ageing – *as well as you can* – in place, introduced at the beginning of this chapter. Participants had very clear ideas about what was a good quality of life for them and what was not. Being able to get out and about for a variety of reasons was at the heart of this.

Mobility contributed to participants' quality of life in many ways. Having the choice and option to get out helped to ensure that individuals do not feel trapped at home. Many participants raised concerns about getting stuck and feared being "imprisoned" in their own homes, which has also been found elsewhere (see Gardner, 2014; Olsson et al., 2013; Sixsmith and Sixsmith, 1991). For many participants, getting out and about was the physical enactment of independence and achieving this enhanced wellbeing. This was predominantly due to the freedom of being able to move and travel in desired ways. These findings connect with literature that has examined the wellbeing benefits of out of home mobility. For example, Mollenkopf et al. (2011) recognise that mobility is an emotional and affective experience, which can create a sense of independence and that independence is an "expression of personal autonomy and freedom" (p.788). The empirical findings within this thesis confirm existing research that has emphasised the importance of mobility (and getting out and about more generally) for wellbeing, with a particular emphasis on the complexity and inter-connectedness of mobility, independence and wellbeing (Schwanen and Ziegler, 2011). There were considerable differences in how much getting out and about was valued, as well as in the extent to which individuals wanted and were able to get out. For many of my participants, just knowing that they could get out was enough for them, they didn't have to then enact this. This highlights the importance of imagined and potential mobility (Metz, 2000). If we were to only look at how often or the extent that participants got out as a measure of its value, such as through activity space data, its importance to older people would be under-valued.

There has been a growth in research examining the activity spaces of older people, to understand where they travel and how (see Hirsch et al., 2016; Hirsch et al., 2014; Perchoux et al., 2019; Tsai et al., 2015; 2016). However, as highlighted in Chapter 3,

a limitation of this work is it is unable to capture the meaning or value placed on this travel, as well as the perceived wellbeing benefits. Responding to this, literature has begun to incorporate more lived experiences into mobility research (for example, Franke 2018; Meijering and Weitkamp, 2016; Milton, 2015; Sturge et al., 2021; van Hoven and Meijering, 2019). Furthermore, activity space research does not allow for the importance of potential travel to be recognised (Metz, 2000). This has implications, because only looking at where people go only tells part of the story and risks undervaluing the importance of getting out and about to older people. As this research has shown, the amount a person gets out does not necessarily coincide with its importance to them. Indeed, for individuals who struggle to get out, a trip to the main street has significantly more value and importance than someone who can do this regularly and who is uninhibited; and who may take this for granted as a result.

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Chapter 6. Getting Out and About to Connect with Others

> But you come around here [to older adult social group], you have a laugh, you have a joke, you go out on the street, and you meet somebody. And that is why community is so important, it is better than a tablet. The doctor can prescribe all the medication he wants but if you haven't got that blanket around you, nothing will do you any good. That is my look at it. (Unidentified Participant from Group Interview)

6.1 Introduction

As demonstrated in Chapter 5, many participants valued getting out and about because of the opportunities it provided to connect with others. Chapter 5 introduced the empirically grounded conceptual model for this thesis: ageing – *as well as you can* – in place, defined as being able to get out and about, in order to participate and engage in meaningful activities and interactions. This chapter develops Chapter 5 further, by showing *how* getting out and about and connecting with others can contribute (positively and negatively) to ageing – *as well as you can* – in place. Throughout this chapter I demonstrate the various ways that participants *enact* their desire to connect with others by attending and being seen in a variety of places throughout their daily lives. These places and spaces then provide the settings for various types of social interaction to occur.

6.2 Phases of Getting Out and About

Within this chapter, I have grouped some of the places important for social interaction into different phases of getting out and about. Grouping places in this way has helped to draw out some of the differences within and between them with regards to how participants interacted with others. The phases I have chosen, have been informed by the literature from Chapter 3, including literature on social infrastructure (Klinenberg, 2018), third places (Oldenburg, 1989; Oldenburg, 1997; Oldenburg and Brissett, 1982), as well as Gardner's (2011, p.268) "sites of significance" for older people and categorisations of third places, thresholds, and transitory zones.

6.2.1 Phase 1: Thresholds

Gardner (2011) argues that thresholds provide "easy and readily available opportunities for social interaction", typically involving neighbours (p.266). The initial purpose of being in a threshold could be to do some sort of garden-related activity, to be in nature, to obtain some fresh air, or it could specifically be to have an interaction of some kind. The interactions are typically more informal and spontaneous, but they may be anticipated, especially if past experiences had shown it is likely to happen. Within this chapter, I focus mainly on interactions within gardens for this phase, as these were most frequently discussed by my participants. I also include experiences of being on a road located in very close proximity to a participants' house. This is not quite a threshold (Phase 1), as it is beyond the garden and technically within a public space, but it was not deemed quite Phase 2 (discussed below) either, because it did not involve travelling as an activity. Being "on the road" was the phrase my participants used for a particular kind of experience within this public space, which happened close to the house and therefore served as an extension of the threshold.[4]

6.2.2 Phase 2: Transitory Zones

This phase of getting out and about is partly captured by third place literature and Gardner's (2011) transitory zones. Within this phase I differentiate between the different purposes behind this movement. As explained within Chapter 3, Gardner (2011) describes transitory zones not as "destinations" but places we "pass through" (p.267). However, by specifying that transitory zones are only passed through, implies that they would not be chosen to visit unless moved through. However, as shown in Chapter 3, this is not always the case, as quite often individuals may choose to move just for movement's sake, without a destination in mind. By thinking of these spaces as transitory zones, rather than actively chosen, risks diminishing the importance of these acts and the value placed on being in these spaces. Consequently, I divided this phase into two sub-categories; moving or travelling in

[4] I distinguish here between chatting on the road outside the immediate vicinity of a home (Phase 1) and chatting on a road or street when out and about, either walking in and of itself, or to or from a destination, which I would consider to be Phase 2.

and of itself, for example going for a cycle or a walk (2a) and moving to get to a particular place or destination (2b), for example getting a bus to the supermarket. Interactions within this phase could be spontaneous or pre-planned, with friends or neighbours of strangers. This recognises both intrinsic and extrinsic benefits of travel (Graham et al., 2020).

6.2.3 Phase 3: Destinations or Third Places

I focus within this chapter on public places beyond the home identified by my participants as important for social interaction, rather than other private dwellings, such as the houses of friends of families. These include the various places where social groups take place, which are predominantly community centres, as well as churches, predominantly to attend Mass. Some destinations were important because they were specifically visited for the purpose of social interaction, whilst others created opportunities for interaction alongside or during an activity, but where socialising was not the primary reason for attending (adventitious interactions). Other destinations were important because they provided the reason to travel and therefore created opportunities to interact with people along the way during Phase 2.

Scheduled and Frequently Attended Destinations

Destinations typically included places that would traditionally be considered third places. However, the features of third places have not been rigidly applied here for several reasons. Oldenburg (1989) traditionally conceptualises third places as informal places, where activities are not scheduled or organised and where membership is not required. However, my analysis showed social groups as the most highly referenced category of places for social interaction, and these were typically engaged with in a frequent and scheduled way. Participants' frequency of attendance varied. Some were regularly attended and part of a daily or weekly routine, whilst others were visited more irregularly. Additionally, some of these engagements were pre-planned and scheduled, whilst others were more spontaneous. Adhering strictly to the traditional view of third places would exclude many participants' important places. Furthermore, findings suggest that the nature of these engagements being frequent and scheduled, and in turn part of a planned daily or weekly routine, was

very important. In some instances, participants attended multiple destinations or meeting places whilst getting out and about. This is a common travel pattern known as “trip chaining”, which is where people, typically women, carry out “several small interconnected trips” in one go (Criado-Perez, 2019, p.30). I believe that the scheduled nature and trip-chaining patterns associated with attending destinations is something that has been overlooked within third place and social infrastructure literature and highlighting it is one of the key contributions of this chapter.

To begin the empirical findings, I continue with Bridie from Study Area 1, cited in Chapter 5 when her overarching functioning, to get out and about to connect with others, was identified. Bridie was one of the participants whose place-based functionings were clearest and best demonstrated the interactions within the different phases of getting out and about. For this reason, I have used Bridie as a case from which I then compare the broader sample’s experiences in Section 6.3. For the remainder of the chapter, I provide participant experiences in each of the phases of getting out and about. Phase 1 in Section 6.4, focusing on interactions within gardens and in front of the house. Phase 2 is considered in Section 6.5, showing how for some participants moving throughout their neighbourhoods provided a guarantee of social interaction due to their “high profiles”. Non-human interactions and interactions with strangers, and how participants varied in terms of how comfortable they were doing this are examined, before considering some of the variations in walking routines and how this influenced participants’ visibility in Phase 2. Phase 3 in Section 6.6 focuses on two destinations: attending Social Groups and attending Mass. Some of the additional outings and interactions that occur due to attending Social Groups in the first instance are also shown. Within this section, I demonstrate how attending scheduled activities such as these, provided additional purpose and structure for participants to get out, before concluding in Section 6.7.

For each phase, the key places of importance for social interaction identified by participants, including the number of references that a category of place was mentioned. Consideration is given to the motivations, purpose, and activities carried out within these different places (RQ2.1). Examples and experiences of the different types of social interactions that occur and who they were with (RQ2.2) are presented, before providing insight into how positive or negative these interactions were and

how important they were to participants (RQ2.3). Finally, I examine how planned or unplanned, frequent or irregular, spontaneous or expected these interactions were (RQ2.4).

6.3 How did participants connect to others whilst out and about?

6.3.1 Continuing Bridie's Story

Throughout Bridie's interview, it was apparent that she was very busy and socially engaged. She proved to be one of the most socially engaged people I met during my field work. She admitted she loved talking to and visiting people because she was "a real chatterbox". Like many participants, Bridie attended several different activities throughout a typical week, where she engaged with others. During her interview, she identified places, activities, interactions, routes, and routines that were important to her when she was out and about. One of the main activities that Bridie carried out throughout her week was attending Mass at a local church first thing in the morning, which she attended most days:

> I go to Mass as often as I can, which is almost every morning. (Bridie)

In addition to attending Mass, Bridie attended different social groups in several community centres throughout the week. The main community centre she attended was her local community centre, located a short walk from her house. Here she attended (and I recruited her from) a craft social group that met twice a week. She was also President of a Ladies Club that met there once a week. In a different community centre, she attended an exercise class at least once a week and attended church meetings regularly. Bridie took part in additional trips because of her initial engagement with these social groups. She explained that once a month Bridie's Ladies Club would take the evening off and do something different and go for a day trip or evening outing:

> We go out with the Ladies Club one Tuesday every month, we take the Tuesday night off and we go to the cinema, or we go for a meal, or we just go for a drink, or we might take the whole day off and go down the country somewhere because we all have free travel, it doesn't cost us anything. So different scenery, different four walls as I do say. (Bridie)

Bridie had another group that she travelled to Dublin with once a month to attend a market and have lunch:

> There is this group of women that I go into [a Dublin market] every third Saturday of the month, and we have our dinner out and go around the market and that. I am out a good lot, so it is very important to have your friends and everything, very important. (Bridie)

Bridie attended additional events at her local community centre when they were on, including a monthly pub quiz. She was also involved with a music group with her daughter in a local church and regularly helped with that.

On days when Bridie did not have a community group scheduled in the mornings, she typically carried out the same routine and walking route during this time. Bridie mapped this route during her mapping exercise, and we drove some of it during her go-along interview (see Figure 6.1 below). This route involved walking to the town centre of Study Area 1 immediately after attending Mass. She would then go to the supermarket, walk back, and have her lunch. Other places she might visit on this route included a second-hand shop and her local credit union. On Fridays, she visited the local post office to collect her pension. Below is an extract from her mapping exercise where she described this route and how she met people along the way:

> This is where I go for my walk, I come out of mass and I come down [street name] and the by-pass and there is the [name of small shopping centre], and I would go down that way and down to here. [Name of supermarket] would be down here. I would go to there and then walk back up to the bridge, cross the bridge and back home. It doesn't look much on that. But there are shops along here. It takes me a good while, again I meet people, I'd be walking with people up here and I'd be yapping with them. And then when I cross the by-pass there's shops here, there is a second-hand shop and I love going into the second-hand shop. And then I would go to the credit union, which is here, and then I would go to [name of supermarket] and I'd come back up from [name of supermarket] and go into [name of second supermarket] before I would come back home. (Bridie)

Bridie reflected during her interview that not a day went by where she did not talk to someone and sometimes, she would not even have to leave her garden for this to

happen. She mentioned that if she was in her front garden, she often talked to someone as they walked by:

> I would talk to anyone [laughs], I would talk to anybody. There is not a day [that] goes by that I don't speak to somebody because all I have to do is walk down to the gate some days and you will meet someone going up or down the road. You can see yourself they are going by all the time. And all I have to do is stand out there [in her garden]. Sometimes during the summer, I would go out and cut the grass and I would time it, it would be half an hour before something comes on the telly or whatever and I could be out there for four hours talking. (Bridie)

As a result of Bridie's attendance in a variety of social groups over time, and because she has lived in her neighbourhood for many years, Bridie knew a lot of people and felt very comfortable in her surroundings:

> *I like the fact that people will never pass you by without talking to you* [emphasis added]. You could walk up the road, which is only a couple of hundred yards, and it could take you an hour, it could take you two hours, you'd be talking to people so much and that is what I like the friendliness and you feel so comfortable in your environment. I feel comfortable anyway. I don't feel an outsider in it, I feel very comfortable actually, I love living around here. Everyone is just so nice, we are very lucky in that way. (Bridie)

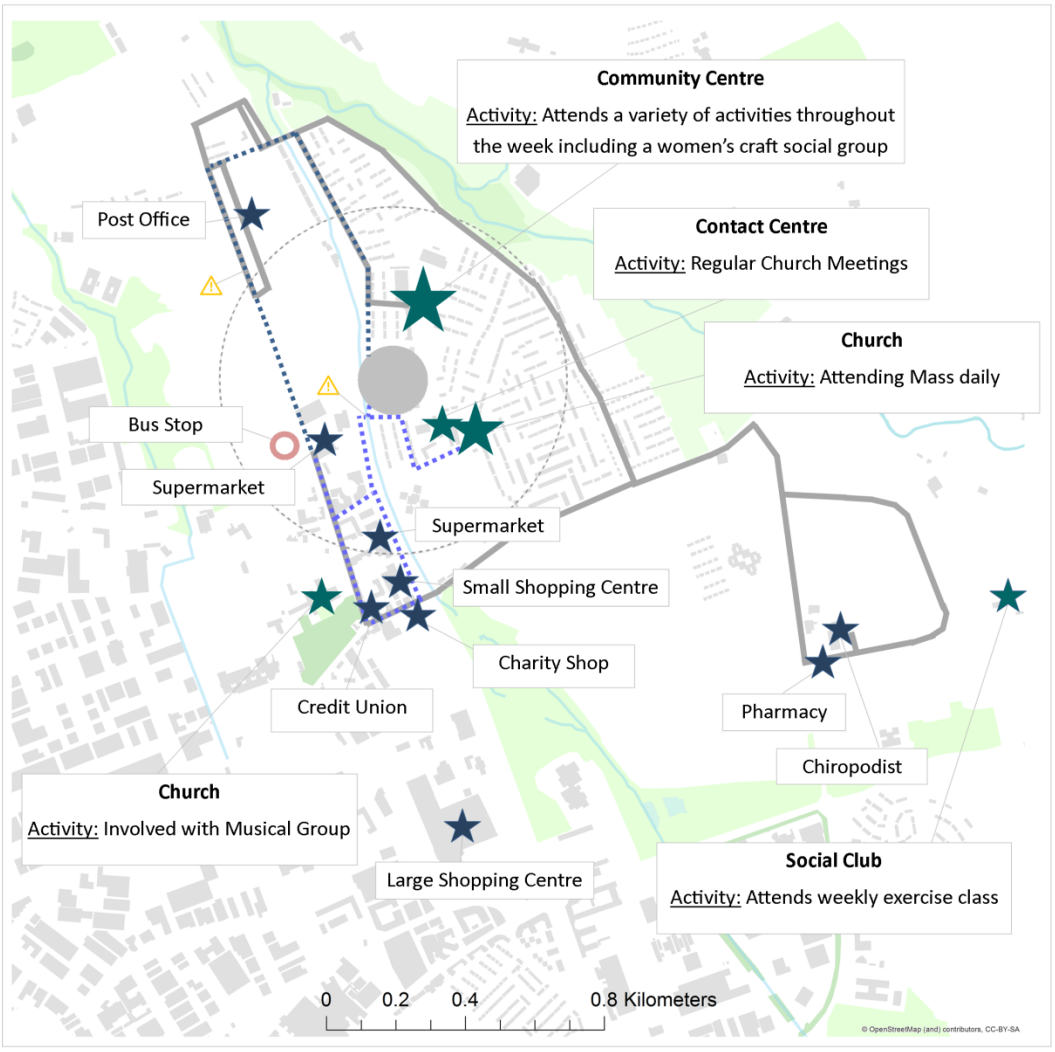
Figure 6.1 overleaf is a map of the key places and routes that Bridie identified throughout her interview, mapping exercise and go-along, complete with a map key. I have labelled the main routes that she travelled within her neighbourhood (Phase 2), as well as the key destinations (Phase 3) that she visited. I have differentiated between scheduled and frequent activities that she attended such as social groups and attending Mass, and other destinations such as shops, post offices and health-related buildings. This was because they were either less frequently attended or not scheduled. I have identified some of the challenges that she identified during her routes, labelled as orange warning triangles. One of these was a bridge close to her house that she had to climb and cross to get over a busy dual carriageway, in order to get to the centre of Study Area 1 where the shops are located. She pointed it out on the map and explained how "That bridge there gets me". Although she enjoyed walking, she found it difficult to climb the stairs because she had COPD and

struggled with her breathing. The second challenge identified was the "long road" that she had to walk to get to the post office. She did not like to do this route because it felt "never ending" and "monotonous":

> Bridie: That is a good walk. This road is monotonous, from the time I moved in here I hated it, I hate walking it, but I have to do it.
>
> Hannah (Interviewer): It is not a very pleasant walk?
>
> Bridie: No. I don't mind walking down but walking back up it, I hate it, it is never ending and ours is the last turn. But look, you do it and that is it.

To summarise, Bridie was a very socially engaged individual, who interacted with others in each of the three Phases. I now consider my broader participant experiences across each of the Phases.

Figure 6.1 Bridie's Places and Routes of Importance and Map Key



Map Key

- Scheduled and Frequent Destinations (Social Groups and Mass)
- Other Destinations (including Shopping Centres, Charity Shops, Supermarkets, Health-Related Places, Post Offices and Credit Unions)
- Bus Stop
- Challenge identified along walking route
- Regular Walking Route after attending Mass
- Longer Walking Route to collect pension at Post Office (weekly)
- Route of Go-along Interview
- Approximate location of home
- Approximate 500m buffer from home

6.4 Phase 1: Crossing the Threshold

Within this section, I discuss the importance of gardens, as well as being in front of the house and on the road for social interaction. Most participants had a front garden and many identified gardens as important to them (32 references). Gardens were discussed in three of the four focus groups and by twelve participants in the main study. Of these, two participants discussed or pointed out other people's gardens during their go-along interviews, whilst one participant described her daughter's garden. The remaining nine participants referred to their own gardens. In terms of the activities carried out within gardens, gardening was the most common activity (16 references). Two of the focus groups and eight participants in the main study mentioned gardening. Shauna (from SA2) described gardening as a particular hobby of hers, although in recent years she was finding her garden difficult to keep on top of, due to a leg injury (discussed in Chapter 5). Three participants mentioned sitting in their gardens or reading as an activity. Several participants specifically mentioned social interaction taking place within gardens or in front of the house (9 references):

> If you were out doing the garden, they would stand talking to you if they were walking. (Participant from Focus Group 2)

> It is nice to meet neighbours on the road and have time to talk. (Participant from Focus Group 4)

> Neighbours would be out in the back garden still; particularly with next door on this side we still have a low wall. And there would be a regular conversation. (James)

> Now I would see the family there if they were in the garden and I'd be standing up there talking over. That is nearly gone, having a chat over the wall. (Shauna)

Interactions typically involved a participant being in the garden and then either chatting with a neighbour in their garden, facilitated by having "low walls" in their back gardens, or chatting with someone walking past their front garden. Many other studies have identified gardens as important sites for social interaction (see Bhatti, 2006; Bhatti and Church, 2001; Burton et al., 2015; Milligan et al., 2004), as well as talking on the road (see Ziegler, 2012).

The use of gardens for social interaction was captured particularly well by Bridie's example, when she reflected if she were to be in her front garden, she would often get talking to someone who was walking by, particularly during the summer. Bridie described seasonality to her being in thresholds such as gardens, which in turn meant there was seasonality to the frequency of interactions within them. This was also described by other participants:

> In the summer if you are out in the garden, somebody passing by, and you'd have a little chat. (Nuala)

> I would talk a bit more particularly with the summer, okay with winter you mightn't spend as long outside, and you wouldn't hang around as much. (James)

I witnessed first-hand one of these interactions during a joint go-along interview with Margaret and Nessa from Study Area 2. During this, we walked from their local community centre, where that they had just attended bingo (and where they were recruited from), back to their respective houses. This go-along interview took place on a sunny early evening in August. At one point, we passed by a house with people sitting in their front gardens. Margaret and Nessa proceeded to chat with them for several minutes. Afterwards Margaret said to me "you see, on a nice day, everyone's sitting out". This demonstrates the important role of front gardens for socialising, as they can provide a space to look out and connect with the world from the comfort and safety of one's own private space. The interactions in Phase 1 typically involved spontaneous, light-hearted interactions with neighbours or acquaintances. For some participants, like Bridie, they were anticipated because they happened regularly and because participants felt comfortable being outside in their gardens or on the road. The frequency of interactions within this Phase, and indeed, whether they happened at all, was therefore strongly influenced by how participants perceived their neighbours and neighbourhoods.

6.4.1 Perceptions of Neighbours

A key topic of conversation during two of the Focus Groups was the importance of good relationships with neighbours. During the Focus Groups, participants reflected on whether they felt they had good relationships with their neighbours. One

participant described the particular nature of these relationships and why they were so important:

> They are essential, having a relationship with them and knowing your comings and goings and looking out for you really without you saying anything re: the house and all of that. So the friendship of neighbours without them coming in for tea non-stop, it is just respect. (Participant from Focus Group 4)

Interestingly, this participant talked about a particular type of relationship or friendship with neighbours, one which was not too invasive or based on *too many* interactions, but instead one of mutual respect and looking out for one another. Several of the participants from the main study also described interactions with their neighbours. Áine from Study Area 2 shared an interaction she had with her neighbour's grandchildren and within this, gave examples of neighbourly gestures her and her neighbours carried out for each other, such as taking out the bins:

> They [next door neighbours] have a little tent in that garden. The kiddies play… The other morning, it was a wild day out of the blue, I was coming out my door and as I came to the door, I knew there was something at the door, and [it was] their tent! The wind had picked it up, and they came over and it was outside my door. I said, "Oh! I have a new spare room!" [Laughter] [I would] also take in her bins. That's what we do. [Name of next-door neighbour] next door might put out the bins the night before for us all, and then if they're not around and they're empty, someone else will take them in and put them in. It's just a little neighbourly thing. (Áine)

Eamon from Study Area 1 described interactions with his neighbours over time and amongst different generations. He described how everyone moved into his estate at the same time. People had since had children and these children had stayed in the same area. He described an instance many years ago where he told a child off for kicking a ball at a wall because it hit his car. He then explained how the person that used to kick the ball at the wall is now grown up. A few weeks ago, his son was out the front of the house kicking a ball against the wall and the father was now telling him off. Eamon described how he made a comment about this to the father, and they laughed about it. For many participants, neighbourly interactions such as these were common. However, some participants also raised concerns about a decline in these

types of interactions. Participants within Focus Group 2 discussed how they felt that these interactions had diminished over time:

> Very little [interaction] on my road now, all young people really on our road and there are electric gates now, you wouldn't see... I could go for a walk for a month, and I mightn't meet or see one neighbour. (Participant from Focus Group 2)

Another participant talked about how the interaction that used to be there "years ago" has "all gone" (Participant from Focus Group 2). Whilst some participants commented on a decrease in neighbourly interactions, there was also a noticeable *absence* of these types of interactions mentioned during interviews, or observed during go-along interviews, compared with interactions in Phase 2 and Phase 3.

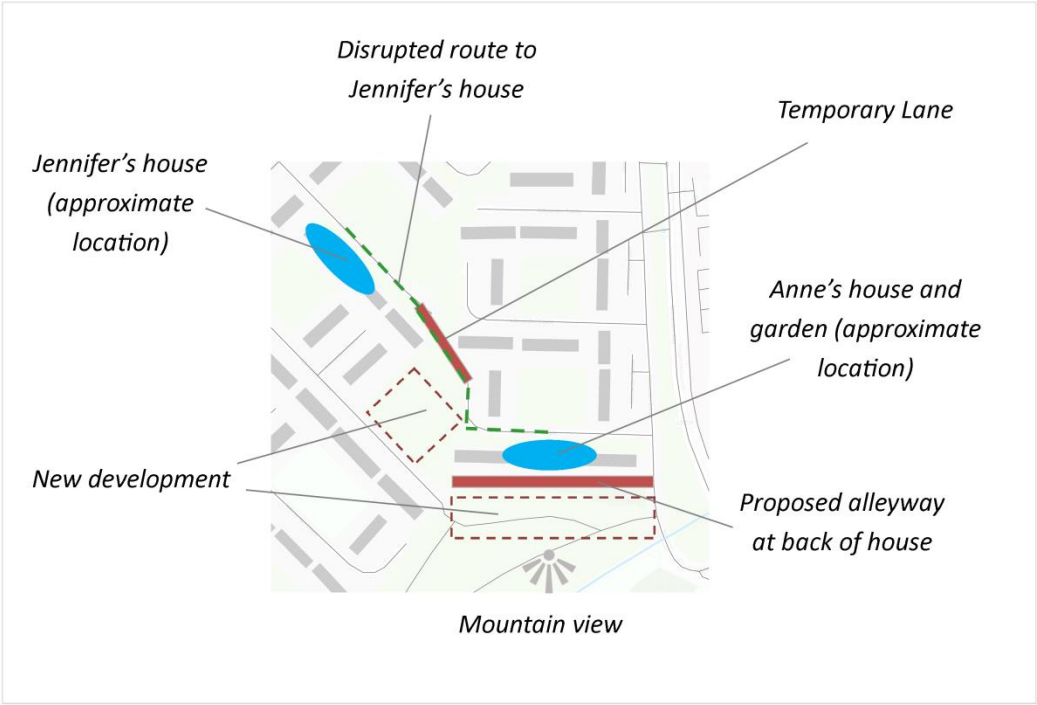
In some instances, participants raised concerns or fears and identified negative interactions with others within this Phase, which provided insight into how they perceived some of their neighbours. Anne showed me two places very close to her home during her go-along interview in Study Area 1. The first was her back garden, a place that was very important to her. She had views of the Dublin Mountains in her garden but what she wanted to show me was a new housing development immediately beyond her wall that she was concerned about. Anne was "distressed" about who would be moving into the houses and whether they would climb over her wall. She was likely to lose her view as a result of this development, which she had for over 40 years. She explained to me that it was not the loss of her view that she was concerned about, but her sense of safety. Anne identified that there used to be a lane behind her garden which was a place for anti-social behaviour. The community campaigned to remove this lane in the 1980s. However, because of this development, a new lane was going to be built, adding to her concerns. She reflected:

> I was a young woman at that stage, now I'm 70 and they're bringing this on us. (Anne)

The second place that Anne showed me was a temporary alleyway close to her house, built whilst the development was taking place. Before this alleyway it was a shortcut to get to her friend's house (Jennifer). During the go-along she took me to this lane to show how unpleasant it was. As we left her house to go to this lane, some

of her neighbours were out by the front of her house by their car. Anne had raised concerns about these neighbours during the interview, alluding to them engaging in criminal activity. During the go-along, I felt uncomfortable when we were outside the front of the house, as the neighbours watched what we were doing, which was intimidating. I made sure that I hid the audio device, because I was concerned for her safety and didn't want them to suspect that she had reported them, or that I was someone official. This example contrasts sharply with the positive interactions earlier and show how for some, interactions with others were far more enjoyable and safer than for others. Figure 6.2 below shows Anne's concerns about her immediate local environment. Within this figure, I show Anne's house and garden, the proposed alleyway, and the disrupted route to Jennifer's house through the temporary lane.

Figure 6.2 Anne's Concerns within Phase 1[5]



Jennifer lived in the same estate as Anne, and they were friends who both attended the social group that they were recruited from at the local community centre. Jennifer

[5] An account of Anne's experiences, along with Figure 6.2 was included in a chapter of a book (see Drilling et al., 2021), which arose from the *COST Action CA15122 Reducing Old-Age Social Exclusion* project, where I was a PhD Forum member and a member of the Spatial Exclusion research group.

talked about how she used to chat with neighbours on the road when she first moved into the estate in the 1970s, but not anymore. She explained that many of her neighbours moved out because a grant in the 1980s incentivised people to leave their social housing and subsequently bought houses elsewhere. She described how she had one "good neighbour" in her immediate vicinity. During Jennifer's go-along interview, as we got into the car, she greeted and chatted to this "good neighbour". She described another instance during her interview of talking to a less well-known neighbour outside her house, who gave her a lift once to her social group.

Both Anne and Jennifer had mixed experiences of neighbourly interactions, largely because of concerns about new people moving into their area. Unlike Bridie, who had positive past experiences, experience had shown them that the people moving in were not always friendly and in some instances, were feared. They did mention positive experiences with neighbours, yet there appeared to be a persistent underlying concern about who was going to move into their area. There was a horizontal cross-section of neighbours, who were perceived as "good" because they were known, either because they had moved in at the same time, were a similar age, or they had moved in later, but a relationship had since developed. These perceptions of neighbours in turn influenced the types, or lack of interactions that happened in these places.

For Jack, who lived in Study Area 2 within an inner-city neighbourhood and whose house was located on a main street into the city centre, it was not so much a concern for his immediate neighbours but frustration with strangers who had stolen items from his garden in the past:

> In my front garden now, as I say I am into flowers and my missus she's into gnomes and stuff like that… we have been robbed more times than anything else you know? And so have a lot of other people around the area you know? … mostly gnomes and little things in the garden, angels or something like that… They go missing… [It would be] be drunken drunkards coming home late at night… Now a fellow around the corner from me, he heard a commotion there one evening, it was about three o clock in the morning and the fellows … these were well to do fellows… and they were climbing into the garden and taking out plant pots, ornaments, the whole lot just for devilment. (Jack)

This example shows that the location of an individual's house may influence the character of any engagement with strangers.

6.4.2 Moving beyond Thresholds

Whilst participants identified examples of interacting with others in thresholds, there were many examples of this not occurring. As a result, there appeared to be a limit as to the type of interactions possible in this Phase. If connecting to others was valued by individuals, relying on social engagement in thresholds alone would therefore not be enough. Participants would need to move beyond the threshold to places in Phase 2 or 3, in order to create additional opportunities to connect with others more regularly and frequently. This was demonstrated by Niamh, who admitted that whilst she liked her gardening, she also liked "mixing" with others, suggesting that this wouldn't be possible unless she went beyond her threshold:

> Oh, very important I would say. Well, for me, I like the house and I like gardening, but I do like mixing. (Niamh)

For some participants, Phase 1 did not feel like it was truly "out and about". For example, Brenda, who lived in sheltered accommodation, described that on Wednesdays she might sit in her communal garden but that she still considered this to be "in":

> Brenda: Wednesday I do nothing, the place is cleaned, I knit. If it is fine, I might sit out there [in her communal garden] knitting.
>
> Hannah (Interviewer): So you stay here on a Wednesday?
>
> Brenda: I am in on a Wednesday.

Another participant from Focus Group 2 saw Phase 1 as very much an extension of the house, but on a day that she had her social group to attend, she was "going out" and this was a different experience:

> I could be in the house all day and I would be very happy there in the garden and all that, but Monday is a day when I am going, and I am going out. (Participant from Focus Group 2)

6.4.3 Summary of Phase 1

Thresholds, in particular gardens and being near the house, were important places for social interaction to many participants. Some mentioned enjoying gardening specifically and others preferred activities such as sitting relaxing or reading. The nature of these interactions was relatively unplanned and spontaneous, although as shown with Bridie, not wholly unexpected. Participants described positive social interactions within gardens, as well as talking on the road in front of their house. These interactions varied seasonally and more likely during the summer when people were outdoors more often. The extent of interactions taking place in thresholds was strongly linked to perceptions of neighbours within the locality. In some instances, participants commented on the changing nature of the populations living in their areas, and how this influenced their perceptions of safety, as well as the nature of interactions that happen. Several participants raised concerns that these interactions have been lost over time, some did not mention them at all, and several participants reported concerns about neighbours or strangers within these places. As a result, participants were sometimes spatially excluded from interactions within these places.

6.5 Phase 2: Moving Through Public Spaces

By cross-referencing both places or importance and activities of importance with social interaction, I identified the key places and forms of movement or travel that resulted in social interaction with others.[6] The key places that my participants described as being important for social interaction whilst on the move included streets and roads (5 references by 5 participants), village centres (1 reference by 1 participant), and local parks (4 references by 3 participants). Shops (5 references by 4 participants) were also frequently mentioned as a place or destination that they were travelling to or from when these types of interactions occurred. Shops have been identified as important for social interaction within existing literature (see Gardner, 2011; Lager et al., 2015; Mahmood et al., 2012).The form of movement, travel and activities most associated with social interaction was walking, including

[6] Note: this is not the number of times each activity of place is mentioned, but specifically how they were mentioned in relation to social interaction.

with mobility assistance devices such as walkers as well as walking dogs (9 references by 6 participants), using or waiting for public transport (5 references by 3 participants), giving lifts (1 reference by 1 participant) and cycling (1 reference by 1 participant).[7] These findings coincide with existing research that has shown these modes of travel are important for social interaction (see 3.2.1 in Chapter 3), as well as literature on the role of dogs as "catalysts" for social interaction (McNicholas and Collis, 2000, p.61).

During interviews, participants often talked about their neighbours and the types of interactions they may have with them. However, during the go-along interview I witnessed this first-hand. Go-along or mobile interviews were therefore particularly illuminating for this phase, allowing observation of when interactions with others occurred in person. Interactions typically happened with neighbours or members from the community who varied in terms of acquaintance, as well as strangers in some instances. If an interaction was with someone known, a more in-depth conversation might be had, or they might ask after someone or their family. The type of interactions that occurred was strongly linked to how well the person was known and how well they knew other people within their community. Common interactions described by participants included greeting someone, including saying hello (6 references), giving someone a smile (1 reference), talking about the weather, or commenting on the day itself (2 references). If one person was driving and the other person walking, beeping a horn might be a way of greeting them. This was mentioned by Louise from Study Area 1. Unusually amongst my participants from Study Area 1, Louise had lived there all her life. Throughout her interview she described how she enjoyed "walking the roads" and that people were always "beeping the horn" at her. She explained with great amusement that this was just what people originally from Study Area 1 do, stating "this is the habit".

There were several instances throughout go-along interviews where participants talked to neighbours or acquaintances. During Nuala's go along interview, we walked for approximately 15 minutes to her public transport stop, accompanied by a family member. During this time she greeted three individuals, one was a neighbour

[7] For a reminder of participant mobility patterns, see Table 4.1

who lived on the same road as her, one was a passer-by that she didn't know but just said hello to and another was her next door neighbour after arriving back at her house. She reflected during her interview:

> If I am coming up the road, I was struggling probably yesterday evening coming up the road and one of my neighbours from up there, "I see you are doing okay, you are still able to get up the hill". (Nuala)

In another go-along interview, Brenda chatted to a neighbour by the gate of her assisted living complex on the way out and with people outside the community centre. In Darragh's interview, we walked to his local church and he described conversations he had previously had with some of the men who were homeless and who slept there. On the way back to the interview start point, a car horn beeped and Darragh saw that his daughter had just parked up, which led to introductions.

6.5.1 Guaranteed Social Interaction

As demonstrated in Chapter 5, connecting to others whilst out and about was highly valued and for some, this meant talking to others whilst moving through public spaces:

> If I go out you would meet them going through that passageway, I would meet them in the park. It is every day and I think that is the secret of where you are living if it is feasible to talk to people. (Shauna)

Michelle, in particular, saw it as an important component of how she defined a good quality of life:

> To be able to get out and meet with people and mix with other people and say hello to everybody, even people you don't know. And sometimes I would say hello to people, and they'd say, now I wonder who that was [laughs]. But it is lovely. I was speaking with a man the other day, never met him in my life, and we had a great chat, an elderly gentleman. And yeah, it is good to meet people and to talk to people and to smile at people. I would say I am very contented. (Michelle)

Four participants (two in each of the Study Areas) commented that one of the best things about where they lived was the guarantee of these types of interaction and the

fact that people in their community would never "pass them by" (7 references). Bridie talked about this during her interview and that it was one of the reasons why she liked her neighbourhood and felt comfortable in it:

> There is *always* [emphasis added] someone you'd meet around at the shops or in the queue and you get into conversation with, I always talk to someone everywhere I go [laughs]. (Bridie)

Louise mentioned this when discussing her rambling and walking through the neighbourhood and how people beeped their horns at her. She explains how "they never pass you" because they were "reared" in Study Area 1. There were many instances of participants stating that there would "always" be someone to talk to. Shauna from Study Area 2 was particularly vocal about this. She reflected that in her neighbourhood it is a nice community to go out and walk in and that one of the best things about her neighbourhood, was that she would "always get a hello".

> That is the beauty of [Neighbourhood in Study Area 2], *no one passes each other* [emphasis added], you *always* [emphasis added] get a hello. That is the beauty of going out in the daytime. (Shauna)

> …it is a nice community if you go out. Just say you are taking a walk out and you meet someone, you may not know them well, but one always says hello, that is the beauty. (Shauna)

> You always meet somebody. You see you always meet someone for a chat, sometimes you have a chat, sometimes you don't have a chat. (Shauna)

She admitted that sometimes she would chat for longer and sometimes she wouldn't, but there was always a guarantee of a hello as a minimum exchange, and she took much comfort from this. Mairead also expressed this guarantee of "always" meeting someone, which meant that she never felt lonely:

> And like here you will always go out and you will always see someone, you will always have a chat with someone, you are never lonely… if [it's] someone that you haven't seen for a while… you might be just going to say "Hello, how are you?", and go off, and then you'd stop… and then, you know, [you would think] I enjoyed that chat. You are never that busy that you can't stop. (Mairead)

Those participants that felt this way about their neighbourhoods, did so because past experience had created norms of behaviour whilst out and about. This was linked to length of time spent in their neighbourhoods, resulting in familiarity and comfort.

6.5.2 Having a "High Profile"

As discussed in Chapter 4, most participants in Study Area 2 had been born in their neighbourhoods and their families had lived there for several generations, whilst in Study Area 1 most people had moved to their neighbourhoods during the 1970s when the houses were built. Most participants had therefore spent a large proportion of their lives within their neighbourhoods, and many were very well known as a result. Margaret revealed in her joint interview with Nessa that her grandchildren would no longer go with her to the village centre within her neighbourhood (including a local shopping parade) because she was always talking to people:

> Margaret: Let's just say my grandchildren stopped coming to the village with me at an early age.
>
> Nessa: You see Margaret was born and reared in the village and she knows everyone, and everyone knows Margaret.
>
> Margaret: And my mother, God rest her, when she died, at the funeral my father said, "I know now why the dinner was never on the table". Because in those days the dinner was on the table in the middle of the day, the poor man got such a shock there were that many people at the funeral. But Nessa is the same, excuse me, it is not just me [laughs].

During Margaret and Nessa's go-along interview, which was the only joint go-along interview conducted, I got a sense of how they would usually chat about the news on their usual walk home together, but also how they would talk to others along the way. Many times during the go-along interview, they exchanged news about people within the neighbourhood. There were three interactions that I observed. I have mentioned one already when they chatted to people sitting out in their garden, but in another example, we observed a lady cleaning the street with a broom across the road. Margaret commented that she was "probably just doing it for a chat if she sees someone she knows passing"; Margaret then shouted across the road to greet her and laughed, saying:

> There's another lady who, who'd chat all day! [shouts to lady across the road sweeping the road] I'm looking at you! [laughs]. (Margaret)

We also met another participant (Áine), who Margaret and Nessa knew from one of the exercise classes they attended. During the go-along they had a brief interaction about when it was due to start back after the summer break. Margaret and Nessa explained during their go-along, that if they were in a hurry, they had to "close [their] eyes". For some participants, like Margaret, having this reputation and being so well known was an important part of their identity. This was demonstrated by Bridie, when she described that her daughter and grandson commented that she knew everyone, and it took her a long time to go to the shops:

> Every time I go down to the shop, I meet … as my daughter used to tell me I am the only one they know that it takes three minutes to walk to the shop and an hour and a half to walk back. So I have a great many friends. As my grandson said to me when he was only five, he said, "Nan, do you know everyone in [Study Area 1]?" [Laughs]. I don't, but I do know a lot of people. (Bridie)

Being well known and knowing others made interactions in Phase 2 more likely and contributed to participants feeling "comfortable" in their surroundings and neighbourhood. This was articulated by Bridie at the beginning of this chapter when she said that she doesn't feel like an "outsider" in her neighbourhood. This demonstrates her place attachment and how this is developed through the social "insideness" that she feels (Rowles, 1983, p.299).

David was another participant with a "high profile" in his neighbourhood. He was the participant in my study who was most visible in Phase 2. Although David had stopped training competitively as a triathlete two years previously, he still carried out a series of daily routines and training regimes, which involved cycling around his local neighbourhood with his dog. He explained these to me during his interview and we enacted some of this during his go-along interview, which was a 3-hour cycle with his dog:

> David: I have a high profile in that sense, I meet lots of people every day.

> Hannah (Interviewer): You are very visible on the street because you are out so much?
>
> David: Yes I am visible and not just here, in [adjacent neighbourhood] you meet lots of people you know because it is a village.

One of the reasons for David's high profile was because he trained many of the younger people in his neighbourhood to compete in triathlons. During his go-along interview, we met one of these children (now an adult). I was introduced to them, and we chatted for several minutes, the topic mostly focused on bikes. In his interview, he described notable people that he enjoyed talking to, whose brief exchanges "make his day":

> I meet an old man, [name of acquaintance 1], I love to meet this man, he is 93 years of age, and we only meet at the supermarket now and then and he gives me a handshake that would crush the average hand. And I grip him and say, "[name of acquaintance 1] how are you?" And we only know one another by our first names. And when I meet that man he makes my day, if I have five minutes. And sometimes if I didn't see him for a month I am saying, did he pass on? He is a wonderful old man. And this is the other thing about it, there was a woman, [name of acquaintance 2], she was a nurse, I used to meet her every day walking her little dog [name of acquaintance 2's dog], she was 95. She had steel cobalt eyes and a lovely personality, and just to meet her for five minutes every day, this is what used to make my day. (David)

Not everyone valued these types of interactions. Michael admitted that he would avoid interactions in these places because he didn't feel comfortable conducting "small talk". However, he would still say hello to people:

> Hannah (Interviewer): And if you were walking along a street would you stop and chat with strangers or ...?
>
> Michael: I would try not to. If I felt that there was something interesting I wanted to talk about or if I knew somebody had a problem … I would certainly do it, but I generally just keep going and just say hello to people. There is a ring road here and it is a known place for people stopping and talking and I just keep going. It sounds very anti-social, but I am not great for small talk.

It is therefore important to remember that not all participants valued or felt comfortable interacting with others, recognising the diverse social needs of older people (Bruggencate et al., 2017).

6.5.3 Non-Human Interactions

Another form of interaction observed during go-along interviews and which described during interviews, was interaction with non-humans, in particular with dogs. June from Study Area 2, described how she regularly walked her dog and interacted with more people because of this. She described how she would sometimes know the name of the dogs she meets regularly but not the owners:

> You meet more people with dogs, and you get to know the name of the dogs and you don't know the name of the people. You say, "ah here is Toby, here is Rocky". And you don't know the owner's name and you can't say, "what is your name?" It wouldn't be nice. But you know the dogs' names. [Laughs]. (June)

David also described how if he went to the shop without his dog, she would be missed and people would ask where she was:

> Oh the dog, [name of dog] went everywhere with me. My dogs, if I walked out there now to the shops someone would say, where is the dog? (David)

During another go-along interview with Dolores (who we meet more fully in the next chapter), we walked for approximately 20 minutes along a local shopping parade. During this time Dolores was greeted by several passers-by, including a neighbour that she had a good relationship with. After she said hello to them, she then told me a story about this neighbour and their family. At another point during the go-along interview, Dolores lit up when she noticed a dog. She greeted the dog and the owner warmly, and they had a brief conversation about the dog. She speculated what breed the dog was and planned to look it up on her tablet when she got home. Dolores kept dogs all her life but was no longer able to look after one due to her health challenges. Existing literature has shown that dogs can be "catalysts" for social interaction and that wellbeing benefits can stem from this (McNicholas and Collis, 2000). In this instance, Dolores demonstrated how the wellbeing benefit of this interaction lasted beyond the event and reinforces how interactions such as these

may be particularly important for older adult wellbeing, especially when no longer able to keep pets of their own.

6.5.4 Interacting with Strangers

Not all of the interactions that I observed during go-along interviews were with people who were already known. I also experienced people greeting strangers during go-along interviews. During Michelle's go-along interview, she said hello to six people on different occasions on an hour long walk around her neighbourhood. The first time this happened, I asked her if she knew the person she was saying hello to and she admitted that she didn't know them. The third time this happened, she turned to me and said "And don't ask me if I know him because I don't" and laughed. There were also some notable instances when participants did not say hello to people. During Margaret and Nessa's go-along some teenagers walked past but they did not say hello to them. This highlights a need to consider the intergenerational nature of social interaction and encounters (also argued by Yarker, 2021), particularly when research elsewhere has shown "discontinuities" with younger populations (Lager et al., 2016, p.1574).

During the main interviews participants were asked how comfortable they were talking to strangers in their neighbourhood. Some claimed they would talk to everyone. Emer describes that she "would talk to anyone", while Louise reveals "I talk to everybody". Edith explained, "Well, I'd say hello to most people, whether I knew them or I didn't know them [both laugh] I would say good morning". This was interesting because both Emer and Edith provided examples where they adapted their behaviour or felt intimidated by others whilst out walking. Emer described how she only walked through certain parts of a local park where she could be seen and avoided areas in the centre of the park where there were a lot of bushes. She mentioned that a man had been killed in the park recently. Meanwhile, Edith described how there were groups of men who drove on motorbikes around her neighbourhood and local field and if she walked on a footpath they might come up behind her, which she described as "quite intimidating".

Other participants were openly far more guarded or cautious about interacting with strangers and explained that there were certain types of people and certain places that

provoked anxiety about talking to strangers. This was connected to experiences and perceptions of neighbours, as discussed in the previous phase. For example, Noelle from Study Area 1 explained that whether she would talk to strangers "depends" on the situation. She provided an example where she would be happy to talk to strangers; this was women of a similar age to her on public transport. Noelle told me about an incident where her bag had been taken and how after that she became more fearful walking to or from places, particularly at night:

> One day I was going to work, and my bag was snatched, and ever after that I gone … didn't like walking … I just, got more fear into me. (Noelle)

Meanwhile, Nuala described how she talked to certain people while using public transport and that she perceived as safe to talk to:

> If I see somebody maybe with children, I might pass some remark. Or in the bus maybe if you are sitting beside somebody, top of the weather, we are always talking about the weather anyway. (Nuala)

Anne appeared to be quite conflicted about interactions with others when she was out. As explained in the previous section, she differentiated between people she knew in her neighbourhood, which were typically the people she moved in with and "new people" that had moved in more recently and she felt less comfortable around. For those people she had known a long time, they would often ask after her mother who was aged 92. She provided an example of having conversations with people in the main shopping centre of Study Area 1. She described how she likes to give everyone a chance and that generally she was quite friendly, until she saw something that gave her cause for concern:

> Anne: I'm quite friendly with people, like, 'til you see maybe something and then... [Pauses]
>
> Hannah (Interviewer): Puts your guard up?
>
> Anne: Yeah, yeah. You like to give everyone a chance.

She described how she would be cautious around certain people when she was walking and that groups of people in particular would make her feel uncomfortable and that she would be "on the alert":

> I think the way, that in general like, the way this, you have to be very cautious when you're walking out, when you see groups coming towards you, you know. I think it's the same everywhere, not only here, you know? You just have to be on the alert (Anne).

During Margaret and Nessa's interview I asked them whether they were comfortable talking to strangers in their neighbourhood, but their response was far more positive, although they did comment that if someone looked "shifty" they wouldn't talk to them:

> Margaret: We do, all the time [laughs] and if we see somebody who looks a bit bothered, we would go up and say, "Are you okay?"
>
> Nessa: If they are looking at maps and they look lost.
>
> Margaret: Yes we do talk to strangers.
>
> Hannah (Interviewer): There would be no one that you wouldn't feel comfortable talking to?
>
> Margaret: No. Well, if they looked a bit shifty, we wouldn't talk to them, we are not that daft.

However, they did not clarify who might fit into this category. As was the case for Phase 1, some participants commented on changes to the social fabric of their communities, which resulted in them knowing fewer people than they did in the past. This had implications for how comfortable they felt interacting with others in Phase 2, as well as Phase 1. Some participants felt there were more strangers than there used to be, with new people moving to the area. This was the case in both Study Area 1 and 2. June from Study Area 2 reflected that she used to know everybody, but now she doesn't. She explained that she still tried to say hello to everyone and commented that most people will say hello if she said hello to them:

> Now there would be a lot of people you don't know because of all the high-rise blocks and all. I mean years ago I used to know everybody, but you wouldn't know everybody because there is a lot of strangers. But you know, most of them will say hello if you say hello to them. You try to say hello to people and make them feel welcome if you can. (June)

Michelle commented during her interview about how people have come and gone and moved to the area. Her experience was that some of the people who had moved to the area didn't want to converse and that they lived very private lives. She found this sad because she really valued those interactions when she was out and about:

> I know lots of people around because I have lived here all my life ... There is a lot of people I find that are moving into the area and they really don't want to know you, they don't want to converse with people. I would never push myself on anybody, I would say hello to everybody, but they live very private lives, and they just don't want to ... It is not the same at all, it is very sad really. (Michelle)

For some participants, fear of others in certain places was so great that they avoided certain areas. One of the clearest examples of this was Moira, who we meet in more detail in the next chapter, and I talk about her experience then.

6.5.5 Variation in Walking Routines

Participants varied in terms of how frequently they moved through public spaces. Participants that both valued the interactions and movement within it and were able to engage comfortably and safely, spent a large proportion of their day in this Phase. This resulted in them being much more visible to begin with, making interactions more likely. David and Áine strongly valued movement in and of itself and had established walking and cycling routines and habits, to the extent that it was very automatic to them. Both David and Áine had developed these patterns over a lifetime and both had been connected with groups that helped them to develop these habits. For David, this was his triathlon group. Although he was no longer part of a group, he still carried out training by himself and was disciplined in his routine. As a result, he was out "all times during the day":

> And as soon as I get myself together the dog and myself are out. (David)

> First of all, I start every morning by working out the important things that needs to be done and I do them early morning and then the rest of the day is down to reading and that. I will be out all over the place, but I am also a home bird. (David)

> That is the routine, I take him [David's dog] out five times a day. (David)

Áine, on the other hand, developed a love of being outdoors through a walking group she joined when she was 16. Aged 83, she still regularly walked and hiked and had a routine every morning where she did four laps of her local park. She walked into the city centre to do her shopping on what she described as a "regular" basis. She described how important walking with others was for keeping her going on hikes:

> As you are walking you are talking to friends and you keep going and that is great. (Áine)

Louise was also someone that highly valued walking or "rambling" as she described it. She described this as a way of life and how she was always out rambling and talking to people. Louise was recruited from a social group for people with dementia and so it was not clear to what extent she still achieved these valued activities and interactions, but it was nonetheless something that was very important to her.

Bridie, Anne, Michelle, Jennifer, and Eamon were participants that made efforts to walk and referred to specific walking routines. For Bridie, this involved going to the shops after Mass when she didn't have a community group to attend. For Anne, this was walking to the centre of Study Area 1 to do her weekly shop. For Jennifer, who had COPD and used an oxygen tank, it was a short daily walk to her local shop to collect her telebingo and for Eamon it was the same routine but through a local park to collect his newspaper (discussed more in Chapter 7). Margaret and Nessa made a conscious effort to "walk everywhere if [they] can". They estimated that they would walk every day for an hour, with breaks in-between. I was particularly struck by their sense of adventure and curiosity about discovering new places. They described to me a trip they made when the new LUAS line opened in Dublin:

> One day we went on the LUAS to [last stop on the LUAS line] to see what was there and there was nothing there, so we just turned around and came back again. (Margaret)

Like Mairead described in Chapter 5, some participants discussed walking in reference to it being an activity that they "should" do more of. For example, James describes how occasionally he might "deliberately go out for a walk" but recognised that he "probably should do it a bit more often". When I ask Emer how often she walked in her neighbourhood, she replied:

> Not enough. I am supposed to have half an hour every day. I am having physiotherapy for my hips, but I haven't been. I didn't get the time lately to do it, but I have to get it. (Emer)

Michael was another participant that mentioned he didn't walk enough:

> If it is once a week, I would be lucky. It should be more. (Michael)

He described that when he looked after his grandchild he would go for a walk with her in the pram, as it gave him an "excuse to go walking":

> I probably don't do as much walking as I should do. One of the things about minding a grandchild is I brought her out in the pram, that gives me an excuse to go walking. (Michael)

In Michael's interview, he explained that he had a lot of pain in his knees that prevented him from walking more and he found walking up hill particularly challenging. Some participants described how they no longer walked as much as they used to or identified health or mobility challenges that made walking difficult and was now seen more as a past tense activity:

> I don't go walking any way much anymore really. (Nuala)

> I like to walk but I haven't been walking as much in latter times, especially at night, because I can't see. (Michelle)

> I used to love walking. (Dolores)

> I used to go around the park, there is a friend of mine, she would be at Mass and the two of us would go around the park. I haven't done that in a while, the wintertime I stop doing it. I went around yesterday or the day before, no it was yesterday I went around, my legs were aching, but I need the exercise. (Mairead)

Yet many participants also recognised how important it was for them to do it and were aware that it would benefit their health and mobility if they did:

> Well not an awful lot, once this week, but I need to walk, I need to keep myself because I feel if I don't walk, I feel stiffness setting in. (Mairead)

Whilst for many participants being in Phase 2 was valued, both for social interaction and in and of itself, the amount it was valued, varied. There were large differences in the amount of time spent moving and travelling, which in turn influenced how much interaction with others occurred as a result.

6.5.6 Summary of Phase 2

In this section I have shown how participant experiences in Phase 2 were very mixed. Some participants felt very strongly about the importance of interacting with others on the streets and roads and talked about it a lot, others only mentioned it briefly. Many of my participants didn't mention it all. Some actively disliked it, or avoided it, or were fearful of these types of interactions. For some, walking and moving was highly valued and so were the interactions that occurred along the way. For others, both movement and interactions were far less likely and in some instances feared and risky. The amount that people moved through their local environments was influenced by how able participants were to move and travel in the first instance, how easy it was for them to get out and whether they had developed routines doing this. Another factor was how safe participants felt moving and travelling through their local environments and the availability of places to walk. This was linked to their mobility and risks associated with the movement, but also the risks associated with who they met along the way. This resulted in large variations in how participants engaged with Phase 2 in and of itself, as well as how likely positive interactions were.

As with Phase 1, if connecting to others is particularly valued by individuals, relying on social engagement whilst moving or travelling through public spaces may also not be enough, particularly if the ability to do this is reduced and there is fear about using these spaces. Participants in these situations would need additional opportunities to engage with others in safe places that are accessible to them and which also create the "excuse" to get out and engage in the first instance. For this reason, destinations are particularly important meeting places and I now turn to these.

6.6 Phase 3: At the Destination

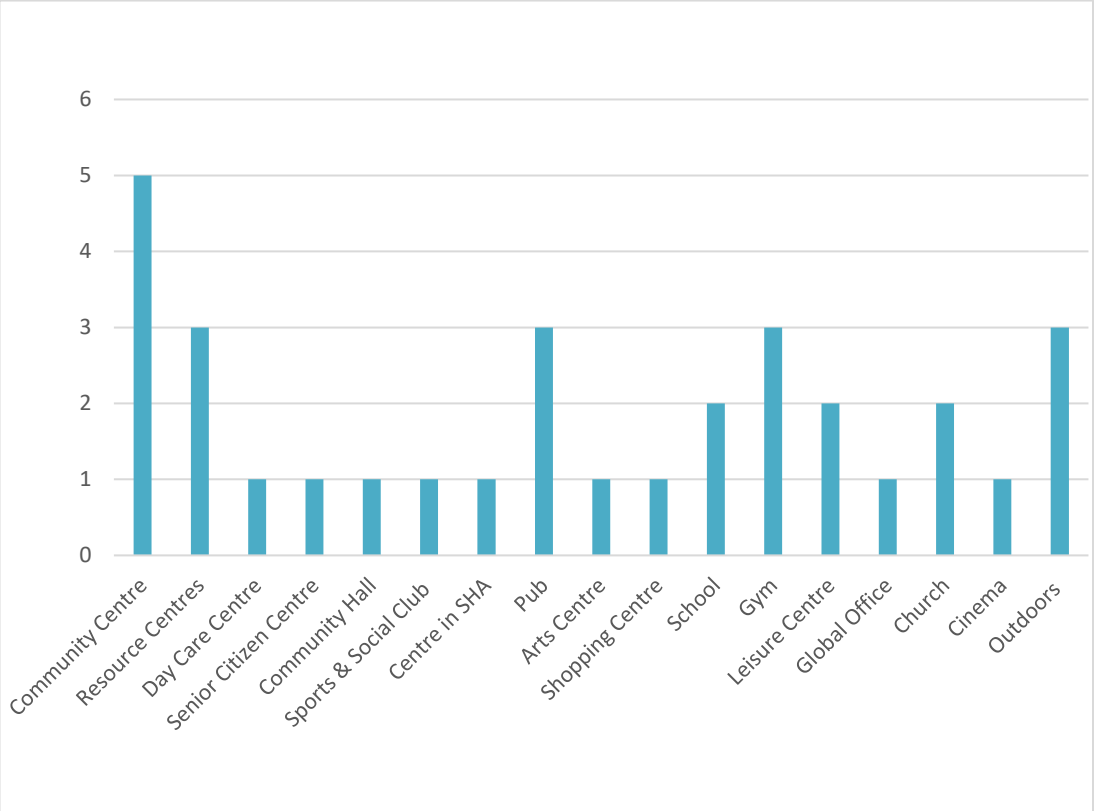
As mentioned when I defined Phase 3 in the previous section, the places most commonly mentioned by participants for social interaction were those places where social groups were attended, i.e. 'Social Group Places'. This category of places was the most commonly referred to by my participants and for this reason I focus on this category predominantly within this Phase. The second most frequently referenced place or destination for social interaction was Churches, typically through attending Mass and so I also explore this place within this phase, although not in as much detail.

6.6.1 Attending Social Groups

> Hannah (Interviewer): Do you think there are good opportunities to socialise in [name of FG2 location]?
>
> Female Participant: If you want them. But it is *useful* [emphasis added] being part of a group of some sort.

In an earlier round of categorisation of places, I identified a total of twenty-seven different *Community Centres*, nine of which were *Main* in that participants were recruited from these places, while eighteen were *Other* places (see Appendix 17). There were a number of different types of place or venues that these social groups occurred, some of which did not take place in community centres. As shown in Figure 6.3, the most common venues were local community centres, or some form of community centre. Social groups also took place pubs, art centres, shopping centres, schools, gyms, leisure centres, global offices, and churches. In some instances, social groups were based in outdoor locations related to the activities that were being carried out. This included a fishing club and a walking and hiking group. To reflect this, in Figure 6.1, I have provided a summary of *Social Group Places*, which has slightly different totals to Appendix 17 and includes those places where social groups were carried out, rather than the particular category of place of community centre.

Figure 6.3 Venues for Social Groups



Some of these places were venues for just one group, while others held multiple groups. Participants connected to others through these social groups alongside the activities they carried out whilst attending. Participants attended a variety of different social groups with different activities and purposes. In Table 6.1, I provide an overview of the social groups and activities that participants carried out at each of the places identified, including the type of place, the social groups and main activities carried out at each group, as well as the number of participants that were recruited from these social groups. In addition, I identify the number of social groups happening at each place, where they were located (either within Study Area 1, Study Area 2, our outside both of the Study Areas), as well as the number of references within the data and the number of participants attending each group.

Table 6.1 Social Group Details

Code	Type of Place	Social Groups & Main Activities	No. of Activities or Social Groups Identified	Study Area	No. of References	Total No. of References		No. of Participants Attending SG
FRSG-SA1-01	Community Centre	Active Retirement Group *(n=3); Bingo	2	SA1	24			3
FRSG-SA1-02	Community Centre	Women's Crochet Group *(n=2); Retired Men's Group with various activities throughout the week *(n=2); Computer Classes; Art Classe	4+	SA1	57			4
FRSG-SA1-03	Local GAA Club	Active Retirement Group with various activities throughout the week *(n=5)	1+	SA1	37	**135**		5
FRSG-SA1-04	Resource Centre	Public Speaking Group *(n=1)	1	SA1	13			1
FRSG-SA1-05	Day Care Centre for PwD	Dementia Social Group with various activities throughout the week *(n=2)	1+	SA1	4			2
FRSG-SA1-06	Contact Centre	Church Meetings	1	SA1	3			1
FRSG-SA1-07	Community Centre	Computer Classes	1	SA1	6			2
FRSG-SA1-08	Shopping Centre	Knitting Group	1	SA1	5			1
FRSG-SA1-09	Pub	Bingo	1	SA1	8			2
FRSG-SA1-10	Resource Centre	Friendship Club	1	SA1	2			1
FRSG-SA1-11	Pub	Bingo	1	SA1	4	**55**		2
FRSG-SA1-12	Arts Centre	COPD Prevention Class; Writing Group; Choir	3	SA1	10			2
FRSG-SA1-13	Leisure Centre	Attending Exercise Classes	1	SA1	6			2
FRSG-SA1-14	Church	Musical Group	1	SA1	7			1
FRSG-SA1-15	School	Venue for Men's Group from FRSG-SA1-02: Bowls, Boulé & 'Go For Life' Games	1	SA1	3			1
FRSG-SA1-16	Sports & Social Club	Active Retirement Group	1	SA1	1			1
FRSG-SA2-01	Community Hall	Active Retirement Group *(n=5)	1	SA2	34			5
FRSG-SA2-02	Community Centre	Bingo *(n=3); Film Club; Scrabble; Tai Chi	4	SA2	16	**77**		3
FRSG-SA2-03	Senior Citizen's Centre	Older Adult Social Group with various activities throughout the week *(n=8)	1+	SA2	11			8
FRSG-SA2-04	Resource Centre	Older Adult Social Groups with various activities throughout the week; [Recruited due to volunteering *(n=1)]	1+	SA2	16			5
FRSG-SA2-05	Social Centre	Bingo	1	SA2	1			1
FRSG-SA2-06	Health Centre	Knitting Group	1	SA2	3			1
FRSG-SA2-07	Leisure Centre	Badminton Class; Swimming	2	SA2	2	**19**		1
FRSG-SA2-08	Global Company Offices	Older Adult Special Events including Zumba	1	SA2	11			7
FRSG-SA2-09	Pub	Book Club	1	SA2	2			1
FRSG-OSA-01	Various Locations	Hiking & Walking Group	1	OSA	3			1
FRSG-OSA-02	Harbour	Fishing Club	1	OSA	1			2
FRSG-OSA-03	Gym	Exercise Classes	1	OSA	2			1
FRSG-OSA-04	Church	Friendship Club	1	OSA	1	**20**		1
FRSG-OSA-05	Gym	Weightlifting	1	OSA	5			1
FRSG-OSA-06	Cinema	Film Club	1	OSA	2			1
FRSG-OSA-07	Pitch & Putt Club	Venue for Men's Group Activity from FRSG-SA1-02: Pitch & Putt	1	OSA	6			1
				Total =	**306**			
	Key:				Colour Coding:			Colour Coding:
	* = social group where participants were recruited from				0-9 References			0-4 Participants
	+ = instances where attending one social group may result in a number of activities throughout the week				10-24 References			5-9 Participants
					25-49 References			10-14 Participants
					50+ References			15+ Participants

Some of these social groups focused on one particular activity, while others had multiple activities within them. The frequency of attendance and how regularly this happened also varied. Most groups occurred once a week, some had multiple opportunities to attend activities throughout the week and some were more sporadic in nature. Participants attended on average two social group places (median). All but one participant (David) attended at least one social group on a regular basis, although as previously mentioned, he was a former member of a triathlon group. Ten participants attended one social group place, thirteen participants attended two social group places. Seven participants attended three social group places and four participants (including Bridie), attended four different social group places.[8]

The Meeting Place

Social groups served an important role in bringing people together, creating additional opportunities to meet and mix with other people. Through thematic analysis exploring what participants said about their social groups and why they were important, "meeting people" was mentioned a total of nine times. There were two instances of participants mentioning how important it was to "mix" with others and how social groups provided this opportunity.

Whilst the social group provided the opportunity and place for socialising generally, participants commonly described the typical forms of interaction that took place. Some of these were similar to those interactions identified in Phase 2, including saying hello to someone (6 references), asking after one another (2 references). Additional interactions identified in social groups were associated with more meaningful interactions, including being given a hug (1 reference), sharing worries or concerns (2 references), or offering someone a listening ear (1 references). Laughter or having a laugh was commonly mentioned (5 references), as well as sitting and "having a chat" (14 references), usually with a cup of tea, which was a very common feature across all the social groups I attended. The emphasis on joy and pleasure is a reminder that social groups related to physical activity need to

[8] Note: Because some places held multiple social groups and some social groups had multiple activities during the week (see Table 6.1), this does not specify engagement throughout the week. I raise this here because it is important to recognise that attending a social group can result in differing levels or opportunities for engagement or attendance throughout the week and varying access to several types of activities.

ensure that these are not neglected (see Phoenix and Orr, 2014). Participants spoke about finding shared or common experiences with people within the groups, particularly if the group was about a particular topic or area of interest. Social groups were important places for exchanging the local news:

> It is a great place for us because some of us age better than others and they can't get very far but going into the [social group] it is good because you get all the information that is happening in the area. (Áine)

They were also places for reminiscing and talking about "years ago", as mentioned by two participants from the group interview from an older adult social group:

> Unidentified Participant 1: And we might talk about years ago, which we always end up doing.
>
> Unidentified Participant 2: We always end up doing that yeah, years ago.

Staying Connected

Social groups provided opportunities to re-connect with people who might have been acquaintances from the past, but for whom participants have since lost touch with. An example of this was provided by Noelle who explained that she would already have known the women that attend her social group from when her children were at school:

> I would know most of the women that comes there as well from the schools years ago. (Noelle)

When Noelle described her local area, she stated that one of the good things about where she lived was that she knew a lot of people. She credited this with the fact that she has always been "involved" in the local GAA club where she now attended her social group. Noelle referred to certain places where she would be "seen" and where she might bump into people and how her social group was an important place where this happened, alongside Mass, or in the local shop:

> You see, I wouldn't be really, in the environment five or ten years ago, because I was working at that stage. And, looking back now, er… working, you don't have the same… you don't have involvement with people outside your job. I mean, people that I knew from going to the schools, when I'm retired, and

> started going to the shops again, I met people and said, "I thought you moved years ago!", because I was thirteen years [working]… And people kind of say "I thought you moved years ago", 'cause the only other place I would be seen really, would be either in this club, or at Mass. (Noelle)

Niamh mentioned that was very important to her to be "involved with different things" that were happening in her local area. Darragh exclaimed during his interview that it was "amazing when you're involved with people, how you get to know other people". Shauna was someone that highly valued talking to others whilst travelling through her neighbourhood, but also discussed in her interview that because of where she lived and the usual routes she took, she had "lost touch" with some of the people from the centre of the "village". She found that her social group offered the chance to "keep in touch":

> I find it very, I won't say relaxing, it is a good chance of keeping in with the community. I wouldn't know many living down this end, they are [name of Shauna's neighbourhood], so if I am leaving my home at the moment, I head up to [adjacent neighbourhood]. So I go this way across the park, rather than the village, so I lost touch with the folks in the village. So the [name of social group] gives you that chance to keep in touch and it is a lovely gathering. (Shauna)

Shauna described how because of certain forms of travel patterns, she was no longer walking through the village, which meant she wasn't seen and therefore didn't run into people within Phase 2 and stay connected to people in the same way.

The people that were met at these social groups varied by depth of acquaintance; social groups were therefore meeting places to connect with new people, as well as meet people who are already known. For one participant in Focus Group 3, they specified that they liked to meet "new" people through social groups, while two other participants, including Anne who specified that it was a place to meet their existing friends:

> Ah yeah, it's great like, being in the club, and all your friends that I have up here, like, they're in that club, and I go on holidays with them, before [we] even went to the club. (Anne)

For those participants who were meeting with friends, such as Anne above, these friends might have even encouraged them to attend in the first place. This was the case for Michelle, who was finding that she didn't "go out that much":

> My friend was trying to encourage me to go because I didn't go out that much and she was trying to get me mixing with other people, [name of friend], and eventually I went down, and I absolutely love it. I love the exercise, it is good for you and especially with my condition [Type 1 Diabetes] it is really good. They are lovely people, all the women, you get to know them, and it is great. (Michelle)

One participant during Focus Group 2 described how it was important to have at least one or two "contacts", who would then encourage them to either go to social groups or meet in other ways, such as going for a coffee or dancing:

> You need to have at least one or two contacts and they would encourage you to go. We go dancing on a Saturday night and sometimes during the week as well and it is just a social thing, you just drop in. (Participant from Focus Group 2)

"School gates" appeared to be an important place where connections were made in the past and in some instances these had sustained over time and developed into friendships. This was the case for Margaret and Nessa, who were neighbours and attended multiple social groups together throughout the week:

> Margaret: And then we met at the school gates.
>
> Nessa**:** Margaret came back [both Margaret and Nessa had spent several years living in the UK before moving back to Ireland] around the same time. We didn't know each other, my son was in the same class so that is how they got to know each other.
>
> Margaret: I think that is how most women make friends, at the school gates.

Having someone to go with to social groups or other outings was one way to make attendance more likely, because it provided additional encouragement, accountability and support to attend in the first instance.

Whilst some participants may or may not have known each other to begin with, by attending the same social group frequently, over time these interactions resulted in "getting to know" people. This was the highest referenced code across all themes related to why social groups were important (10 references and 7 participants from main study). Nuala, who was aged 89 and attended an social group weekly, explained why she enjoyed attending her group. She admitted during the interview that whilst she did not engage with activities as much as she used to, she still attended the social group that she was recruited from with her niece. She explained that she enjoyed it because she has attended for a long time and she had got to know the people there. Michelle, when speaking about her social group, mentioned how great it was that she has got to know the women that attended. A participant in Focus Group 4 described that as a result of attending one of her social groups on a regular basis, she knew approximately fifteen additional people "by their first name". Another participant from the same Focus Group described that in social groups there were "regulars" that you then got to know.

Getting to know people created a "bond". Bríd and Anita, who attended the social group for isolated older people and took part in the group interview, described how people who initially attended might feel nervous, but they gave it a try. After a while they felt at home:

> You make a bond when you come in [to the centre]. People come in here, they might be a bit nervous, they come along and try it and before you know where you are they are at home. (Bríd)

> It takes people who are lonely out of their own homes, and it helps them to communicate with everybody else. (Anita)

Sometimes a bond made at a social group led to new friendships, as was the case for Mairead:

> If there was something bothering you [name of Michelle, who also attends the centre] is a great friend, I would ring up and if you were missing, she would ring up, where are you, are you all right? You have good friends around. (Mairead)

These bonds helped participants remain connected to others through the social group, but also throughout the week once they had left the social group, demonstrating a "ripple effect" of third places (as described by Fong et al., 2020, p.1). This was because people would look out for each other and if they did not attend one week, they would be missed and someone would check that they were OK. This is consistent with findings from Alidoust et al. (2019) and the nature of social relationships and ties found in third places amongst older people. One participant from the group interview described how she knew there were people around from the social group if needed, which comforted to her:

> You mightn't see anyone until next Monday but on Monday I will come here and see them and then I might be lucky, and I might see them two or three weeks, but I know they are around. (Unidentified Participant from Group Interview)

Jack described that because of his involvement volunteering at a social group, he met a lot of people at the centre and as a result he was not "stuck for anything":

> I am meeting a lot of people here… I'm not stuck for anything. (Jack)

Owing to the fact that participants were recruited through social groups, most attended them. Michael was unusual amongst the participants in that he only attended social groups that were a mix of ages and expressed a dislike and avoidance of groups that were age-segregated. Michael felt that quality of life was about "what suits the individual" and he was someone who highly valued "self-education". He felt that a lot of people his age had decided to "retire mentally as well as physically". He had received several requests within his community centre to join clubs specifically for his own age but had resisted, stating:

> I don't want to be with people my age, no disrespect, because there is a mental thing that is going on, that it is kind of like people waiting to pass away, if you know what I mean. Rather than challenging themselves, improving their skills, learning. Like, a lot of people, if you talk to them about learning something new, they will tell you, "I am too old for that". People just want to sit around and have a chat and maybe do as little as possible. There is nothing wrong with that, but I think there is kind of an acceptance when you get to a certain age that you fall into a certain trap and people accept it. (Michael)

Michael felt that there was increasing opportunities now for people to do new things and challenge themselves "right to the end". He saw value in "having a go" and trying something new, even if it was difficult and felt that older adult specific groups did not offer him adequate opportunities to do this. He felt that they were places that could be quite negative, and instead he wanted to surround himself with what he perceived as more positive experiences. He reflected that Men's Sheds were a better social group than many, because they "build and create things", however, because he had spent his whole life doing this, he was not interested in doing that in retirement. Occasionally, when he attended workshops, they included people of just his age group, but the focus of the group was usually on writing or other creative tasks, rather than it being an old age space. He saw this as an important distinction.

Michael's reflections raise some interesting points about the role of social groups and the nature of activities within them. Yarker (2021) has argued for the need to consider the intergenerational dimensions of social infrastructure and it appears that more critical interrogations of age-segregated groups are needed. Michael demonstrates that age-specific social groups are not always perceived positively by older people themselves, and do not see themselves as fitting in or belonging in these spaces. This is due to the nature of the interactions, as well as the activities being carried out. This finding aligns with existing research that has shown that not all older people value social groups (Gallagher, 2012) and that there is a need to provide a wider range of creative activities to appeal to wider audiences, including more creative programmes such as those identified by Phinney et al. (2014) in Chapter 3.

6.6.2 Attending Mass

In addition to social groups, attending Mass at church was identified as an important place for connecting to others by some participants. Churches were mentioned or referenced a total of ninety-six times and within this, fourteen distinct religious buildings were coded as places of importance. There were thirty-seven references to attending Mass as a specific activity by fifteen participants.

How frequently did participants attend Mass?

Of the participants that took part in full one to one in-depth interviews and mapping exercises, a total of ten participants revealed that they attended Mass at least weekly and twenty attended Mass in some form. Returning to Bridie, as shown at the beginning of the chapter, one of her main activities that she carried out throughout her week was attending Mass at a local church first thing in the morning. In addition to Bridie, Edith, Mairead, Dolores, Áine and Nessa also attended Mass most days or daily. Noelle, James, June, and Margaret attended Mass weekly, typically on weekends. Another nine participants (Niamh, Méabh, Darragh, Emer, Seamus, Shauna, Brenda, Bríd and Anita) mentioned that they attended Mass, but did not specify how frequently they attended. Jennifer mentioned that she used to attend Mass more regularly, but due to health constraints she only attended more important events, such as funerals.

Darragh, Emer and Bríd were actively involved with the church and the Mass proceedings. Darragh regularly did readings during Mass, while Emer was a sacristan at a hospice,[9] and Bríd was a Eucharistic Minister.[10] Attending Mass was not the only activity that participants carried out in churches or religious buildings. Four participants mentioned additional activities that they also carried out, including Bridie, who attended two social groups associated with or located in two different churches. James volunteered with a charity organisation based in a church building that delivered food to those in need, and Emer volunteered at a hospice. Darragh spoke of attending retreats that happened at his local church. Shauna and Darragh mentioned that they also liked to visit church when Mass was not on, to sit and contemplate. This gave them tranquillity and inner peace:

> I go to Mass wherever I am or sometimes I pop in if I need tranquillity when there is nothing being said. (Shauna)

[9] Someone who prepares a church for prayer and worship.

[10] Someone who assists the priest in offering communion (consecrated bread and wine) to Mass attendees.

> I would simply take a walk up to [local church], sit there for a few minutes, think of many of the people that have passed on, say a few prayers … It gives me inner peace as well. It's a great sense of peace. (Darragh)

Nessa explained that it was a space for her to contemplate and be grateful for what she had:

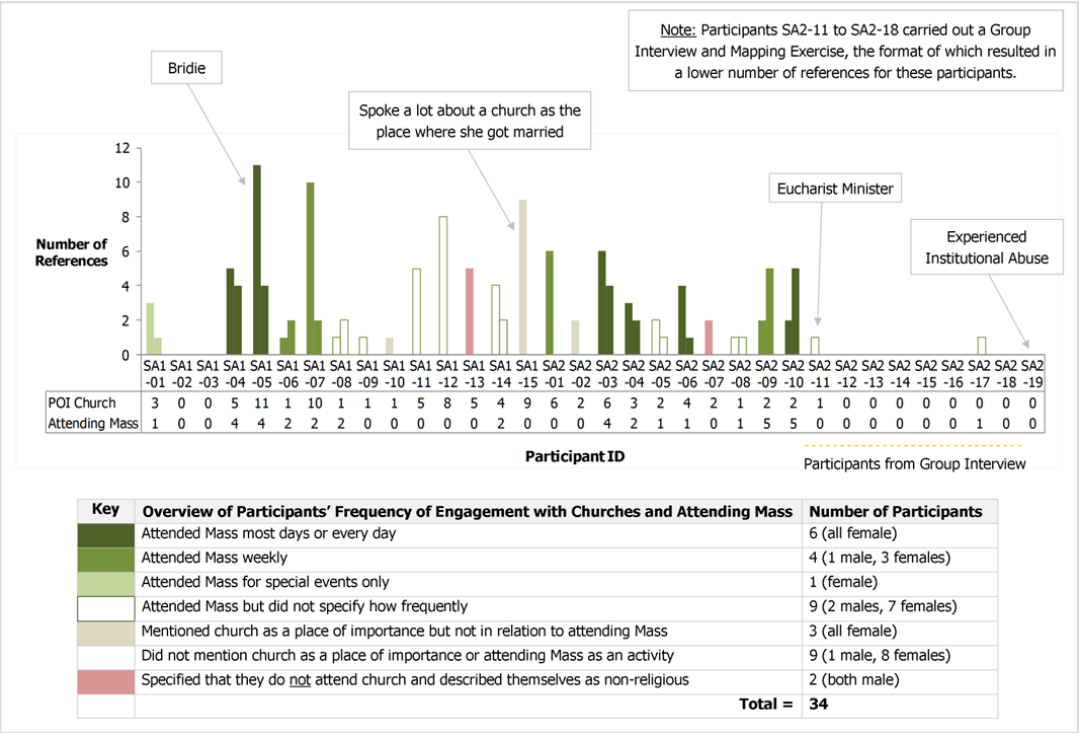
> And I am very thankful for that [that she has good enough health to be independence], thank God. One of the reasons I go to Mass every morning is just to thank God that I am as independent as I am. But your friends and your family are in the background, and I think that gives you a bit of a boost as well, a bit more confidence. (Nessa)

Twelve participants did not mention churches or Mass as either a place or activity that was important to them. That did not necessarily mean that they did not attend, but it wasn't important enough to mention compared to other activities. Half of these participants took part in the group interview, where there were fewer opportunities to identify places than in the individual interviews. David and Michael were the only participants who specified that they were non-religious. Michael confirmed that he did not attend church, and how he struggled with religion as a concept. He spoke about how he recognised the important role the church has had in the past, being at the "heart of the community", but expressed that this was declining and raised concerns that there hasn't been anything to replace it. James stated that although he attended Mass weekly, it did not necessarily mean that he agreed with everything it stood for. Jack mentioned during his interview that he had both witnessed and experienced clerical abuse as a child. He did not specify whether he attended Mass or church, although it was heavily implied, when he stated how he "would never go to see the Pope or anything like that". Figure 6.4 provides a summary graph of the key trends of attending Mass across all participants in the Main Study and how this varied.[11] It shows the frequency that participants attended Mass, how many times a

[11] The number of references are slightly different in Appendix 16 (89 references) compared Figure 6.4 (95 references) because there was one instance where 'Church' was generically coded (7 references) but could not be attributed to a particular place. I do not include this in Appendix 17 but do in Figure 6.4. In Figure 6.4 I also removed one reference to a church where a participant confirmed that this was not their church during a go-along interview.

church or Mass was referenced during the interview and whether this was discussed positively or negatively.

Figure 6.4 Summary of Participants' Engagement with Mass and Church



Key	Overview of Participants' Frequency of Engagement with Churches and Attending Mass	Number of Participants
	Attended Mass most days or every day	6 (all female)
	Attended Mass weekly	4 (1 male, 3 females)
	Attended Mass for special events only	1 (female)
	Attended Mass but did not specify how frequently	9 (2 males, 7 females)
	Mentioned church as a place of importance but not in relation to attending Mass	3 (all female)
	Did not mention church as a place of importance or attending Mass as an activity	9 (1 male, 8 females)
	Specified that they do not attend church and described themselves as non-religious	2 (both male)
	Total =	**34**

For those that attended Mass, why was it important?

For those that attended Mass daily, it was important for several reasons, and again this is best demonstrated using Bridie as an example. During the interview, Bridie described that religion itself was very important to her and she enjoyed attending Mass, but that there was more to Mass than just the event and ceremony itself. It was one of the key places where she developed her friendships and social connections within her neighbourhood:

> My religion is very important to me, the church isn't too far away as you know, and I like going to mass… I just love to go to mass and there is a great community there, you will always get chatting to somebody, make friends from around there. (Bridie)

Later in the interview, Bridie referred to someone in her neighbourhood that was finding it difficult to leave her house. Bridie recommended to her that she should

attend Mass, not because she wanted to "preach religion" to her, but because it was the place where she had made all her friends over time:

> Now I don't preach religion, because I like my religion, but I don't preach it, but I used to say to her [someone she knew that wasn't getting out of the house and felt lonely], "All you have to do is go around to Mass some Sunday and say hello to this person and the next week another little word and another little word". That is how I made all the friends. (Bridie)

In addition to Mass being the place where social interaction takes place, it was a reason for Bridie to be up in the morning and to get out of the house, and an important component of her morning routine. Edith and Mairead also commented on the importance of this routine and how it motivated them to leave the house:

> Get my breakfast, go to Mass, come home, and go back out to anything that's going on. (Edith)

> Usually, my day would be I go over to Mass, I get up at eight and potter around having my breakfast, tidy around, have my shower and I might be ready at ten, I am slower than I was, and if I wasn't going out, I'd be slower again. So it kind of motivates you. And I come back. I used to go around the park, there is a friend of mine, she would be at Mass and the two of us would go around the park. (Mairead)

6.6.3 Additional or Extended Outings and Interactions (Phase 3+)

Attending social groups and Mass were useful for attending an activity and socialising at the destination, but another way that they were useful was through providing additional opportunities to engage with others. This took place either before, immediately after through "trip chaining" (Criado-Perez, 2019, p.30), or at a later date. Bridie provided an example of this earlier on in the chapter, where she attended Mass first thing in the morning (Primary Destination) and then carried out movement (Phase 2) throughout her neighbourhood, where she might then go to the shops (2nd Destination) and to the post office (3rd Destination). Mairead provided an example where she went for a walk around the park with a friend of hers after attending Mass. What was interesting about this form of trip chaining was that the first destination visited was the one that was scheduled and frequently attended, so it was already an established habit. This was then followed by a walking route that was

not as formally scheduled but was a routine carried out with some degree of regularity, although for Mairead, she did refer to this in the past tense. I return to the concept of trip chaining in more detail in Chapter 7, focusing on Dolores. However, these findings suggests that trip chaining is particularly important for older people whose mobility is more restricted and who may be unable to get out multiple times per day. This adaptation strategy has also been found by Gardner (2014).

Noelle described during her interview that as a result of attending her knitting group, she became friendly with one of the other women. She then arranged to meet her for a coffee before the activity. She explained that one of the benefits of attending social groups was that she can then "get out another day":

> I … got very friendly with a woman from [name of another town], and I meet her beforehand… we go into a coffee shop for a cup of tea beforehand… actually can get out another day by going to these things [social groups] as well, because you could make friends and you could go for a cup of coffee. (Noelle)

A common component of several of the social groups, particularly those that were older-adult focused and organised through *Active Retirement Ireland*, was that being a member resulted in occasional special outings, day trips or trips away that were organised through the social group itself. Seventeen participants spoke about attending either day trips or trips away through their social groups (61 references and twenty-one distinct places). Day trips or outings included city-centre attractions, cinema, theatres or day trips to particular places, typically coastal locations. Jack carried out a number of fishing trips through his social group to a variety of different locations. In Study Area 2, four participants mentioned that they had been invited to the offices of a global company located within their neighbourhood and that this had been organised through their community groups. This office group then provided special outings and activities for them.

Trips away mainly involved long weekends to other parts of Ireland. Again, coastal locations and large cities were popular. Áine mentioned travelling abroad with her hiking group. Noelle mentioned during her interview that outings were so popular in her social group that there was now a waiting list to join the group. This underlines that there can be a "ripple effect" of both social interaction and additional outings

and challenges the narrative that older adults mobility declines with age. In some respects, then older adult mobility might grow and develop in unexpected ways that extend far beyond the immediate local environment.

Darragh and James both attend the same men's group in Study Area 1. What was unusual about this group was the broad range of activities provided throughout the week. Darragh and James identified multiple additional places that they attended through the men's group, depending on their interests, in addition to their weekly meeting and activities. For James, this involved playing pitch and putt, whilst Darragh preferred photography and music. Through the men's group Darragh mentioned attending photography-related outings, as well as attending a choir and music group. He mentioned visiting one of the members who had moved into a nursing home to perform music with this music group. Both mentioned the trips away they were about to go on, as well as the weekly Games Nights held at the local school.

Some participants mentioned that attending destinations such as social groups also led to increased interactions when moving through their neighbourhoods (Phase 2). James explained how through retirement he had got to know more people. There were over 40 people in his men's group that he knew and most of them lived a short distance to him. He explained that because of this, when he went out, there was a strong chance he would meet one of the members of his men's group, or even members from another of the groups within the community centre, such as the women's group. He also knew people in his community through being involved with associations and school boards over the years:

> And that could be quite often and even more so in recent years as I am retired and you get to know more people, I know forty-seven, forty-odd people of our own … most of them would be within half a mile of here you know what I mean? When you go out, you're likely to meet one of them or you're likely to meet one of the women, we don't have a women's …we just have a men's club but there is a women's group beside us there in the same place, I know a lot of them, and I have known a lot of them for years. I was involved ten years ago in the association; there are still some of those people around. Also, the school board for years ago I was on that for the … there is still some of them around.

> If I was out, I would be out and about a bit, I would regularly s peak to someone. (James)

As a result, he spoke regularly to people when he was "out and about" in Phase 2, but this was in large part attributed to attending social groups.

6.6.4 Getting Out and About with Purpose

Participants tended to attend destinations in a much more planned way than with Phase 1. As shown in the previous section, travelling through Phase 2 was more likely by having something an excuse to do so, for example by having a destination in mind to attend. Having a purpose or a reason to get out was one way to ensure that getting out happened. One of the reasons why social groups and Mass (for those that attended regularly) was so important, was that having something scheduled created a reason to get up and get out on a given day. Some participants were able to create these schedules or routines related to getting out and about without the need for external accountability, for example David and Áine. Yet, these participants were more the exception than the rule. Many participants such as Eamon benefitted from external accountability, and I discuss his routines in more detail in Chapter 7. Noelle spoke about the importance of one of her social groups, which was her craft social group that she attended on a Tuesday, because it helped her get into the routine of getting up and then getting out:

> It's just to get into the routine, you just get up in the morning and then out. (Noelle)

Having something scheduled provided participants with a *reason* or the excuse to get out and leave the house. This created a bigger pull and motivation to get out and about than leaving the house for an activity that was unscheduled and could be carried out at any time, for example going to the shops. This makes sense, because if someone didn't have to be somewhere, then they may just stay at home. Some participants found it much easier than others to push themselves to create these types of habits. For example Mairead admitted during her interview that sometimes she needed a bit of "a little bit of a push to do things" and used the example of attending her local social group to illustrate this. She described herself as the type of person that would try something once but if she did not like it she would not continue

participating. However, she also recognised that there had been occasions at her social group when she had tried something new and enjoyed it.

> I need to have a little bit of a push to do things but if I don't do them, it doesn't bother me too much. In saying that when I have done it, I say "I enjoyed that". I wouldn't do anything I wouldn't enjoy, I would try something once anyway and then that is not for me. (Mairead)

Having a scheduled and regular group to attend made it much easier to leave the house and engage in activities beyond the home. The act of scheduling something and repeating the activity made it more likely to happen and more likely that the person got out. This was best articulated by one of the participants from Focus Group 4. During the focus group, she revealed that on the day that she had her social group to attend, she got out "with a difference":

> Female Participant: And time out from the house because I could be in the house all day and I would be very happy there in the garden and all that, but Monday is a day when I am going, and I am going out.
>
> Hannah (Interviewer): Do you think it is important to get out of the house?
>
> Female Participant: It is yes, not that I don't get out, but I get out *with a difference* [emphasis added].

The fact that she had something booked in, meant that the way that she thought about getting out changed because she had purpose in what she was doing. As mentioned in the previous chapter, some participants expressed concerns about being "stuck" in the house. Scheduled and regular activities created reassurance to participants that this would not happen (see Clodagh in the previous chapter). As established in the previous chapter, it was important for older people to get out and about, to have time out of the house, so that they could feel better when they came back. Having a reason to do this was very important, but so was the regularity of this reason, because the process of carrying out the same activity over time led to the development of valued habits and routines. Many participants talked about the importance of routine in their lives and some of these routines were in relation to engaging with scheduled social groups. Noelle in the quote above talks about routine and how her knitting group created the routine of getting out and so does Eamon, whose routines I present in

Chapter 7. Brenda talked about the day that she attended her knitting group, which she runs. She described how it "stood out" compared with other days in the week, because it was a routine. Interestingly, she did not think it was her favourite day; this was going to visit her children and grandchildren. Nonetheless, it was still important to her, because it was part of her routine:

> Brenda: My knitting day is a routine, it stands out among any other day.
>
> Hannah (Interviewer): As your favourite day or just a routine?
>
> Brenda: It is just a routine. My favourite day is going out to the children, especially this weather.

These findings align with existing research that have emphasised the importance of routines and regular rhythms for older people and this theme continues into Chapter 7 and Chapter 8 (Lager et al., 2016).

6.6.5 Using Destinations to Structure the Week

A common pattern of daily routine that I observed in the vast majority of my participants, and particularly illustrated through Bridie at the beginning of the chapter, was attending multiple social groups and this was a way of adding structure to their weeks. Whilst most participants demonstrated some structure to their weeks, only two participants explicitly reflected and commented on this. The first was Margaret. In her joint interview with Nessa, she described her weekly routine and its similarity to Nessa's and the importance of "structure every day":

> There is a structure every day. And Saturday morning we meet up in the village, the six of us, for coffee. And Nessa goes to Mass most mornings, me not so much. Saturday evening, we try and go to six o'clock Mass. Sunday Nessa spends the day with her family, and I spend the day with my family, or not as the case may be. There is something going on on a Sunday, we are occupied. (Nessa)

Meanwhile, when Brenda described her weekly routine, she reflected how planned it was. She said this with a degree of surprise, suggesting it is not something she had actively thought about and created, but had happened more organically over time:

> So I think my week is really planned, isn't it? I have Wednesday and Thursday morning here and a Friday morning here. But now sometimes I have to go to a doctor on a Friday or the chiropodist or things like that on a Thursday or Friday but that is not regular, it is kind of once a month. (Brenda)

Jack was another participant that was engaged with a number of social groups. He was a member of a fishing club, as well as a gym where he practiced weightlifting. He also volunteered at a local community centre. As a result he had "things to keep him going":

> I have things to keep me going… every day I have something. (Jack)

Noelle reflected on the absence that she would feel if she didn't have her social group to attend on Monday, that she "would have nothing". In addition, Darragh described how "occupied" he was because hewas involved in so many activities through his men's group and local community centre where he taught computer classes. The examples above show just how busy and involved participants were, where they not only attend one social group, but had multiple activities and projects they were involved with, keeping them busy to a level that they found satisfying to them. As found by Lager et al. (2016, p.1574), busy was the "preferred rhythm" of most participants (p.1574).

6.6.6 Summary of Phase 3

Within this section, I have shown how "useful" social groups were for participants, by providing the meeting places to (re)connect with people in their communities. Attending Mass in churches was another destination that many participants attended frequently and in a scheduled way, and that was important for connecting with others. However, there was far more variation in frequency of attendance. I have shown how attending a destination such as a social group can lead to additional interactions and engagement with places beyond the meeting itself. Having destinations scheduled helped participants to get out "with a difference" and with more purpose. As a result, many participants attended and scheduled multiple destinations such as social groups and attending Mass. This helped to ensure that social interaction was not left to chance and also provided reassurance that the week would be satisfactorily occupied.

6.7 Conclusion

Connecting to others was a key component of why getting out and about was important for most of my participants. This chapter has explored the key places that were important to my participants for social interaction. I grouped these places into three different phases of getting out and about: thresholds; moving through public spaces; and being at destinations, in this instance attending social groups and Mass. Each of these phases provided opportunities for different forms of social interaction and with different people, including neighbours, friends, acquaintances, and strangers. Throughout this chapter I have shown how interactions in Phases 1 and 2 were valued but were not always the most reliable places for interaction and there were marked differences in how or whether participants interacted in these phases. Comfort in these places was strongly linked to past experiences. Personal and environmental factors combined to influence the ease with which someone got out and created variations in perceptions of safety and comfort in these phases. This in turn influenced how physically present participants were, as well as how possible (positive) interactions were. This connects to the themes identified for a good quality of life and to age – *as well as you can* – in place Chapter 5, emphasising the importance of feeling safe and secure to engage in meaningful activities and interactions.

Some participants lived in neighbourhoods where they could be reassured those exchanges would occur, but in other neighbourhoods there were fears or concerns about who they might meet. Whilst interactions in all these phases were valued, I have shown that social interaction could not always be guaranteed in Phases 1 and 2 for several reasons and that seasonality influenced the amount of time spent in these places. If connecting to others is desired on a more constant basis, relying on interactions in Phase 1 and 2 would therefore not be enough. Almost all participants engaged with others in destinations or meeting places, the two most common were social groups and attending Mass in church. In this chapter I have shown how scheduled and frequent attendance in these places had several advantages for social interaction, both during the event and beyond the event, as well as advantages for getting out and about generally. I have shown also how it was common for participants to attend multiple destinations throughout the week in a planned way

and use trip chaining to optimise their time and interactions whilst out and about. I now present my final empirical chapter, which continues these threads and focuses in more detail on four individuals' experiences of getting out and about.

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Chapter 7. Navigating ageing - as well as you can - in place with health and mobility challenges

7.1 Overview of the Chapter

In Chapter 5, I conceptualised ageing – *as well as you can* – in place, as having 'good enough' health and mobility, to be able to get out and about to participate and engage in meaningful activities or interactions. Within Chapter 6, I showed some of the ways that participants interacted and engaged with others, as well as the places and phases where this happened. I have already shown in the previous two chapters that getting out and about was easier for some participants than others and how this varied across my entire participant sample. For example, in Chapter 5, I demonstrated how the need and ability to get out varied between participants, as well as for the same participant at different times, depending on seasons, weather conditions and times of day. In Chapter 6, I provided insight into how some participants avoided certain forms of getting out and about and the reasons for this.

Within this chapter, I continue this line of enquiry to more fully answer my third research question: What factors influenced the ease with which participants could get out and about to engage in meaningful activities and interactions? I focus upon four participants with the greatest health and mobility challenges: Edith in Section 7.2, Eamon in Section 7.3, Moira in Section 7.4, and Dolores in Section 7.5. I explore their experiences of ageing – *as well as they can* - in place and how they navigate and negotiate getting out and about in ways that are meaningful to them. For each participant, I provide an overview of what was most important to them for a good quality of life and to age well (RQ1), as well as the places, routes, routines and interactions that were most valued (RQ2). I then consider their person-environment fit, exploring the factors that made it easier or more challenging to get out and about in ways that are meaningful to them (RQ3).

Each individual's lifeworld is described in geo-narratives with related annotated maps. Preliminary results relating to Edith, Eamon and Moira from Study Area 1 were presented in an article (Grove, 2021) for *Social Science and Medicine*. This chapter has a fuller discussion of the lifeworlds, particularly relating to RQ3, and it

also includes a fourth participant, Dolores. Edith and Eamon were chosen because they exemplified ageing *as well as you can*, in that they are still able to do things that are important to them as they age in place with health and mobility challenges. Moira, on the other hand, was chosen because she was struggling to accomplish her valued functionings as a result of a less supportive environment. Whilst Dolores lived in a more supportive environment (Study Area 2), she was considerably older than Edith, Eamon and Moira, and faced a number of challenges to getting out and about owing to reduced health and mobility. Different health and mobility challenges are presented to offer a breadth of experience and to offer insight into how certain conditions may influence daily experiences.

7.2 Edith

> I mightn't be able to walk very far but I enjoy my life.

Edith, aged 74 had lived in her neighbourhood for 48 years. Interviewed in her home, she explained that life was "mostly what I can do for other people, not what other people can do for me". The most important things to Edith were her family, neighbours and friends. Reciprocity and helping others was highly valued and her wellbeing was greater when she was able to do things for others. Edith had Parkinson's disease and consequently took the difficult decision to retire early from a job she loved. She was unable to walk far, requiring frequent pauses. She used a walker, deploying it as a seat when she needed to rest. Edith's main hobbies were singing, set-dancing and crafts.

Getting out of the house to meet others each day was very important to Edith, and vital for her quality of life. During her interview she evoked an image of an older person that was something she wished to avoid and which introduced Chapter 5:

> I don't want to be the granny sitting in the corner with a shawl around her shoulders and a blanket around her knees, I want to be able to get up and go.

Getting out was a goal that she admitted she didn't always meet due to her health challenges, however, she still tried very hard to engage in activities that were important to her. Edith noted that her version of living might not be considered living to others, however, what she strived for was living to her:

> It's very important [to get out and about]. First of all, I don't want to become a vegetable sitting in the corner. Life is for living and for whatever bit I have left I want to live it. It might not be living to other people, but to me it's living. You know, just to get myself up in the morning and get myself showered, washed, whatever I do. Get my breakfast, go to mass, come home, and go back out to anything that's going on.

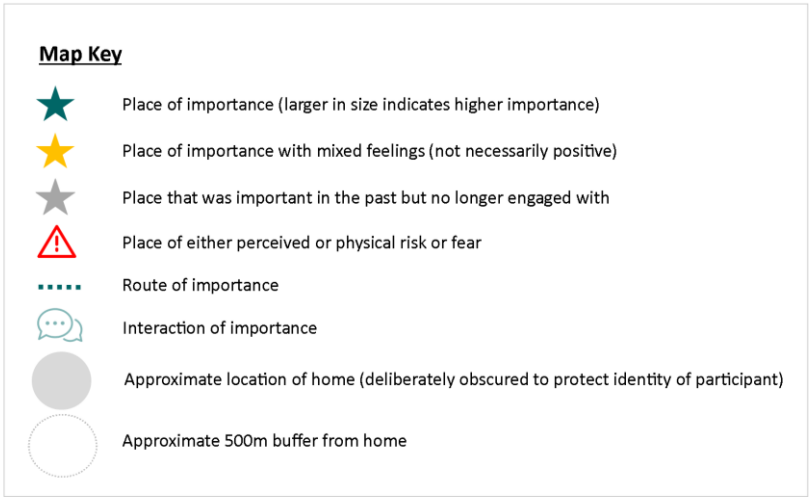
Edith felt that she had a good quality of life because she could still get out and about in some form:

> I'd like not to be sick, and I'd like to be doing the things I used to do when I was 60. But that's not ever going to happen again. But I think I have a good quality of life. Even though I have all these things wrong with me, and I have many things wrong with me, I still enjoy life, and I still think I have a good quality of life… I'm still able to get around… And whether it's a 5 minutes' walk up the road, and 10 minutes to get back [smiles], it's a good day that I can do that.

7.2.1 Navigating personal projects based on existing and changing capacities

Edith had a clear sense of a "good day" versus a "bad day". Going for a short walk at a slow pace constituted a "good day". Several places were integral to her conceptualisation of a good life, and these were identified in her mapping exercise and interview. Figure 7.1 shows that within her immediate local environment, there were five important outdoor "personal projects" (Curl et al., 2016; Little, 1983). Edith's personal projects involved visiting certain places or destinations to undertake activities and carrying out certain routes. One place and activity that was important to Edith, as shown in Figure 7.1, was Mass at her local church, which she tried to attend daily. She walked short distances within her local area, such as walking up the road or to her local park, although she admitted that she found this difficult due to tree roots obstructing the footpaths.

Figure 7.1 Edith's Lifeworld and Map Key



The place of *most* importance to Edith at the time of the interview, and which she "lived for", was her community centre in the neighbourhood adjacent to her own. Here she attended a craft social group twice a week. Edith drove locally and usually picked up two of her friends on the way to the centre. Edith had attended the social group for six years. During her engagement with the centre, she explained that she experienced a transformation in her mood and emotions, which she brought home with her, lasting longer than the activity itself. She summarised the positive impact that going to the centre had on her:

> The centre is the place you can go to when you're happy and when you're sad. The times I have gone to the centre, and I feel the weight of the world on my shoulders. And the way I say to them is that I bring a basket, an imaginary basket… and it's weighing so heavy to get out there. And when I come back to it at the door, I lift the basket up and it's so light to bring it back in. Then my worries are shared… and I feel better when I'm back in. So it's my way of trying to explain to people the way I feel… while I go out sometimes with a tear in my eye, I come back with a smile on my face.

Edith admitted that when she first went to the centre, she dreaded it. Her daughter suggested she go, and Edith initially said "no" because she felt that she was too young to attend. However, when I spoke to her six years later in the interview, it was her most valued activity and she exclaimed that if she could go five days a week she would. She described how supportive the staff were, how they waited for her when she arrived to help carry her walker out of the car. The centre was one of the key places that Edith connected to others, where she met people, talked, laughed, and drank tea. She was supported so that she could still attend with health and mobility challenges. In addition to the regular meetings, the centre had tours during the summer, where they would hire a bus and take day trips to different locations.

Edith identified some places and projects that were no longer possible for her to attend. This included her workplace, shown in Figure 7.1 in grey. She also identified places beyond her immediate environment that she no longer visited, including pubs, where she used to participate in set dancing and singing. These are not mapped because she did not specify during her interview where these happened. She had to give these activities up because she did not feel comfortable going out at night and stated "those days are over":

> I don't go out in the evening much, unless I'm out and I don't come back, but I don't normally go out in the evening. And I certainly wouldn't go out at night on my own.

Time of day was therefore an important factor in whether Edith got out. Seasonal and weather variations were shown in Chapter 5 to be an important component for some participants as to whether they got out, but for Edith this did not appear to be as much of an issue. I interviewed Edith immediately after the unprecedented snowfall and her community centre had closed as a result. There was still snow on the footpaths in her neighbourhood but the roads had been cleared. Earlier on in the morning, prior to her interview, she had been out to Mass. She stated that if the community centre had been open she would have found a way to get there:

> Whether it's hot or it's cold I'd still go down to the centre… It's very important for me, for, to get out. I just, could not stay in all the time. I don't want... [pauses] As I said, if I just sat in all the time, I would seize up and, I just... I don't want that.

Edith found it very difficult to sit at home all the time, because she seized up, one of the symptoms of her illness. Due to her fear of seizing up, she had additional motivation to leave the house. As a result, she appeared to be less willing to stay in more in the winter, because she was already limited in other ways. The interaction of a number of factors influenced the extent that weather and in particular, snow was an issue for Edith. One enabling factor was that she drove to the centre rather than walked. The condition of the roads were better than the footpaths as they had been cleared first and some of these roads had been cleared by her neighbours. She also knew that social support was available when she got to the centre.

7.2.2 Summary

Edith, as is common in those with Parkinson's disease had both an increased risk and fear of falling, as well as concerns about seizing up or freezing of gait (Jonasson et al., 2018), leading to reduced time spent walking in her neighbourhood and carrying out more local and familiar driving routines. Yet despite these challenges, Edith was still able to get out and about with her health challenges and had a clear sense of a good life for her. Whilst she would have preferred not to be ill or have reduced

capacities, she appeared to have come to terms with these limitations and had made several adaptations to her routines and projects. Edith had been forced to give up some of her more valued activities, such as work, dancing and singing, while other activities such as going to the local park were now carried out more passively. To compensate for those activities she had lost, she had found new activities through her community centre to engage in. Attending this community centre was very important to Edith's wellbeing and she provided a powerful explanation of her transformation after attending. There is evidence to suggest that individuals with Parkinson's disease face an increased risk of social withdrawal and difficulties participating in activities (Kudlicka et al., 2018; Bramley and Eatough, 2005). However, Edith showed that with the right social supports, it was possible for her to continue attending.

Edith had found a way to conceptualise a good quality of life so that she was still able to attain it and feel good about herself. She felt that she had a good quality of life because she enjoyed life and was still able to get out most of the time to attend valued projects. She had a clear sense of what a good day was for her. Reference to good or bad days is common within literature about participants with chronic health conditions (Charmaz, 1991). This recognises the fluctuations in health that are experienced and the potential disruptions to daily routines that can occur as a result. Whilst her condition sometimes resulted in disruptions to her routine, when she was able to, she showed additional determination to get out. This was also found by Charlton and Barrow (2002), who identified a "fighting spirit" in some of their participants with Parkinson's disease, defined as a strong desire to "maintain as normal a life as possible in spite of the illness" (Charlton and Barrow, 2002, p.476). This was reinforced for Edith by a clear visualisation of someone that she did not want to be and feared she might become if she didn't get out. This determination was so strong, that additional factors such as seasonal or weather variations did not impact her in the same way that other participants described (see Chapter 5). This was highlighted with her assessment that she would have found a way to get to the community centre if it had been open. Edith's lifeworld demonstrated the negotiation process and risk assessments she carried out when making decisions about when to go out, as well as how certain activities were prioritised and held on to over others.

7.3 Eamon

> I like to do things myself… You can say, "oh but I've Alzheimer's now I'm afraid I'll get lost", [but] you've got to push yourself a bit, you know? (Go-along Interview)

Eamon lived in the same neighbourhood as Edith and had done so for over 40 years. Eamon had Alzheimer's disease and was recruited through a dementia day-care centre he attended several times a week. During a joint interview with another attendee (and participant) and with his carer, I asked him how he defined a good quality of life. He explained that it was important for him to "keep up with neighbours", to remain independent by doing things for himself, and in turn, to feel like himself. As with Edith, it took very little to draw Eamon into an account of his wider lifeworld.

7.3.1 The importance of routine

On days that Eamon attended the day centre, a minibus arrived outside his house at 9.30am to collect him. During the interview, Eamon described the importance of having an activity or project to be up and ready for. He had a routine where he made his wife breakfast at 9am and was ready waiting outside by 9.30am:

> I have to be up every morning, if it's rain or snow, I've got to be up.

Like Edith, variations in seasons or weather conditions did not significantly influence Eamon's routine. This was because he had an activity that he had to be up for, and was also made easier by the mode of transport. He explained that if it was a cold morning or raining and he wanted to stay in bed for a bit longer, he couldn't because his minibus would be there to collect him:

> It's great, I can't do that [stay in bed for longer] … 'cause the bus is coming for me [laughs].

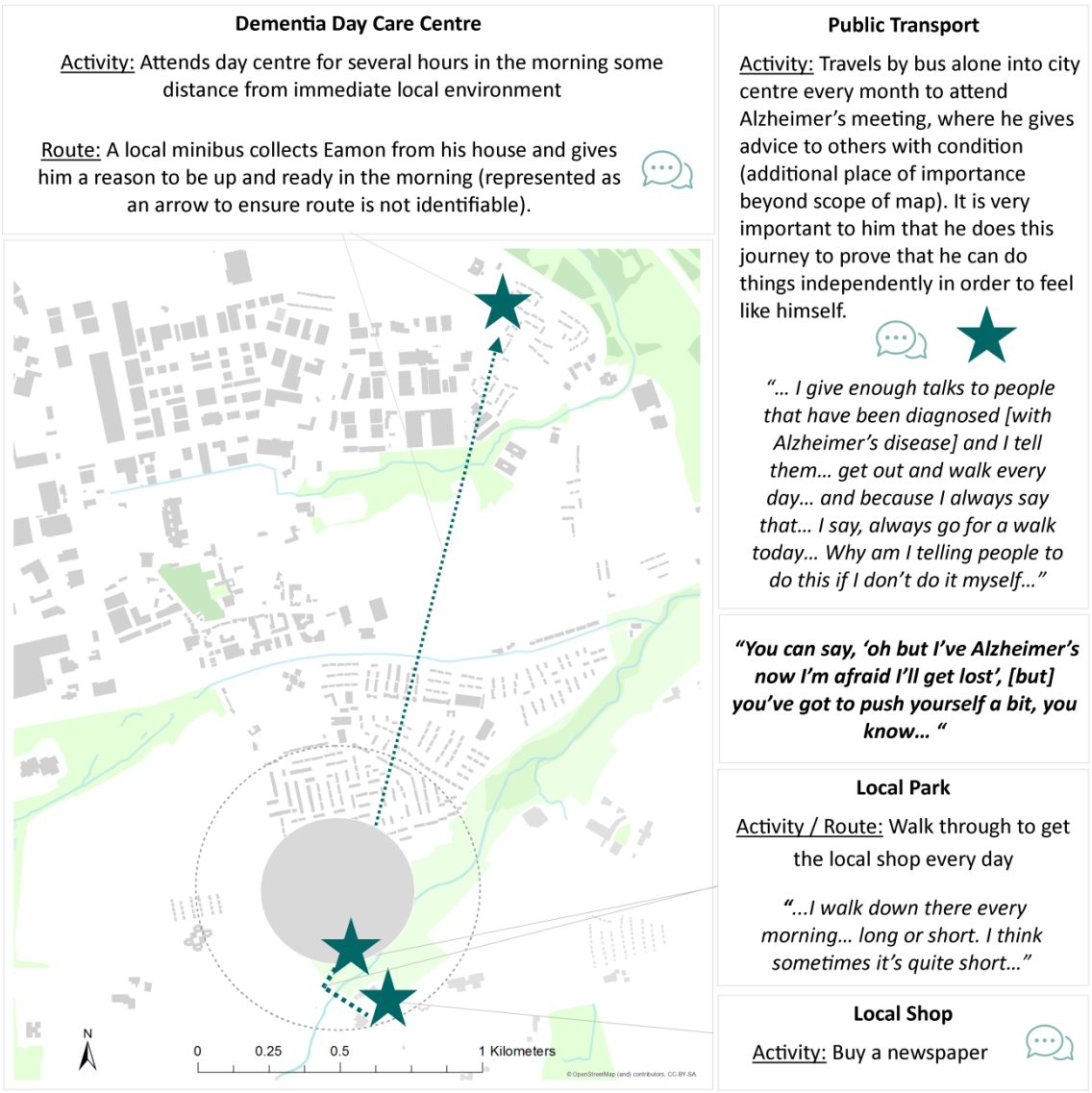
Eamon felt that routines were a very important part of managing his condition and admitted that he had routines for everything, which he believed "protect" him. He had routines about getting dressed, taking tablets, and leaving items in particular places around the home, but also when it came to leaving the house and engaging

with the wider neighbourhood. One of his most valued daily routines was walking through his local park to visit the local shop and buy a newspaper. His go-along interview involved driving from the day centre to his local park and walking some of this daily route. Figure 7.2 illustrates Eamon's outdoor personal projects, which included attending the day centre, and walking to the shop every day. It is not known whether he made this route to the shop *every day* or not, but he had the intention and desire to do so. He admitted himself, that although he tried to walk every day, the length of this varied depending on how he felt and the map shows this aspiration, which was met on some days but not others.

Another important activity that Eamon participated in once a month was traveling by public transport to attend an Alzheimer's Society meeting, also shown in Figure 7.2. Here he gave a talk to others with the condition and shared his experiences. He advised other people with Alzheimer's to get out and walk every day and this in turn gave him an extra push to do it himself. He remarked during the interview "why am I telling people to do this if I don't do it myself?". Talking at the centre gave Eamon a sense of purpose and of pride. People listened to him, and he was a role model for others. Eamon explained that an important part of feeling like himself was going for a walk and being independent. He mentioned that occasionally people offered him lifts or taxis to his meetings and offered to go to the shop for him. However, maintaining his independence was very important to him, so he tried to do these activities on his own.

Neighbourly support played a role in helping Eamon to achieve and maintain his independence. His neighbours knew about his diagnosis, and during his go-along interview he told a story of how he went to go for a walk in his local park one day and two of his neighbours interrupted him as he left the house. They asked him where he was going and he said "I'm going for a walk", however his neighbours told him he was wearing the wrong shoes and escorted him back to the house. He was grateful for this, and rather than saying "you've Alzheimer's you shouldn't be going walking", his neighbours said "you're wearing the wrong shoes, you can't go for a walk in them". Eamon felt this was very nice of them and a "lovely way to do it". In Eamon's own words, "the main thing is for people to have patience".

Figure 7.2 Eamon's Lifeworld



7.3.2 Summary

Eamon told very similar stories on both occasions and some of the time references were inconsistent. However, the *meaning* and *value* he placed upon these stories was evident and consistent. Like Edith, he underlined the practicalities and negotiations involved in sustaining a sense of a good life with cognitive health challenges. This included creating a series of routines to manage his Alzheimer's when out and about. These daily routines were important for his sense of self and feeling independent and this has been shown elsewhere as important for people with dementia and in particular, Alzheimer's disease (Olsson et al., 2013; Öhman and Nygård, 2005).

Eamon negotiated with others when they suggested adaptations to his routines to protect him. Whilst this was done out of concern for him because he might get lost, this would have had a negative impact on his wellbeing and sense of self, as he would have had to concede that these routines were no longer possible. Eamon's personal projects gave him purpose, an extra push, and a reason to get up in the morning. Additional provisions such as a minibus to collect him meant that he was able to travel safely beyond his immediate local environment, extending his activity space. As a result, Eamon dwelt in a lifeworld and with functionings that went well beyond the home and, like Edith, stressed the importance of altruism. Alongside this evident interdependence and social support, Eamon was still able to insist that he had significant independence.

7.4 Moira

Anywhere I'm going I really need a lift.

Moira was aged 66 and my youngest participant and had lived in her neighbourhood for 40 years. Moira lived in a different area to Edith and Eamon. Her neighbourhood was built several years later and was located on the periphery of Study Area 1, a suburban new town. Moira had Chronic Obstructive Pulmonary Disease (COPD) and found it difficult to walk long distances as she got out of breath easily. When Moira was asked how she would define a good quality of life she emphasised being able to get up, get out, and do her own shopping and cleaning:

> Well, I think once you're able to get out, get up… you know, yourself, and take your own shower... look after your own, you know? Able to do your own cleaning and washing… once you're able to do things like that and do your own shopping.

7.4.1 Challenges with maintaining independence

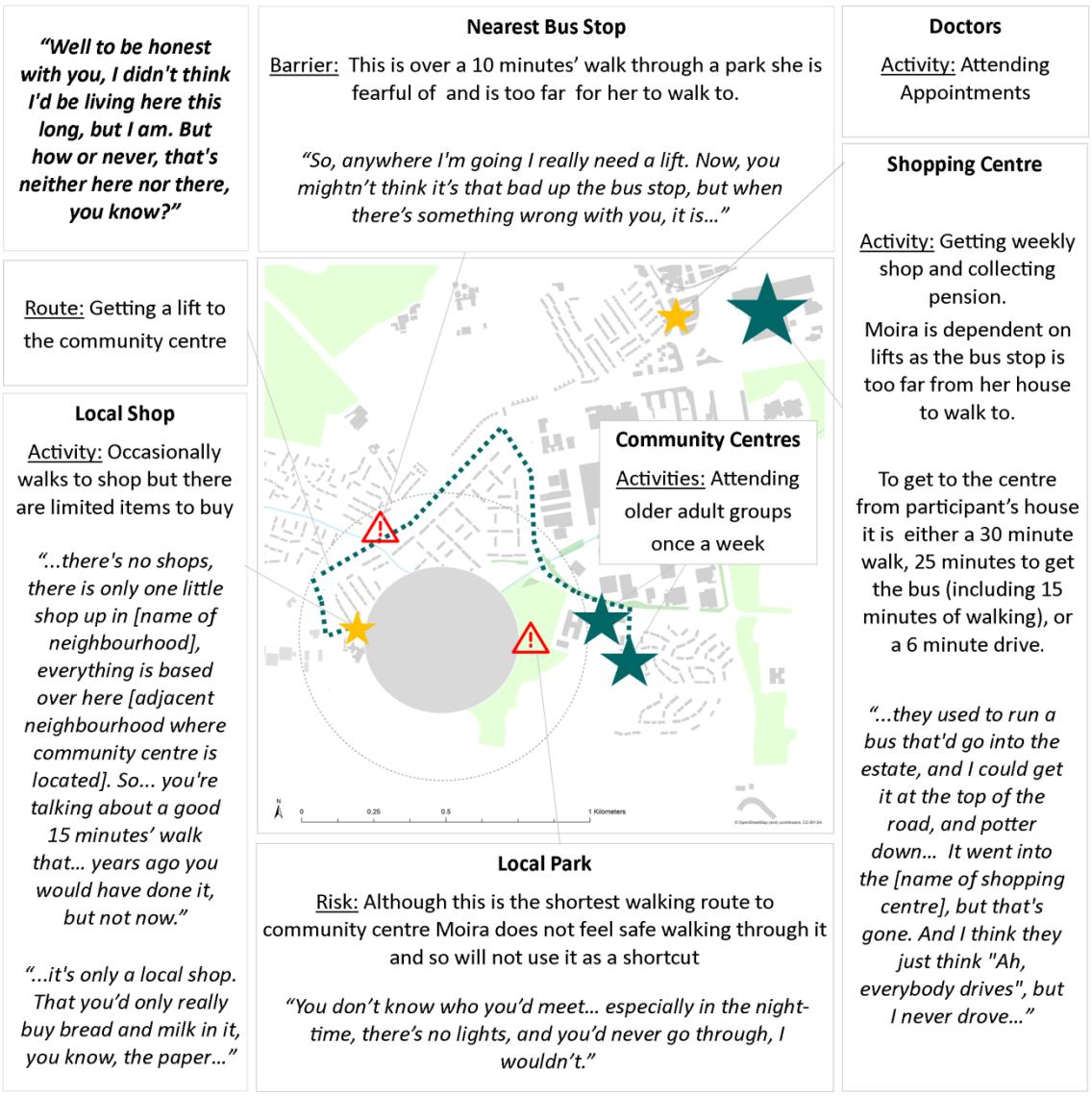
Like Eamon, being independent was a highly valued functioning for Moira; this meant being able to do activities within her home, as well as in her broader local environment. The places Moira identified as important to her during the mapping exercise were predominantly related to carrying out errands and utilitarian projects, such as going shopping, going to the post office to collect her pension, and attending

doctor's appointments. During her mapping exercise, Moira pointed out in the town centre the shopping centre, which she attended once a week to do her grocery shopping and collect her pension, as shown in Figure 7.3. She relied on a lift to get to the centre, usually from a family member. This was reflected in the format of her go-along, which was a driving go-along. It took 30 minutes to walk to the centre or town from Moira's house, and travelling on public transport took 25 minutes, which included 15 minutes of walking. This was too far for Moira to walk. She mentioned a local bus that used to go into her estate, but it was no longer running. She suspected it was because of an assumption that people drove, but she did not learn to drive, and this was something she regretted.

In this more geographically isolated and car-dependent neighbourhood, activities like shopping were a challenge, because it was not easy to get to the town centre where most services were concentrated. Moira identified a small local shop located in the estate, but its supplies were extremely limited. She occasionally used it if she ran out of milk or bread. Moira expressed frustration that some of her friends in the adjacent neighbourhood had more convenient services, including a post office and better local shops. When describing the last week and her routine, she mentioned two days when she did not leave the house.

Two additional places that Moira identified as important were local community centres in an adjacent neighbourhood (see Figure 7.3), where she attended an active ageing group and social group once a week, one of which she was recruited from. In order to participate, Moira obtained a lift from a friend who also attended. During her go-along, I drove us 3.8km in just under 27 minutes, from the community centre, to her doctor's surgery in the town centre and then finally to her house. She stopped off at the shop on the way to pick up some milk and bread. During her mapping exercise, she explained that it looked as though it was a short distance to the community centre from her house on the map, but in reality it was much further. It took approximately twenty minutes to walk to the community centre via the main roads, which was too far for Moira. A much shorter route to the centre was walking through her local park. However, as identified in Chapter 6, she did not feel safe walking through it, because it was very open and she was fearful about whom she might encounter.

Figure 7.3 Moira's Lifeworld



When Moira explained that her fear of walking through the park was related to not knowing who she would meet, she alluded to distrust of some of her neighbours. Whilst Edith and Eamon both demonstrated strong place attachment to their neighbourhood and neighbourly ties, this was not the case for Moira. She knew some of her neighbours that had moved to the area at the same time as she did, but many of these people had since moved out of the area. This was connected to policy initiatives in the 1980s in Ireland, also mentioned in Chapter 6, which financially incentivised people to move out of their social housing and relocate elsewhere. Moira's neighbourhood had been disproportionately impacted by this. Moira expressed sadness about those that had moved and revealed concerns about new

people moving in. She expressed regret that she was still living in the area and missed the way that her neighbours and friends used to call into houses but explained that this no longer happens. During her interview, she expressed a desire for more positive interactions with her neighbours than she currently had. Whilst Moira did not have strong connections with her neighbours, she did visit family members regularly and they visited her. Her daughter had been living with her but had recently moved country for work, so she was living alone at the time of her interview. She looked after her grandchildren most days and visited family members on the weekend.

7.4.2 Summary

Moira described challenges achieving her desired personal projects, and her reliance on lifts conflicted with her valued functioning of being independent. Her neighbourhood served to exclude her from valued projects in many ways. She was spatially excluded, living in a geographically isolated and car-dependent neighbourhood. Research elsewhere has shown the disadvantage and challenges to participation that older people, particularly women, face when living in suburban environments and do not drive (Zeitler and Buys, 2014; Giesel and Rahn, 2015; Stjernborg et al., 2015). In addition, to difficulties travelling, Moira had reduced services and destinations to engage with in her immediate environment. Her neighbourly social environment had been impacted negatively by policy initiatives several decades ago, the impact of which she still felt today. Moira's lifeworld demonstrates the importance of recognising structural or macro factors that can influence and change, not just the physical environment, but also the social environment (Buffel et al., 2018; Lager et al., 2013). This displacement of others, impacted negatively on her place attachment, and caused to her to feel that she no longer belonged (Fullilove, 1996). Certain characteristics of her social and physical environment were therefore not supporting her to age as well as she could.

7.5 Dolores

> Look, I have come to terms with the fact that you can't expect to be 21 when you are nearly 90. So if I walk as far as [name of local church] and back, I am delighted with myself.

My final participant for this chapter is Dolores. Dolores was aged 89 at the time of the interview and was one of the oldest participants in this study. When I asked how she defined a good quality of life, she emphasised being able to move putting "one foot in front of the other", being happy with what she had and staying out of the "obituary column":

> To be happy with what you have got, don't be yearning after things that were, and don't be sorry they are gone, be sorry [sic] they lived. I mean there is no point in killing yourself, we all grow old, if you are lucky, you will grow old and you are still able to move. So if you can put one foot in front of the other and you don't put your name in the obituary column, you are okay [laughs].

Dolores lived alone in a semi-detached home in an inner-suburban neighbourhood. When at home, she thoroughly enjoyed reading. She had a tablet that she played solitaire on and emailed her friends. As mentioned in Chapter 6 when I described an interaction she had with a person and her dog during her go-along interview, Dolores was passionate about dogs. Whilst she kept dogs as pets for many years, she was no longer able to manage looking after them and so no longer had her own. In terms of activities outside the home, Dolores loved walking, particularly in green and blue spaces and used to spend many hours walking her dogs in the past. She enjoyed meeting friends or family members for coffee or lunch, as well as visiting art galleries exhibitions and gardens. Dolores described certain routines that she carried out within the home and when she left her home:

> Well, every day is different, thank God. I get up … I would have my breakfast, which consists of porridge and a mug of tea. Then I would get ready to go to Mass, ten o'clock Mass … it depends whether I would meet friends and have coffee or whether I would come straight home, whether [name of younger sister] was coming over, whether I was meeting friends afterwards. Like last Tuesday I met [name of friend] down in the [name of hotel], I walked down the [name of river]. But I try to get out every day anyway.

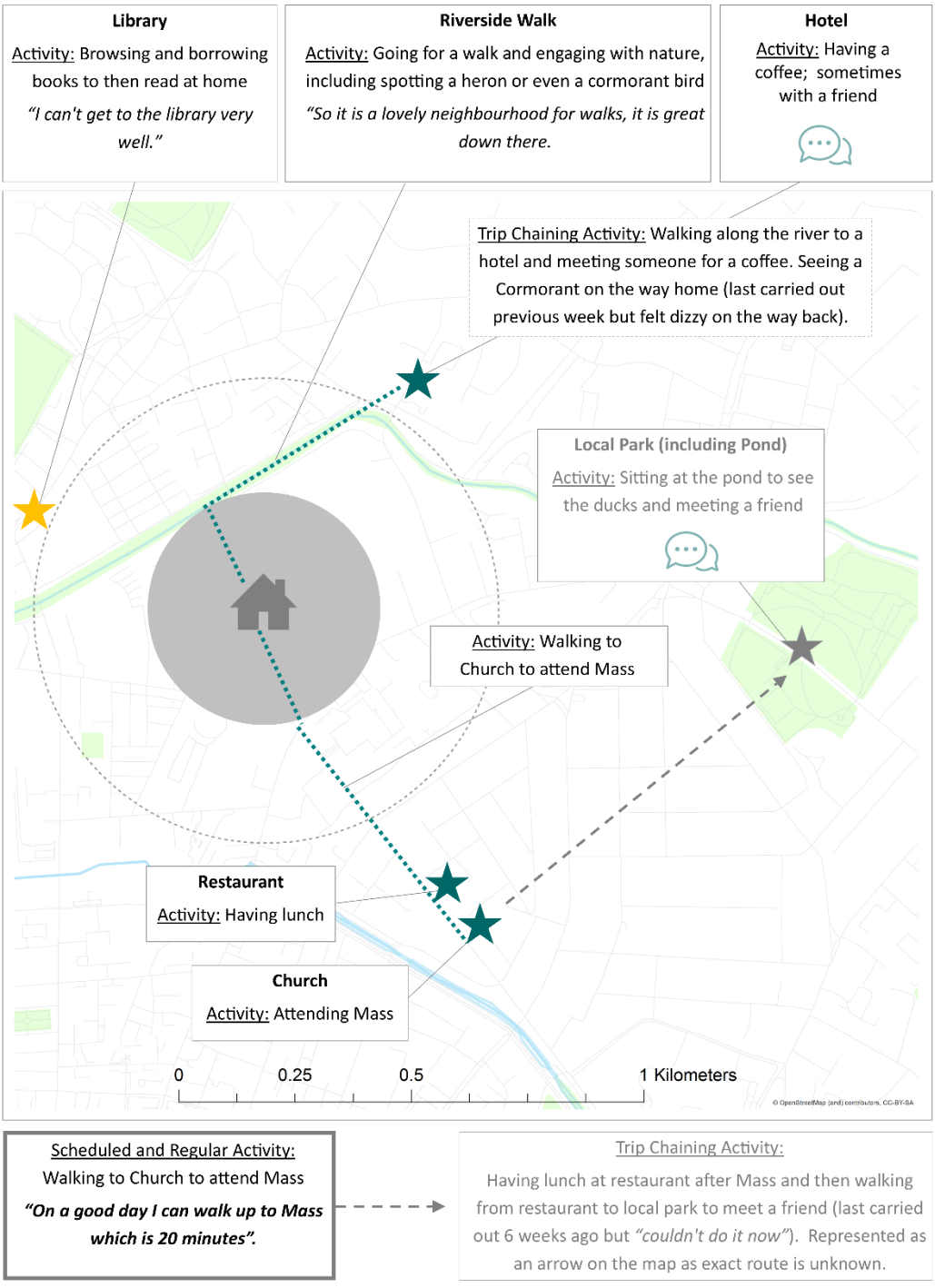
Dolores was the only participant to have been recruited through a Public Health Nurse. When I asked if she was limited at all by health challenges, she said quite matter of factly:

> Of course I am for God's sake. There are days I can sweep the floor but there are days I can't.

Dolores referred to various health challenges throughout the interview, although the exact nature of her health conditions was not clear. One condition that she did reveal was vertigo, resulting in spells of dizziness, although she managed this to an extent with medication. Dolores' mobility was very restricted, and she used a walker. She talked about walking predominantly in the past tense, recognising that it was an activity she was not able to carry out as much as she had previously. She was not able to climb stairs and had a stair lift at her home, as well as a "claw grabber" to pick items up from the floor.

Out of all my participants, Dolores identified the most challenges getting out and about. As a result of these difficulties, there were many instances where the activities she valued were no longer possible. At the time of the interview, she was negotiating and navigating additional challenges that had further restricted her movement as she had been in hospital the previous week. Despite these restrictions and the risks she faced as a result, Dolores demonstrated a great deal of determination to get out and tried to get out every day if she could. Dolores conceptualised a good day as being able to get out to Mass first thing in the morning. She tried to go to Mass six days a week and to return to the quotation at the beginning, if she managed to walk to and from her local church (approximately 800m away and shown in Figure 7.4 below), she was "delighted" with herself. Dolores had a sense of what she felt able to walk based on her capacities at the time of the interview; a distance manageable to her on a "good day" with her walker was 20 minutes away. Dolores walked to Mass using her walker most days but on Sundays she got a lift from a neighbour.

Figure 7.4 Dolores' Lifeworld



7.5.1 Trip chaining and negotiating finite energy budgets

Whilst she declared that "every day is different", the beginning of each day was quite structured and similar. However, what she did after Mass varied depending on whether she had arranged to meet a friend or family member. A common practice for

Dolores therefore, as identified as a pattern across many of my participants in Chapter 6, was to "anchor" herself to an activity that was scheduled and was a consistent routine, to get out in the first instance (Lager et al., 2016, p.1574). She then carried out more flexible and varied arrangements afterwards in the form of trip chaining. This was particularly important for Dolores because of her restricted mobility and energy budget. During her mapping exercise, she described an ambitious outing that she carried out about six weeks ago prior to the interview. This outing involved attending Mass, going to a restaurant for lunch, and then onto a local park much further away:

> And one day I went to 12:40 Mass [at local Church], this is about six weeks' ago, I couldn't do it now, and came out, had a bit of lunch in the [name of Restaurant] and then I walked up to [name of Local Park]. That was a big, big deal for me at that time, but I made it. It took about half an hour, and I went in, and I was so chuffed. It was a Friday, I texted [name of friend] and said, "Where are you?" "I am down at [name of post office] getting my pension." "I am up here in the park." "Right, I'll be up". So up she came anyway, and we sat at the pond for a bit.

She described this as a "big, big deal for her", due to the distance, and was really pleased, or "chuffed", with herself when she managed it. Since this walk, Dolores' mobility had become additionally restricted and at the time of the interview, she felt that this routine would be beyond her capabilities; when she explained she "couldn't do it now". For this reason, it is shown in grey in Figure 7.4.

Dolores spoke about another routine that she commonly carried out, also shown in Figure 7.4. This involved walking along the river to a hotel where she then had a cup of coffee. Sometimes she did this on her own and sometimes she met a friend. Both the hotel and riverside walk were located a short distance from her house, and she described carrying out this trip the previous week. This riverside walk was a place and route mentioned several times. She particularly enjoyed seeing the different types of birds, including the "ubiquitous seagull" and occasional heron. The last time she had carried out this route she had been delighted when she saw a cormorant for the first time. However, on the way home she felt dizzy and had not completed the route since.

The local library was another place important to Dolores because she was an avid reader. Dolores had a Kindle but preferred not to read this late at night because it affected her sleep. Recently, she had "run out of reading" at home, however, she explained that she "can't get to the library very well". This was because the library was in a different part of her local neighbourhood, in the opposite direction to her usual routines (see Figure 7.4). Dolores' use of tense when talking about her routines, routines and places of importance were sometimes inconsistent, as if she was unclear herself of what she could currently do and what was no longer possible. For example, in the mapping exercise, she described a route she would take "I go down to [name of library], which is by the [name of building it is next to]." I asked how often she visited the library and she replied, "Whenever I need a book, whenever I feel like it". However, she then immediately reflected:

> ….it depends on (a) how I feel, (b) what the weather is doing, and we will have to wait and see. I just can't, I have to wait and see how I am feeling.

She wasn't sure if she could still get to the library but was hopeful, she still could:

> I could go around to the library. I am not sure whether I can do it now or not, I hope I will. Anyway, the library is just the same length as the church, 20 minutes.

Dolores reasoned that because it was the same distance as the church, she could potentially do this trip, although it was unlikely she could do both unless it was a particularly good day. Based on an understanding of Dolores' regular routines, capacities, and priorities, it became apparent how other directions then became unavailable. This highlights that when an individual has to negotiate smaller "energy budgets" to manage reduced capabilities, some instances this means only being able to move in one direction at a time, emphasising the "fragmented" nature of reduced mobility, as other options that are lower priorities and in different directions become unavailable (see Lord et al., 2011).

In many ways, Dolores' immediate physical and social environment were more supportive than for Edith, Eamon, and Moira. Within her inner-suburban neighbourhood, she lived on a main road, with a local shopping parade a short distance away (this began less than 100m away and ended 250m away from her

house). The shopping parade included restaurants, coffee shops, her doctor's surgery, supermarkets, and a post office. One of the main benefits of her immediate local environment was that "everything is on tap". In addition to local shops, there were many places nearby where she could walk, including local parks and her favourite riverside walk (this began approximately 250m from her house). However, Dolores identified several barriers that made getting out and about particularly challenging for her. Some of these barriers meant that she was no longer able to carry out certain activities. For example, prior to a fall in 2008, she had attended a choir group, but was no longer able to participate because she could not climb the stairs in the building. At the time of the interview, Dolores was not attending any social groups. She attended a friendship club associated with her local church, but they were on a break over the summer when she was interviewed. The group were intending to meet for a meal in a few weeks' time and Dolores was hopeful she would be able to attend.

7.5.2 Variability across personal and environmental factors

Dolores admitted that on any given day, she had to consider how she felt, as well as the weather conditions. Like Gardner's (2014) participants, weather was a "constant consideration" (p.1252). Dolores struggled with windy conditions and mentioned how the wind stopped her from going out and how she had been "knocked down by the wind years ago". Dolores was particularly fearful of windy conditions because she did not weigh very much. She worried she would be knocked off her feet. During the mapping exercise, she pointed out a place that she avoided in windy conditions. This was the entrance to her local train station, the design of which created a wind tunnel effect.

> It is a bad day if I can't get out to walk. It is usually because, even if I don't feel great, I still go out, but it is the wind. What started that was I couldn't get a taxi, I rang but couldn't get a taxi, I forgot it was Father's Day. So [name of younger sister] said there's always taxis at [close to the train station] … when I got to [the train station], my God, it was like being in a vacuum, the wind, and I was holding onto a post and a man came along and I said, "Please would you help me down...?" There was only the one taxi, being a Sunday, so anyway I was in bits, really terrified. The rollator, which is a heavy thing, was taking off as well.

Time of day was another important factor and she mentioned that she would "never go out at night". During Dolores' go-along interview, I was able to get a sense of how she engaged with her immediate environment. During the go-along, Dolores and I walked along the main road where her house was located. Dolores was very keen to carry out the go-along interview and we agreed a distance that would be manageable for her on the day. We carried out a loop that involved passing through her local shopping parade, which had several shops, pubs, and restaurants. The interview took just under 20 minutes and was a round trip distance of approximately 540m. This route is shown in Figure 7.5. Dolores pointed out several places where she had fallen in the past. Whilst she admired the trees in her local area and found them "beautiful", she also described them as a "nuisance", due to the way they caused the tarmac to become uneven, highlighting how environmental features can simultaneously serve as assets and hindrances.

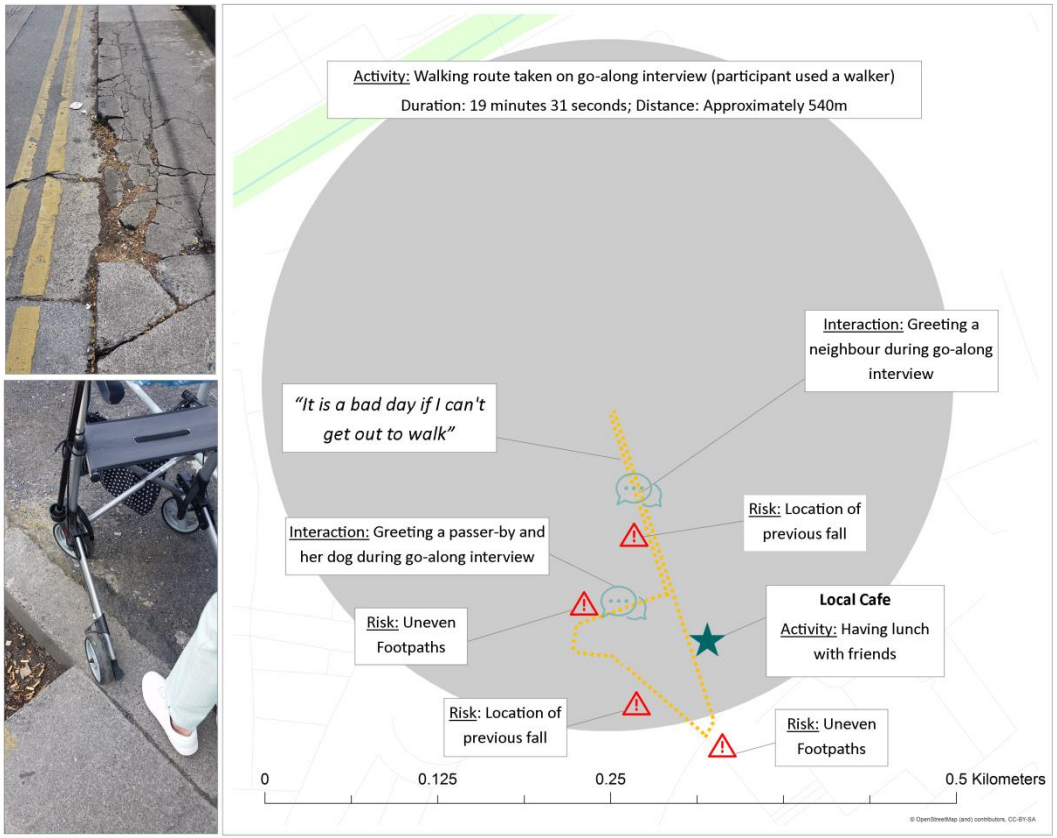
Throughout the interview, Dolores referred to a few "incidents", which had impacted negatively on her health and mobility. One of these was the "awful fall" she experienced in 2008, where she broke her hip and cut her knee quite badly, resulting in her no longer being able to attend her choir. She described another fall where she had hurt her legs and they had bruised. Dolores pointed out some of the footpaths that were cracked and uneven (see Figure 7.5). She showed me how difficult it was for her to lift the walker up and over these footpaths. This had become an issue for her recently in particular, because she had lost some of her strength:

> Lately either I've lost my strength, or… the thing has got stuck, because now I find I've got no strength to put it down.

Dolores described how she had to watch out for other people using the footpaths and would look up and down her road to see if someone was coming. She was particularly cautious of cyclists and people running. When I asked her how her environment could be more supportive, she replied:

> Honest to God, I can't think of anything except the bloody paths.

Figure 7.5 Dolores' Go-Along Route



7.5.3 *When challenges become insurmountable: making mistakes and mustering through*

> Well everywhere was important when I could get there but now I can't.

Dolores' interview provided insight into how she made decisions about whether to engage with certain places beyond her immediate environment. In many instances, environmental variability and uncertainty meant that she no longer attended certain places or used certain modes of travel. As a result of the interaction between her mobility and her physical and social environment, there were several places important to Dolores that she could no longer attend. The main challenge with visiting places beyond her immediate environment was that she had to use public transport because she no longer drove. Dolores had several public transport options available to her in reasonably close to her home, including a bus stop (approximately 600m away) and a train station (650m away). However, past experiences had knocked her confidence and created so much fear, uncertainty, and risk, that she now

avoided using them. She described several examples which highlight the challenges she faced, and these are now discussed.

Dolores faced several challenges when getting on a bus. She described the inconvenience of having to get past a lot of people when it was busy, as well as not wanting to inconvenience them by them having to get off to let her on. She described the variability of the bus drivers and buses, how some would be happy to lower the ramp and wait for her to get settled, while others wouldn't. The implications of this variability was the difference between her potentially going to Accident and Emergency or not:

> And then when you are getting off… you couldn't go from town to get off at [name of her bus stop] because there would be all people standing and how are you going to get your rollator past all these legs? They just don't want to move and they really all have to get off. So that really is a no-no… Some of them [bus drivers] are very good, they will lower the ramp, some of them won't bother… They don't say I don't want to, but they say I can't or something. The rollator is very heavy, trying to get that up, then trying to put my card up to the thing, then trying to get up to the thing before he starts... Some are very good, they wait until I am sitting down, some of them start straight away and I am holding onto the rollator with one hand and the pole with the other and I am afraid of my life of falling because I am not steady on my feet. So it is not worth [saving] €10 to end up in A&E [sic].

Dolores described a time when she had to travel to hospital for an appointment. On this day, she decided to "chance" the bus, stating the high costs associated with getting taxis all the time. She got onto the bus, however when she was sitting on it, she hit and injured her elbow:

> I had to go out to [name of hospital] to get a [name of a type of scan] and I decided I would get the bus out, chance it, because it is very expensive to get taxis everywhere. So anyway, it was okay, I got on, I have a seat on the rollator, and I sat on the rollator but whatever way the bus jarred I hit my elbow and when I got off the bus my blouse was all blood. I am on aspirin. I had plasters, so that was okay.

She managed to make it to her appointment and afterwards a friend came out to meet her. It was not clear whether this meeting with her friend was pre-planned or because

of her accident. Her friend had intended to get the train home, but Dolores decided to get a taxi instead because her confidence had been shaken by her experience of using the bus. Furthermore, Dolores struggled to use trains because of the large gap between the train and the platform, as it was too difficult to lift her walker onto the train:

> So, we got a taxi home, it was €25, it was worth it because I was terrified. You see the DART [name of Dublin rail network], mind the gap, and the rollator is very heavy and trying to get on and trying to anchor it. And as I said the thing about the DART would be fine except for the gap, the gap is terrible.

Dolores spoke about a "very, very brave" trip she made approximately six weeks ago, when she spontaneously visited a cousin that she had not seen for months. Her cousin lived in a seaside town 50 minutes away and she used the train to visit her. She described the trip to me and how she had created a plan to carry out the least amount of walking for both of them, as well as ensuring that the weather conditions were suitable:

> So I decided, this day was a beautiful day, so I rang [name of cousin], are you at home? Yes… So I went up to [name of nearest train station], thank God, well of course I wouldn't go on a windy day. And it leaves me right into [name of seaside town] opposite the [name of restaurant]. So she met me at the [name of restaurant] and we had lunch. We didn't go anywhere else, just back to the station. It was just to meet her.

When she returned home, she made a deliberate strategy to try to get into the last carriage. This was to avoid having to walk the whole length of the platform when she reached her station. When she arrived at the platform, Dolores and a man intended to get off the train, however, he pressed the button, and it didn't work. The man ran up to a carriage where the door was working to get out. He tried to hold the door open for Dolores but the train conductor at the top of the train did not see what was happening and tried to close the doors. The man was able to catch the door and eventually helped her out. She concluded her story stating: "That was the only incident". This story shows how an unanticipated disruption to public transport created an additional challenge for her. In this instance, someone had been there to help her. However as far as I could tell, she had not used the train since.

These “incidents” or bad experiences on public transport left her feeling afraid of using them and resulted in Dolores having no alternative but to use taxis instead if she wanted to travel beyond her immediate environment. Using taxis, Dolores visited some places, but did so far less frequently, owing to the cost. An example of this was going into town, which she described doing “occasionally”. In this way, she was able to overcome some of her barriers to an extent. However, she also described how there were certain places that she thought were worth using a taxi and others that were not. The places that she no longer visited beyond her immediate environment were typically green and blue spaces, such as gardens or beaches, even though she highly valued these places. Dolores prioritised the use of certain activities over others and even though engaging with nature was important to her, it was possibly seen as too indulgent to spend money on taxis. She was more likely to use a taxi for what she considered necessary trips. This included meeting a friend, or attending appointments, but she did not “feel” like using them for visiting gardens:

> I would love to go to the Botanic Gardens, but I don’t feel like paying a taxi there and back. My neighbours are great, but I am not going to ask them to bring me to the Botanic Gardens, they are busy working or whatever.

Dolores described in many instances during her interview how “truly blessed” she felt to have the support of her neighbours, family, and friends, as well as her home help. Like Edith, she described the additional support she received during the snow:

> It is a very friendly neighbourhood and people are so kind, can I open the gate for you, can I get you a message? And during the snow there I was ... There was a queue at my door [laughs].

She did not do her own “main shopping”, her next-door neighbour did this for her and she had meals delivered to her. She mentioned that sometimes she was not in, so she had an arrangement with the delivery person to leave them in a bag inside her bin. In this way she was dependent on others, who supported her to remain independent enough to stay at home with modifications. However, there was a limit to this and while they were very supportive in many ways, she would not ask them to bring her to gardens. She described how she has come to terms with this and what she has:

> Where else would I like to go? Howth, Dun Laoghaire, Bray [seaside towns] but I am satisfied now with what I have. I have had to come to terms with what I have, and I don't expect people to be bringing me out.

As explained already, Dolores usually had to see what the weather was doing and how she felt on the day to decide to what extent she would get out and about. However, she didn't always get this assessment right. The previous day she had been into town, however she described it as a "big mistake" because she didn't feel very well. She also talked about times when she regretted going and it was a "big mistake", but she managed to "muster through":

> I went into town, a big mistake, I really didn't feel great, and I shouldn't have gone into town, I got a taxi of course, I can't go on the buses anymore, but my God, big mistake. Anyway, I managed to muster through, and I met my sister-in-law.

Despite doing her best to manage risks and make strategic decisions, both her capacity and environment could still be unexpectedly diminished.

7.5.4 Summary

Dolores highly valued getting out and about in her local neighbourhood, and like Edith, conceptualised a good day in terms of being able to get out to walk in it. Dolores engaged with a number of places of importance, including attending Mass at church. She felt a real sense of accomplishment and wellbeing when she engaged with these places. The amount she was able to walk had changed over time and certain valued places were no longer available to her. The implications of this was that she had to limit her activity space to closer to home, or use taxis, in case she felt unwell whilst she was out. This meant that she was not able to experience as much variation within her local environment. This was one of the few instances during my research where I could get a sense of capacities changing even within the past few weeks. She demonstrated how she continually managed her expectations and negotiated what she was capable of, based on her past experience.

Dolores identified a number of challenges and risks that she faced on a daily basis and that had injured her in the past. For example, some of the footpaths created many additional risks for her, and she was reminded of these when she carried out her daily

walking routines. Her mobility restricted her movement and there were routes that she would have liked to carry out and places she would like to visit, but felt they were now too far for her. The main reason for this was that public transport had become too challenging and uncertain for her to use. Unlike Eamon and Edith, she was much more impacted by weather conditions and how she felt on the day, highlighting how weather has both the:

> potential to comfort, invigorate and connect, but also to disorientate, threaten and isolate, at times supporting moments of wellbeing, at others exacerbating experiences of impairment and disability (Bell et al., 2019, p.270).

There was a clear sense of her activity space reducing over time. However, it was not in a uniform way, as certain activities were prioritised over others, using taxis to occasionally extend beyond her immediate environment. Like Edith, Dolores demonstrated remarkable determination and spirit to get out and about because it was so important to her. However, sometimes this resulted in her pushing herself into situations where she had to be particularly "brave" and confront risks that might easily have been minimised through considerate and age appropriate design. Getting out and about therefore, led to a sense of regret, a lucky escape, or a story to tell. Sometimes it created a dent to her confidence and served as a reminder to make adjustments. And unfortunately, sometimes it led to serious incidents and injuries that forever changed the way she got out.

7.6 Conclusion

The ease with which Edith, Eamon, Moira and Dolores were able to get out and engage in meaningful projects was influenced by the interaction of a number of personal and environmental factors. To obtain a true sense of the factors that influenced getting out and about, it was necessary to consider the interaction between the individual's existing capacity, what was important to them, as well as the extent to which the physical and social environment supported their attainment of personal projects and meaningful activities. As has been shown through these lifeworlds, both personal and environmental characteristics were dynamic, and interacted in complex ways. They were also highly varied; indeed what was a barrier for one person served as a motivation to get out for someone else. This has important

implications for how we conceptualise and define age friendly environments and support older people to age well in place, which I will discuss further in the next chapter. Whilst objective characteristics of the physical and social environment are important to consider, we must also take into consideration the way that older people view and navigate their local environment through the lens of their existing capacities and priorities, which has in turn been shaped by the environments they have lived over a lifetime.

Of particular note here, is that for individuals who found it challenging to get out, it was no less valued. As demonstrated by Dolores, even when there were additional challenges, risk or stress that came with getting out, she still sought to get out in some instances and had decided on certain activities that were still important enough to get out, whilst others had been let go. This demonstrates both remarkable determination, resilience and strategic decision making abilities (also shown by Ewart and Luck, 2013; Gardner 2014; Holland et al., 2005). This was because the activities, interactions and places that lay beyond her home gave her wellbeing benefits that outweighed the risks. Whilst engaging with *some* risk is a natural part of everyday life and can even contribute to a "sense of dignity" (Marsh and Kelly, 2018, p.297), I can't help but wonder whether there might have been some relatively simple interventions that would have meant that she did not have to engage with such *high* risks for her, so that she could continue to exercise the right to engage with what mattered most. I now consider what approaches and supports might help older people in Ireland to age better in place.

Chapter 8. Discussion and Conclusion

8.1 Introduction

The overall aim of this thesis was to explore older adults' lived experiences of ageing well in place; specifically, how individuals engaged and interacted with their local physical and social environments. The research design was a detailed multi-stage qualitative and geo-spatial approach, involving the use of focus groups, interviews, mapping exercises and go-along interviews (in-situ methods). In the first empirical chapter (Chapter 5), I examined how participants defined a good quality of life (RQ1), focusing in on how important getting out and about was for this. This led me to conceptualise and define ageing well in place through a new conceptual model of ageing – *as well as you can* – in place, which focused on the importance of being able to get out and about to carry out meaningful or important activities.

Whilst getting out and about was valued, the way that individuals engaged with their local physical and social environments, as well as what was important to them, was extremely diverse. In Chapter 6, I provided an overview of the key places, routes, routines, activities, and interactions of importance to my participants whilst out and about (RQ2). Overall, shops, banks and post offices (aspects of a typical high street), green and blue spaces, as well as the places where social groups were held, were the most highly referenced place categories and social interaction was the most highly referenced activity. Owing to the importance of social interaction whilst out and about, in Chapter 6 I presented my participants' experiences of social interaction (or lack of it) in different phases of getting out and about: when they left their homes, whilst travelling, and when they arrived at destinations to carry out regular and scheduled activities. The activities and destinations I focused on were attending social groups within community centres (or related buildings) and attending Mass at their respective local churches. In Chapter 6, I also explored individual barriers or enablers that influenced their ability to carry out personally meaningful projects; in this chapter the focus was on social interaction in particular (RQ3). Results demonstrated the importance of scheduled and regular activities to provide reasons to leave the house, give a sense of purpose and to provide guaranteed forms of social interaction. This led to deepening relationships and often provided additional reasons

to get out through trip chaining, either immediately after the activity or later. Results highlighted the importance of the social environment and the role of social support from neighbours, family members or friends and how this influenced place attachment, belonging and perceptions of safety whilst out and about. They clearly showed that this was not a uniform experience and there were marked differences in the experience of social interaction across participants.

In Chapter 7, instead of focusing on the collective experience of my participants, I focused on four individuals who had identified health and mobility challenges, Edith, Eamon, Moira, and Dolores. I presented a spatially referenced account of their lifeworld as an annotated map and story, identifying what was of most importance to them for a good quality of life (RQ1), the places and activities that were of most importance to them (RQ2) and the extent that they were able to age well in place by engaging meaningfully with their local physical and social environments. I demonstrated how valued functionings and independence were negotiated over time in response to health or mobility challenges (RQ3).

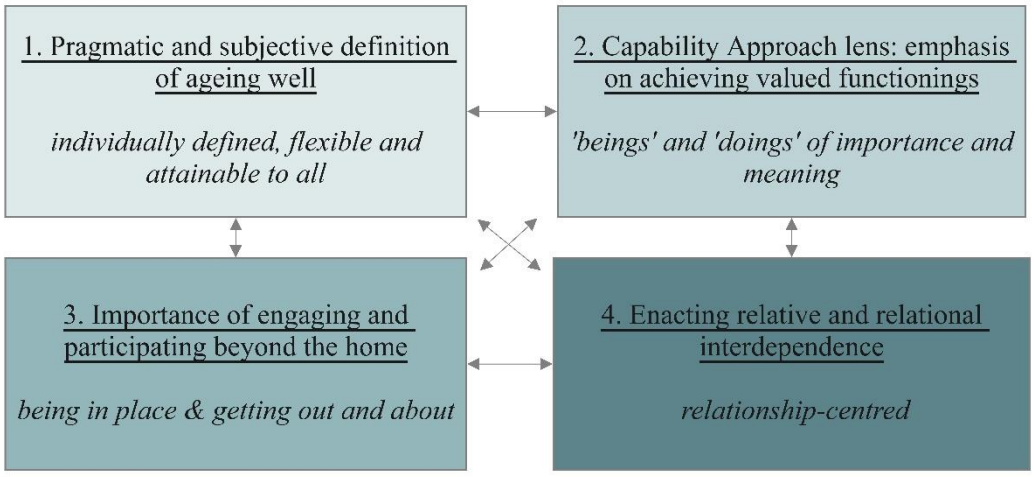
In this final chapter, I situate my findings in relation to existing literature and consider the implications of what I have found. In Section 8.2, I present and further develop the theoretical model I have developed for this thesis: ageing – *as well as you can* – in place. I provide an overview of its four components and situate these components in relation to existing literature. In Section 8.3, I outline two key recommendations that geographers and planners could implement to support older people to age – *as well as they can* – in place. Finally, in Section 8.4 I reflect on some of the challenges and limitations of this research, including a reflection on the Covid-19 pandemic.

8.2 Ageing – as well as you can – in Place

The main conclusion reached through my empirical findings was that participants defined quality of life and ageing well in place subjectively, according to what was of most importance to them and based on their existing person-environment context. From this, I have developed a lay-informed theory of ageing – *as well as you can* – in place. This is a relationship-centred model that integrates the concepts ageing well

and ageing in place through a Capability Approach lens. It has four interconnected components (see Figure 8.1). The first component is a pragmatic and subjective definition of *ageing well* (used interchangeably with quality of life). This is individually defined, with an emphasis on doing the best you can, for as long as you can, based on individual capabilities and circumstances at a given point in time. It continually meets individuals where they are at, meaning it is inclusive, dynamic, and attainable for all. The second component of this model is an emphasis on achieving *valued functionings*, i.e. the "beings" or "doings" of everyday life that are important or meaningful to an individual (Sen, 1993). The third component of this model recognises the importance of participating and engaging beyond the home to feel and be *in place*. Finally, the fourth component builds and connects the ideas of enacting relative independence on the one hand, with the importance of the social environment on the other, to highlight how *interdependence* plays a vital role in shaping the experience of ageing well in place.

Figure 8.1 Ageing – as well as you can – in Place



The "as well as you can" part of this theoretical model was underpinned by existing literature critiquing objective definitions of ageing well (see Section 2.3 in Chapter 2). The particular phrase was presented by one of my participants from Focus Group 1. When I asked them what they thought terms such as healthy or successful ageing meant to them, they stated:

> I suppose as we are getting older our quality of life depends on how our health is, you know, it is very important to keep yourself *as well as you can*

> [emphasis added] and as positive in your thinking. (Participant from Focus Group 1)

I felt this statement represented what my participants overall were telling me: the importance of having realistic and attainable definitions of ageing well and a good quality of life. This quote also highlighted that in lay definitions, there is considerable overlap between these terms. Of all the participants, Edith was the most influential in developing this theory, when she stated:

> It might not be living to other people, but to me it's living. (Edith)

Existing research has argued that objective definitions of ageing well can leave the majority of older people feeling like failures, putting pressure on those with health and mobility challenges to reach a goal that is not possible for them (Stephens et al., 2015; Stephens, 2016; von Faber et al., 2001; Jeste et al., 2010). Edith alludes to these high standards and that she may be falling short in some way, yet all I could see was her strength and courage after receiving a life-changing health diagnosis. I was particularly struck by her attitude, her resilience, her caring nature towards others, her determination to continue carrying out her most valued activities and her appreciation of a "good day". She was ageing as well as she could.

8.2.1 A pragmatic and subjective definition of health and ageing well

When asked to define a good quality of life, many participants identified that "having their health" was very important to them. However, health was very differently defined by participants and often this was in accordance with existing abilities. There was little evidence of expectations similar to the traditional World Health Organisation definition of health (World Health Organization, 1946, p.1) as a "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". Instead, the way that participants defined health was pragmatic, rather than perfect. For those living with health and mobility challenges, they wanted to age as well as they could for as long as they could, recognising and accepting that the ageing process was likely to result in some reduced capacities, slowing down, or re-negotiation of expectations. But what did matter to participants, was that their health was good enough to still be able to do what was important to

them. The importance of more pragmatic and nuanced definitions of health have been found elsewhere in research examining ageing well and quality of life of older people through a Capability Approach lens (Gilroy, 2006; Stephens, 2016).

These findings align with Huber's (2011) alternative definition of health, which is more appropriate for individuals living with health or mobility challenges and is defined as the "ability to adapt and self manage in the face of social, physical, and emotional challenges" (p.1). Whilst there were some common themes identified, which aligned with existing literature on quality of life (discussed in Chapters 2 and 5), overall, my results demonstrated that lay definitions of a good quality of life are extremely diverse, reflecting the heterogeneity of the older adult population. Furthermore, they do not necessarily align with clinical or validated measures or ideals of quality of life, health or ageing well. This empirical work adds to existing research that has argued for the need to also consider and define ageing well, in particular healthy ageing and quality of life, through a subjective and lay-person lens (Cosco et al., 2013; Bowling and Gabriel, 2007; Bowling and Iliffe, 2006; Fernández-Ballesteros et al., 2008; Richard et al., 2005). Examining perceptions of a good quality of life, it becomes apparent that quality of life is more a "process", than a "fixed state" (Scott et al., 2009, p.134).

8.2.2 A Capability Approach lens: emphasis on achieving valued functionings

Health and mobility were important to older people because they enabled functioning and flourishing. However, for those constrained participants, they still felt it was possible to have a good quality of life, providing there were adequate and individually defined supports in place to achieve their valued functionings. This was illustrated by Edith, Eamon, Moira and Dolores in Chapter 7, who all had clear and realistic ideas about what a good quality of life or a good day meant for them. These findings align with existing research that has examined and defined health and ageing well using a Capability Approach. Such research has defined health, not as the requirement to achieve good physical health, but "the capability to continue to do valued things in later life" (Stephens et al., 2015, p.729), or the "abilities to be and do things that make up a minimally good, flourishing and non-humiliating life" (Venkatapuram, 2011, p.20). Such an approach recognises that "a person's well-

being or quality of life is located in the opportunities that they have to lead the life they value" (Stephens, 2016, p.4). This definition of health and wellbeing is far more attainable and importantly, can still be achieved with physical decline. This work therefore adds weight to existing research that has argued for the need to consider ageing well, wellbeing and quality of life through a Capability Approach lens. However, the model of ageing – *as well as you can* – in place adds an important contribution to existing work, which is the consideration of *where* these valued functionings occur.

8.2.3 The importance of being and feeling - in place: getting out and about

The third component of the model recognises that getting out and about and being *in place* matters to older people. I define this as both physically *being in their most valued place(s)* (i.e. getting out and about) but also *feeling in place*, which connects more to intangible feelings or emotions about a neighbourhood, including sense of belonging, place attachment or feeling safe and secure (Rowles, 2018). The research findings and theoretical model align with existing work that has argued for the need to consider the broader than home environment of older people when examining experiences of ageing in place (Wiles et al., 2012). Participants identified and valued a number of places, activities, interactions, routes and routines that they carried out (functionings), which involved leaving their homes. As a result, being able to get out and about in meaningful or important ways, was an important component of ageing *well* in place. Furthermore, the attainment of this was important to feel in place. The importance of place for a good quality of life in old age is by no means a new idea; it is one of the key principles within health geography and geographical gerontology. Gilroy (2008) has argued that older adult "well-being is determined to a significant degree by quality of place" (p.146) and that the quality of an older person's home, neighbourhood, as well as their mobility between the two, is vital for a good old age.

Examining the importance of place for a good quality of life through a Capability Approach lens, all participants identified valued functionings which required getting out and about in some form. Getting out and about was a valued functioning in and of itself for most participants. As a result, getting out and about was either directly or indirectly important to all participants within this research project. Both Gilroy

(2006) and Meijering et al. (2019) have identified specific capabilities and functionings important to older people and have emphasised the role of the physical and social environment in supporting older people to achieve these functionings and capabilities. Broadly, there was considerable agreement of the valued functionings identified by (Gilroy, 2006) and (Meijering et al., 2019), and those identified by my participants. For example, the importance of independence, being mobile, engaging with others and the importance of a safe neighbourhood in which to enact independence through mobility were shared findings. Where this work differs from existing work, is that I have spatially grounded valued functionings with the use of geo-spatial approaches and provided annotated maps to illustrate *individual* experiences of this. In particular, I have shown how a valued functioning such as independence, may be defined very differently by an older person, depending on their person and environmental context. This work therefore adds to existing research through a geographical application of the Capability Approach. In particular, I have shown where these beings and doings take place, how they are negotiated by older people throughout their daily lives, as well as the individual barriers or enablers (or resources) that may support people to achieve their particular set of capabilities.

8.2.4 Connecting with others: Enacting relational and relative interdependence

This thesis has contributed to the empirical understanding of why getting out and about was important for a quality of life and ageing well. Existing research has stated that it is generally accepted that getting out and about is important to older people (Holland et al., 2005). The empirical findings within this thesis show the nuances within this assumption and provide insight into why this is the case. I argue that the overarching reason that getting out and about was important to my participants is firstly, it was the physical enactment of independence and secondly, because it allowed my participants to connect with others. I have combined these two ideas within this section through the concept of interdependence.

The idea of independence is often identified as a policy priority, particularly within more individualistic societies. As shown by this research, it was valued as a vital component of a good quality of life and ageing well in place by many of my

participants. Within a Capability Approach to older adult wellbeing, freedom or independence is regularly cited as the overarching valued functioning (Meijering et al., 2019; Sen, 1993). Within Chapter 5, I revised my theme relating to independence to label it *relative* independence, recognising the different ways it was conceptualised by participants with differing capacities. The idea of relative independence connects to Hillcoat-Nallétamby's (2014) work, who has argued that policymakers need to shift away from an "oversimplified dichotomy between independence and dependence" and instead recognise the more "dynamic" nature of relative independence (Hillcoat-Nallétamby, 2014). Furthermore, Ball et al. (2004) have identified strategies older adults have employed to maximise their independence. An important component of this was redefining independence over time to align with what they could currently attain. This suggests that older people have more pragmatic and flexible definitions of independence, as well as ageing well and health. In particular, what constitutes independence for one individual may be perceived as dependence by someone else (Wiles et al., 2012).

This research has confirmed the importance of independence but has also highlighted the diversity in how it was conceptualised and negotiated by individuals over time. Many of the ways that it was conceptualised by my participants has been found in existing literature. In a study examining the *meaning* of independence for older adults in assisted living, residents emphasised a strong desire to remain autonomous and physically independent (Ball et al., 2004). Furthermore, independence had multiple dimensions and emphasised certain beings and doings, such as: being self-reliant (being able to do some things for yourself), preserving individual identity by carrying out certain tasks, having valued roles and passing time in meaningful ways. Whilst my participants identified *independence* as being important to them, when this was examined further through their actions and everyday activities, what they described more closely aligned with the idea of *interdependence.* This has been found elsewhere in the literature (White and Groves, 1997).

The idea of independence versus dependence align with more objective and bio-medical definitions of successful ageing independence is an "ideal state" and dependence by its definition, insinuates a deficit or a failing in some way (Beeber, 2008; Bell and Menec, 2013; Breheny and Stephens, 2009; White and Groves, 1997;

Smith et al., 2007). Yet in practice, complete independence and autonomy, like successful ageing, are unrealistic and unattainable for most people (White and Groves, 1997). Interdependence, on the other hand, recognises that most people are dependent on others in some way, with most people relying on some form of social network or support (Beeber, 2008; White and Groves, 1997). Furthermore, independence in old age usually requires some support from humans, such as neighbours, friends or family members. It may also involve support from non-humans including pets, with a growing literature recognising the importance of pet ownership on mental health and wellbeing of older people (see McNicholas, 2014; McNicholas and Collis, 2000; Gee and Mueller, 2019; Hui Gan et al., 2020; Young et al., 2020). Furthermore, support may be obtained from assistive technologies and walkers (Goins et al., 2015; Schwanen and Ziegler, 2011), such that for the older people, as for so many others, the living body can be thought of as a "cyborg" or more-than-human, a composite of both living organism and machine technologies (Andrews and Duff, 2019; Joyce and Mamo, 2006). Interdependence recognises the "contribution and assistance of others" and the vital role that this plays in supporting older people to be independent (White and Groves, 1997, p.86). As Wiles (2018, p.36) argues:

> for governments to encourage healthy ageing in place requires much more than simplistic rhetoric around independence and autonomy. Such rhetoric is often framed in highly individualistic, middle-class and middle-aged terms and fails to recognise that in fact all of us are interdependent and that concepts like 'autonomy' can mean quite different things in varying social and cultural contexts.

Flexible or "fuzzy" conceptualisations of independence that aligned more with interdependence were commonly demonstrated by my participants (Schwanen et al., 2012, p.1313). For instance, Nuala, at aged 89, wanted "a little bit" of independence and her family provided her with social supports so that she could get out and act in a relatively independent way. Meanwhile, Eamon was happy to attend his dementia day care social group and take the minibus to this, as well as give talks about his experience of Alzheimer's. However, he preferred to attend these via public transport himself. In this way, both Eamon and Nuala were interdependent but still able to express choice and agency in how they spent their time outside of the home;

for example, by attending valued social groups several times a week. They were also able to decide which areas of their lives they would like support and which they wished to maintain independently. In this way, they were still able to assert some autonomy and claim that they were relatively independent. This confirms existing literature that has found being able to have *some* choice and agency, or the "right to mediate and control their decision making" is a vital component of independence whilst ageing in place (Wiles et al., 2012; Ball et al., 2004; White and Groves, 1997 p.87). Ball et al.'s (2004) participants emphasised the importance of having some choice and autonomy and avoiding dependency by accepting some help but importantly, refusing it where they could.

This research has confirmed that for most participants, independence was relational and often negotiated with others. Many participants expressed that they did not not wish to be a *burden* on others. This has also been found elsewhere on literature on ageing and independence (Ball et al., 2004; Bell and Menec, 2013; Hillcoat-Nallétamby, 2014; Schwanen et al., 2012). It was important to many of my participants that they were still able to contribute towards helping others, in addition to receiving supports. For example, Edith was grateful for the social supports at her community centre to assist with getting her walker out of the car, yet she also liked to give to others in other ways by providing friends with a lift and looking out for her neighbours. Both Edith and Eamon demonstrated how important reciprocity and altruism was to them, because it helped them to be involved and connected. Reciprocity was an important part of their identity and helped them to feel good about themselves and their communities. The importance of altruism, reciprocity and helping others has also been identified as important in research on older adults and independence and is a key component of interdependence (Ball et al., 2004; Bell and Menec, 2013; Hillcoat-Nallétamby, 2014). In particular, research has shown that participants are more willing to accept help and not perceive themselves to be dependent, if they are able to reciprocate in some way (White and Groves, 1997).

This research has demonstrated the important connection between an individuals' social environment (including social supports) and the ability to maintain independence through forms of interdependence. These findings connect with a large body of literature that has examined the importance of the social environment for

older people. An important finding was that my participants were able to compensate for more objectively unsupportive environments or declining mobility through social supports. Existing research has found that older people themselves recognise the need for social supports to remain independent and that a lack of social supports can lead to social exclusion (Bell and Menec, 2013). This recognises the importance of the social environment as an important component of ageing well in place, in particular literature that emphasises the *relational* nature of this (Lager et al., 2013; Lager et al., 2015). Owing to the importance of the social environment, in particular social supports and social interaction found within this thesis, I revised the model of ageing – *as well as you can* – in place from what was initially a person-centred approach, to a relationship-centred approach. This is based on Nolan et al.'s (2004) critique of person-centred care, who argue that such approaches can ignore the importance of interactions, relationships and interdependence.

8.2.5 Summary

The research for this thesis has allowed me to conceptualise what ageing – *as well as you can* – in place meant to older people themselves. A key thread throughout this model is to recognise the diversity of the older adult experience and how they define ageing well in place, based on their differing personal-environmental contexts. I have demonstrated the fluidity of lay conceptualisations, in terms of how complex concepts such as health, quality of life, ageing well and independence are understood. Yet what shone through this data was the importance my participants placed on *connection*:

> So the bottom line is that we need connection, connection to people, connection to facilities, connection to what we need. (Participant from Focus Group 4)

My participants valued being connected with themselves, they valued relationships and being connected to others, such as friends, family, neighbours, acquaintances, and animals. They valued being connected to something bigger than themselves and having a higher sense of purpose and belonging through their activities. This included connection to place, community, to nature, and in some instances religion.

As a result, they demonstrated what Weathers et al. (2016) would define as spirituality:

> Spirituality is a way of being in the world in which a person feels a sense of connectedness to self, others, and/or a higher power or nature; a sense of meaning in life; and transcendence beyond self, everyday living, and suffering (p.93).

In the next section, I consider the following question: how can geographers and planners support older people to age – *as well as they can* – in place?

8.3 Recommendations: how can geographers and planners support older people to age – as well as they can – in place?

Supporting older people to age – *as well as they can* – in place, as opposed to ageing in place, requires a different response because of the emphasis on subjective experiences of what matters most to people. As a result, there is no "one size fits all" approach that will support older people to age *well* in place (Hammond and Saunders, 2021, p.10). As my own background is in planning and geography, within this section I consider what these disciplines can do to support older people to age – *as well as they can* - in place. I have two overarching recommendations, informed by my findings, existing literature on ageing, wellbeing and environment and drawing from my own experience working as a Planning Policy Officer. The first recommendation focuses on how geographers or planners could support individuals to age – *as well as they can* – in place, building on Finlay and Rowles (2021) ideas about *clinical geography*. The second recommendation looks at more of a neighbourhood and structural level and considers how to prioritise and incorporate more wellbeing into the design of age friendly environments.

8.3.1 'Person-in-Environment' Interventions for Ageing Well in Place

Recommendation 1: Support individuals to age – as well as they can – in place through person-in-environment interventions

A key component of supporting individuals to age – *as well as they can* – in place, is to ensure that they continue to feel and be *in place* by recognising the importance of

getting out and about to older people. A promising new sub-discipline within geography, that could be utilised to prioritise this, is the idea of *clinical geography*. This involves applying geographical or spatial knowledge and working directly with individuals, in order to co-produce and apply "person-in-environment" interventions (Finlay and Rowles, 2021, p.2). A key goal of this is to support people to physically be and feel *in-place* (Rowles, 2018), which can in turn enhance health and wellbeing. Clinical geography operates at the scale of the individual within the context of their immediate environment. This aligns well with the principles of ageing – *as well as you can* – in place because it is inclusive and involves "meeting people where they are at" both physically and psychologically through its person-centred approach (Registered Nurses' Association of Ontario, 2010). However, for the reasons explained earlier, I would extend the ideas of person-centred to more of a "relationship-centred" approach. As a result of its person-centred approach, it is built on a recognition of the subjectivity and heterogeneity of individual experience and the uniqueness of a persons' "history, abilities, needs, and preferences", as well as an awareness that this will change over time (Finlay and Rowles, 2021, p.2). Clinical geography goes beyond and complements traditional person-centred care, which would typically focus on home supports and be delivered by health practitioners such as nurses or occupational therapists. Instead, it broadens the scope, allowing for greater consideration to be given of the neighbourhood elements of ageing in place.

On a practical level, this involves working with individuals to identify their "person-in-environment challenges and opportunities" as well as determining their "priorities and preferences" (p.3). Of relevance for this thesis, is their suggestion of developing "strategies to get outside the home" (p.6). I see great potential in clinical geography and think it could be applied to support and empower older people to navigate what ageing – *as well as they can* – in place means to them and to then help them attain it. For example, geographers can help older people identify what matters most to them; where they have resources and may need support; and co-produce strategies that will help them to stay connected and engaged. It can help individuals be proactive about potential challenges that may arise as part of the ageing experience and develop a plan that works for them, receiving support when needed to remain inter-dependent, autonomous, and well within their communities. This will help to ensure that individuals can continue to make decisions and remain in control of their lives, as

well as feel comforted and reassured, knowing they are doing the best they can. An important area of future research will be the trialling of clinical geography approaches. This could involve working alongside health and social care practitioners, developing and evaluating the success of "in-environment" interventions to improve older adult wellbeing. However, it will be vital that measures of success reflect what is important to older people themselves.

This section has provided recommendations at the individual level to provide them with increased agency, but alongside this, it is vital that we consider the broader structural context and the unequal nature of the ageing experience. In particular, there is a need to think about the way we plan and design our built environments to ensure that wellbeing is prioritised.

8.3.2 Prioritising Health and Wellbeing in Urban Planning and Design

Recommendation 2: Prioritise mental health and wellbeing in urban planning by focusing on reducing health inequalities and social exclusion.

Whilst my research confirmed that getting out and about was vital to my participants sense of ageing *well* in place, there were marked differences in the extent that their local environments could be considered supportive. When opportunities were available and it was safe to do so, my participants highly valued social interactions with others, engaging with nature and moving through their immediate local environments. However, my research also identified instances where it was not safe for my participants to get out and about and how this produced risk, fear and in some instances, avoidant behaviour. This impacted negatively on my participants' ability to engage with their local environments in meaningful and restorative ways, feel a sense of belonging and place attachment within their communities, and feel independent. This in turn, negatively influenced their wellbeing, quality of life and their overall experiences of ageing in place.

To provide supportive environments for ageing *well* in place, we need to prioritise aspects of the physical and social environment that are restorative and provide more *quality* of experiences for older people. There is a large body of literature that has examined the ways that local environments can influence health and wellbeing. This

includes extensive research and theory within the disciplines of health geography, including the concept of therapeutic landscapes, as well as within healthy urban planning. Returning back to the idea of the *Restorative City* framework developed by Roe and McCay (2021) and introduced in Chapter 3, there are two pillars that have relevance for this recommendation on reducing health inequalities and social exclusion. The *neighbourly city* recognises the importance of the social environment for quality of life and wellbeing. If we want to provide supportive environments for ageing well in place, planners must value and prioritise the social environment. This includes providing greater opportunities for older people to participate and engage with others, which in turn will foster deeper social connections. This requires a need to pay attention to the subtle and softer details of local environments and is a much "quieter" approach to urban design, which "assigns importance to the smaller signatures – the settings for 'episodic' moments of city life" (Roe and McCay, 2021, p.2). This includes moments such as spontaneous social interactions, which were so important to my participants throughout this research and which have also been identified in existing research (Gardner, 2011; Fingerman, 2009; van Eck and Pijpers, 2017; Finlay and Kobayashi, 2018). The best way to design a neighbourly city is to build a variety of forms of social infrastructure, providing opportunities for people to engage and interact within the various phases of getting out and about.

A key recommendation of my thesis therefore is that we need to invest more in the *quality* of our physical and social environments. As Gilroy (2006) notes:

> If our policy goal is to improve quality of life by supporting independence and involvement in the community then meeting a friend for lunch or going to look at the spring flowers needs to be taken as seriously as getting to a hospital appointment (p.351).

Connecting back to the findings from Chapter 6, providing supportive environments for older people to age well in place involves paying attention to features of the built environment that influence whether social interaction happens. This includes the orientation of gardens, the provision of safe, accessible walkable communities where people can pause along the way and with a variety of destinations, activities, and reasons to get out for all ages and interests so that lifelong habits can develop. This also connects to elements of the playable city, another pillar of the *Restorative City*

framework. Supportive environments require community centres and third places to host a range of social groups and provide people with reasons to leave their homes. They require safe transport provision to support older people getting to and from these valued places with reduced risks. They also requires paying attention to the location and grouping of destinations, so that they provide opportunities for trip chaining. This elevates the importance of our high streets and how they are so much more than a place just for shopping (see Fullilove, 2020). Finally, supportive environments require green and blue spaces and public realm that are invested in and are well-maintained, so that people feel safe and comfortable talking to others. This will build social capital and deepen social connections.

The importance of social participation is already accepted within policy, and is one of the eight domains of an Age Friendly Environment (World Health Organization, 2007a). However, planning policy has been slow to respond to the age friendly and healthy environment agendas. This is partially due to the lack of integration of health and planning within policy and practice, despite calls for them to be "re-united" (see Chang and Ross, 2015). Whilst there has been some progress, significant challenges remain. A key one is that there remains a lack of *prioritisation* placed on healthy urban planning within governments, compared with economic growth (Chang and Ross, 2015). This has led to "tokenistic" references within planning policy, rather than significant and much needed change (Carmichael et al., 2016).

As demonstrated throughout this thesis, critiques of the Age Friendly Environment model have highlighted that the movement has not addressed the unequal and diverse experiences of ageing in place (Hammond et al., 2020; Buffel et al., 2018; Finlay and Finn, 2021), with those living in "difficult" or "unsuitable" places at increased risk of social isolation and spatial exclusion (Scharf et al., 2007; Severinsen et al., 2016). A strength of a Capability Approach to ageing well in place, is that it allows for the consideration of the role of inequalities, by exploring how different resources can influence the ability to achieve capabilities (Meijering et al., 2019). Meijering et al. (2019) argue that independence is intrinsically related to an individual being able to exert their agency and convert a resource into a functioning and that this differs considerably between individuals in differing contexts. For example, someone living in an unsupportive environment may be able to overcome the specific barriers of

this, by ordering a taxi instead of taking public transport when this becomes too difficult. However, this requires money, which may or may not be available.

Through examination of individual lifeworlds, it was possible to identify the specific challenges that individuals face as they get out and about, and the ways that they negotiate and manage this, drawing on a variety of resources if they have them. This research complements Meijering et al.'s (2019) work and contributes to it by showing the way that these negotiations vary depending on the activity in question. Even when an individual potentially has the resources available, they may not choose to use it for some activities and may prioritise some activities or projects over others. As shown by Dolores, the activities that may get dropped are those that may be perceived as more indulgent (such as visiting a beloved garden) rather than necessary (such as a hospital appointment). I would question why one needs to be chosen over the other, if we value the quality of life of older people then we need to support both. Findings raise the importance of interventions that incorporate elements of "social prescribing", which could potentially provide benefits for health and wellbeing for those individuals that may need additional support with engaging (see Hamilton-West et al., 2020; Woodall et al., 2018). However, the success of such interventions would be influenced by whether there is adequate provision of services available to begin with, whether they match with older adults interests and whether there are adequate supports getting to and from these places, recognising the specific needs of the individual.

Overall, older people living in the most unsupportive environments with the fewest resources will find it most challenging to age well in place. This was demonstrated by Moira; she was the youngest of all my participants, lived in the most unsupportive neighbourhood and had few resources to compensate for this, resulting in her not feeling like she could be independent and was instead reliant on others. Her lack of social supports, her declining mobility, combined with perceived environmental barriers connected to distrust of her neighbours, meant that she struggled to carry out valued functionings and was not ageing as well as she would have liked. The quality of the local environment and the extent that it can be restorative is an under-recognised and under-appreciated *resource* for wellbeing and for ageing well in place. It is important that we recognise this within planning policy so that we can

identify “thin” places and intervene to provide “thick” places where necessary (Duff, 2010).

Recognising the subjectivity of experience of ageing well in place, raises the importance of including older people within the planning process, as they are the experts within their local communities and lives. In order to provide more restorative environments for ageing well in place, first we have to determine what that looks like in a particular local context. This cannot be done without engaging older people. It is therefore vital that we conduct more participatory research and community engagement within planning policy to ensure that age friendly interventions are locally appropriate. There is already excellent research that has led the way on this and provided excellent guidance on co-designing with older people (Handler, 2014; Buffel and Phillipson, 2018; Hammond and Saunders, 2021; Hammond et al., 2020; Doran and Buffel, 2018; Buffel, 2018). To understand the different experiences and needs of diverse population groups, requires *alternative* research designs (Handler, 2014) and methodologies that are more qualitative, creative, spatial and participatory, such as those included within this thesis. For those groups who are more disengaged and disempowered from the planning process, additional efforts will be required to ensure that their perspectives are heard.

8.4 Reflecting on the Challenges and Limitations of this Research

Within this section I reflect on some of the main challenges and limitations of this research. I focus on go-along interviews as a method, recruitment and sampling limitations, as well as Covid-19 implications.

8.4.1 Carrying out go-along interviews

Go-along interviews provided valuable insight into my participants’ experiences. They captured aspects of lived experience and context that would not have been possible with the use of traditional interviews. This was the first time I had used go-along interviews as a research method and so I want to offer here an honest and critical appraisal of the method, which I often feel is missing in journal articles and books. Carrying out go-along interviews with older participants with diverse needs

was not easy. It required empathetic and sensitive caring skills to match the participants' pace and needs. Adopting a more care-full approach was more emotionally draining than traditional approaches. I had not anticipated the level of responsibility and concern I would feel towards my participants during the go-along interviews and sometimes this lasted well after the interview, particularly when they experienced challenges.

I tried to balance the potential risk of taking part in go-along interviews with the right to participate and to carry out inclusive research and the right of older people to engage with some risks as part of their daily lives (Marsh and Kelly, 2018). I managed this by making the go-along part optional and asking participants to do what was normal or manageable to them at that moment. As a result, I would not expose them to any additional risks than they might experience as part of their everyday life whilst out and about. However, I had not anticipated how I would react when I carried out go-along interviews where I perceived the risks of their usual behaviour to be greater than they did. Sometimes it was only after the go-along interview that I reflected on the journey and questioned whether they were pushing themselves for my benefit or using me as a 'crutch' themselves for their own benefit. Would they have gone out in the same way had I not been present? And did I make them feel safer than was usually the case? It was not always easy to obtain a sense of what was normal to a particular participant during the interview and to navigate these "ethical tensions" (Marsh and Kelly, 2018, p.297).

Go-along interviews are far more time-consuming than traditional interviews and the interview transcripts are much harder to analyse and transcribe because they are conducted in the 'real world'. In my three-hour cycling interview, I lost a significant proportion of the conversation because we cycled along a very windy path and had to rely on my field notes after the event. Reflecting on the experience of conducting go-along interviews, I feel that more care-full approaches are needed for both researcher and participant whilst carrying out these methods, particularly as they are growing in popularity. As researchers we need to have more honest and critical discussions about the challenges of carrying out these methods. I think that better ethical and safety protocols, training, and support could be developed for researchers to navigate ethical dilemmas whilst in the field, as well as recognise the emotional challenges

that this type of fieldwork can bring (Punch, 2012). The RGS-IGB Geographies of Health and Wellbeing Group ran a 'Hack Day' in July 2018 led by Sarah Bell, Ronan Foley, and Andrew Powers on the topic of In-Situ Methodologies. This was a valuable space for researchers to come together and discuss some of these issues and led to a co-authored paper on the subject (see Foley et al., 2020) and I hope these important conversations will continue.

8.4.2 Sampling and Recruitment

My recruitment process involved trying to obtain maximum variation (Tashakkori and Teddlie, 2010). I took several steps to diversify my older adult population (discussed in Chapter 4), yet some of these were unsuccessful, reflecting the challenges of engaging with harder to reach population groups. As a result, there are noticeable absences within my sample. This includes participants who are homebound. As a result, I cannot comment on how getting out and about was perceived by those who could no longer attain this and how they felt about this. All but two of my participants (David and Dolores) attended a social group of some kind and Dolores was on a break with her group for the summer. The importance of social groups comes through because my participants engaged with these. However, I do not have perspectives from older people who do not use them and why this might be. Most of the participants attended social groups with an older adult focus, apart from (Michael), who stated that he avoided these groups, because he did not like engaging with groups where everyone was older; instead preferring groups based on activities for all ages. This is important to note, because the growth in older adult social groups within Ireland has been a relatively recent development. Whilst my participants enjoyed attending these groups, they will not work for everyone. Some people may actively avoid them, feel excluded from these groups, or might wish to attend but are prevented from doing so for several reasons.

The diversity of my sample was limited, in that all participants were Irish. Future research could therefore seek to engage with population groups who have not been represented within this thesis, to examine what ageing – *as well as you can* – in place means to them within their specific contextual and the challenges to achieving it. This includes older people who are: homebound, not attending social groups,

members of the travelling community, homeless, LGBTQi, migrants, and living in a variety of assisted living situations or institutional settings. Finally, my fieldwork was not longitudinal, it took a snapshot of my participants' lives at one moment in time. Owing to the importance of flexible and changing needs within the ageing – *as well as you can* – in place model, future research could follow the same participant over different seasons or throughout several years, to explore how their definitions change and how they negotiate different beings and doings that were of importance to them in response to lifecourse transitions.

8.4.3 Covid-19

This fieldwork was completed before the Covid-19 outbreak. As a result, I was not able to present empirical work about how this impacted the everyday routines of getting out and about. However, there has been research that has examined the lived experience of Covid-19. Results from this research have indicated that being locked down at home negatively affected mental health, producing "psychological parallels" with imprisonment and "unintended adverse consequences" (Dhami et al., 2020, pp.11-12). This was particularly the case for older people, who were advised to 'cocoon' or 'shield', owing to increased rates of hospitalisation and death for this age group. This approach was highly criticised as being ageist and homogenising the older adult population (Leahy, 2020). Findings revealed various coping strategies and adaptations made by older people (Finlay et al., 2021). The importance of routine "as a strategy to feel normal or purposeful in everyday life" (p.4) was identified, as well as getting out and about to get outdoors, engage with nature and exercise (Finlay et al., 2021; Guzman et al., 2021). This suggests that getting out and about remained very important, if not more important to older people throughout the pandemic.

Alongside evidence of resilience, coping and adaptation, there was also evidence of widening inequalities throughout the pandemic, with those older adults living in more deprived urban areas being disproportionately affected, as they were already experiencing disadvantage due to both social and spatial inequalities (Buffel et al., 2021). With restrictions of 2km and 5km throughout lockdowns in Ireland, the quality of the immediate physical and social environment would have significantly

impacted the ability to stay well during this time. It remains to be seen how older people re-engage with their local enviroinments 'post-Covid' and whether they are able to regain what might have been lost, or whether some activities may have changed for the better.

Buffel et al. (2021) have identified six age friendly principles to guide cities in their Covid-19 recovery. Of key importance is prioritising resources in the most deprived neighbourhoods, investing community-based services, such as social infrastructure and green spaces, and engaging older people in the design of these cities. Throughout the pandemic there have been many challenges, but it has also provided a chance to reflect on what is really important. We have witnessed unprecedented urban changes throughout this time, including the incorporation of many characteristics of healthy, active and restorative urban design, for example cycling lanes, widening footpaths and outdoor seating areas (Roe and McCay, 2021). I am therefore cautiously optimistic, that with so many global environmental and societal challenges currently facing us, that these incite the urgency we need to re-prioritise and focus on what matters most to us for a good quality of life. I believe, as my participants did, that this revolves around human connection in daily life. If planners, policymakers, researchers, as well as older people themselves were to prioritise this and work towards the goal of ageing or living – *as well as we can* – in place, it could lead to dramatic improvements in both our local environments and our quality of life. We know how to provide restorative environments, but it requires all of us to demand and value it for it to happen.

8.5 Conclusion

Increasing numbers of Ireland's ageing population will be cared for within their homes in the future, as policymakers adopt an ageing in place framework. The aim of this is for older adults to remain living within their homes and communities for as long as possible (Department of Health, 2013). Whilst this is often deemed to be what older people themselves prefer, it is important to recognise that the experience of ageing in place will vary, depending on the congruence between personal characteristics and values, and the social and physical environments that people age (Lawton and Nahemow, 1976). Rather than a blanket goal of ageing in place, I argue

that a far better policy goal would be to prioritise ageing *well* in place. Such a goal recognises that the experience and quality of ageing in place matters and might allow Ireland to achieve the goals set out within the *National Positive Ageing Strategy*, which were discussed at the beginning of this thesis. Rather than leaving individuals to their personal and contextual fates, it would allow us to consider what type of places promote human flourishing and quality of life and design these to support older people to live meaningful and engaged lives. To do this, it is necessary to meet older people where they are at, and offer person-centred solutions, recognising that this is subjectively defined by the older person themselves. In this research, I have shown that rarely is an older person's definition of ageing well in place perfect or static. Instead, it is instead good enough for them at that current moment and subject to change over time. However, a common goal for most older people, is to get out and about, to benefit from the variety of possible wellbeing benefits that leaving the home can provide. As a result, we must first listen to older people to find out what ageing *well* in place means to them at a particular place and time, and second, we need to bridge the gap where environments are not able to support an older persons' valued functionings. This will require person-centred solutions, to support older people to get out and about safely and enjoyably for as long as they may wish.

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Appendices

Appendix 1. Philosophical and Theoretical Underpinnings of the Thesis

Theoretical Underpinnings (from Chapters 1 and 2)

- Capability Approach (CA) lens to ageing well in place and quality of life - emphasis on subjective valued beings and doings that only an older person themselves can define
- Recognition of diversity and heterogeneity of older adult population, including whether older person has health or mobility challenges
- Recognition of broader determinants of health including the built and natural environment and how certain environments are more 'supportive' for ageing in place.
- Importance of broader than home environment and 'getting out and about' for a good quality of life
- Focus of inquiry: working class suburban places 'newly aged'

Ontology

- Both objective and subjective ways of knowing (multiple realities)
- Rejection of a purely objective truth, instead recognition of the diversity of experience and interpretations.
- Emphasis on lived experience, lay person definitions, and subjective ways of knowing

Epistemology

- Pragmatism
- Interpretivism
- Recognition that truth is impartial, incomplete, dynamic, and contextually bounded; methods capture a moment in time.

Methodology

- Qualitative Research Paradigm – 'Big Q'
- Emphasis on spatial approaches and 'in-situ' methods to capture qualitative details and experiences of place
- Informed by Qualitative GIS, recognising that spatial work can be Qualitative

Study Design

- Multi-staged and multi-method study combining qualitative and geo-spatial methods
- Flexible, 'care-full' and inclusive approach

Data Collection Methods

- Focus Groups
- Semi-structured Interviews

- Mapping Exercises
- ‘Go-along’ Interviews

Data Analysis Techniques

- Thematic Analysis
- Person-centred ‘lifeworld’ mapping and use of ‘geo-narratives’ to combine spatial and qualitative data

Appendix 2. Stage 1: List of Questions

Questions explored in the Focus Groups:

- What activities and interactions outside the home are important to you?
- Why are these activities important to you?
- Does your local area make it easy or difficult to do the things that are important to you?
- What do you think it means to live or to age well?
- How would you define quality of life?
- If you were researching this topic, what questions do you think might be important to ask, and who would you ask?
- Are there particular older adults that may be more or less restricted by particular environments?
- Are there issues that are of particular importance to people in Ireland?
- If you could tell policy makers or decision makers the things that would support you (or people you know), to live and age well, what would they be?

Appendix 3. Stage 2: Interview, Mapping Exercise and Go-Along Interview Schedule

(Page 1 of 3)

Interview Schedule

Main Interview

Introduction

- Have you ever done an interview before? *Set out what is to be expected, can stop at any time, longer than a survey, interested in your perspectives – so how you really feel about thinks, not what you think I might want to hear.*
- Could you start by telling me a bit about yourself?
  [Prompts if needed]:
  - Where are you from originally?
  - *If attending social group,* how long have you been attending this group?

Individual Interests / Hobbies

- What do you like to do?
- What are your hobbies and interests?
- What things are important to you?
- What are your hopes and aspirations for the future?

Local Environment / Neighbourhood

- How long have you lived here?
- Have you lived anywhere else?
- Could you tell me a bit about your neighbourhood?
- Can you identify some things that you like about your neighbourhood?
- Can you identify some things that you dislike about your neighbourhood?
- Do you think your neighbourhood has changed over time? If so, how?

Engagement with the Local Environment

- I would like you to think about a typical day in the last week – where did you go and what did you do?
- How important is it to you to get outside the house?
- How motivated do you think you are to leave the house?
- How much of your time do you think you spent outside of the home?
- How often would you leave the house?
- Are there particular times during the day when this happens?
- How do you think this might have changed from, say, five years ago?
- Have you had to adapt your behaviour at all during this time for any reason?
- Do you feel that you are ever limited by what you can do by your health?
- Are there any places that you might like to go but for some reason you are unable to?
- How often would you talk with people outside the home?
- Who would this be with? E.g. friends / family / neighbours / strangers?
- Where would this happen?

Mapping Exercise

Introduce participant to map of their local area

- I would like you to identify particular places that are important to you
- I would also like you to identify the places you have visited in the last month?
- Which of these places are most important to you and why?
- Are there any additional places that you would like go to but would find it difficult to get to?
- *[If yes]* - Why is this?
- Are there any places in your local environment that you dislike?
- Are there any places that you might feel uncomfortable and would avoid?

For each location:

- Why is it important to you?
- How do you get there?
- Was it easy or difficult to get there / Why could you not get there?
- Are there specific reasons for this?
- What route do you take to get there – please could you draw on the map
- How long are you there for?
- How often would you visit?
- What time of day is this?

Activity Space Boundary

- Please draw a boundary on the map to identify where you have been in the last month
- To what extent is this a typical month?
- Are there particular things that might have influenced the amount you get out and about?
    - E.g. Weather / Season / Ill-health?
- How do you think this boundary might have compared to say, five years ago?

Improving the Supportiveness of Local Environment

- Do you think your local environment supports you to do those things that are most important to you?
- How would you define a good quality of life?
- If you could tell policy makers or decision makers the things that would support you (or people you know), to live and age well, either now or in the future, what would it be?

Concluding Questions

[If hasn't come up in main interview]:

- Age?
- Member of **social groups** in past or now?
- Live alone or with people?
- Would you spend most of time with people or alone?
- Housing / **accommodation type**? How long have you lived here?
- Do you own, or have you ever **owned a car**? Or does your partner?
- Does your **health** ever limit what you would like to do?
- **Green spaces** – what do you think of them? Do you use them at all?
- **Weather** – does the weather ever influence you getting out and about?
- **Neighbours** – how often would you talk to them, what is your relationship with them?
- **Friends / family** – do you have people that you can count on if you needed to? Do they live close by?

Thank for taking part in interview, ask if they would also be willing to show me some of the areas you have been talking about in another short interview 'on the move'. This could be a walking interview or driving interview depending on your preference.
If no, ask about further recruitment – do they know of people who may be interested in taking part.

Go-Along Interview

- I would like you to show me some your local neighbourhood
- You can decide where to go and what to show me
- You might want to show me some of the places we have talked about that are important to you, or where you may have identified some challenges

Conclusion

Thank participant for taking part, ask if they have any questions and how they found the experience.

Further Recruitment

- Do you have any friends of neighbours that you think might also be interested in taking part in the study?
- Can I give you a leaflet to give them?

Appendix 4. Stage 1: Social Group Details

This table includes details about the community groups that participated in Stage 1: Exploratory Focus Groups.

Focus Groups (n=31)	Details about the Community Group
Focus Groups 1 and 3: Day Centre Group FG1: n=8 FG3: n=8	Run by the Health Service Executive (HSE) in Ireland, older people with health and mobility challenges living in the community were referred to this centre. Members attended at least weekly for a full day of activities, including art projects such as weaving, singing, card games, bingo, exercises, tea and lunch. The centre also had options to book appointments with health specialists and hairdressers on site.
Focus Group 2: Arthritis Walking Group FG2: n=6	Members attended a weekly meet up where they carried out seated class exercises and warm up, before walking (weather permitting) around the scenic grounds of a publicly accessible estate. Afterwards, members had tea and biscuits back at the community space and took part in line dancing.
Focus Group 4: University of the Third Age Group (U3A) FG4: n= 9	Members met weekly with the aim of enhancing social and educational opportunities. They organised and attended a range of activities and trips, such as visits to gardens, museums and historic houses.

Appendix 5. Stage 1: Invitation Letter

INVITATION TO PARTICIPATE IN A GROUP DISCUSSION EXPLORING HOW OUR LOCAL ENVIRONMENT INFLUENCES EVERYDAY LIFE

I am a PhD student interested in how where we live influences how we live. Our local environment can play a big part in how we go about our daily lives and whether we can do those activities that are most meaningful to us, and therefore contribute to our overall quality of life.

In particular, I am interested in finding out environmental features are important to people and how this changes over time. I would then like to explore how local environments can meet every day needs and wants.

This is the first stage of my research and I have been making contact with community groups, as I am looking for local perspectives to help inform the direction my research will take. Your advice and input is highly valued, as you are the experts of your local area. I believe it is very important that I get advice about how to research this topic from people that have experienced this first hand within an Irish context.

I would therefore like to invite you to take part in a group discussion (approx. 6-8 people). The discussion will last no longer than one hour and will be a one off event.

I will ask you a number of questions about what you think it means to "live well" and how our environment can at times help or hinder our ability to do this. I would like to know what characteristics of your local area are most important to you and what a supportive or unsupportive environment might look like. We will then have a discussion about how we can best research this. For example, what questions do we need to ask and what methods could we use to make sure that we understand how different people interact with, and are influenced by their local environment?

If you are interested in finding out more, please email or telephone me. I will be holding several of these group discussions as I am looking for a range of perspectives, so please share this with anyone that you think might also be interested.

Thank you, Hannah Grove | Email: Hannah.Grove@nuim.ie | Tel: 083 865 5063.

This research is part of a PhD at Maynooth University, funded by the Health Research Board (HRB)

Maynooth University National University of Ireland Maynooth

SPHeRE Structured Population and Health-services Research Education

HRB Health Research Board

Appendix 6. Stage 1: Information Sheet

(Page 1 of 2)

Information Sheet

Hannah Grove, research student in the Department of Geography, Maynooth University would like to invite you to take part in Stage 1 of a research project looking at the ***everyday experiences of older adults, focusing on the supportiveness of their neighbourhood environment***.

Before you decide whether to take part it is important for you to understand why the research is being done and what it will involve. Please take the time to read the following information carefully and ask questions about anything you are not sure about.

What is the purpose of the study?

The aim of this research is to explore the experiences of older people that are living at home, and to identify how supportive or unsupportive their neighbourhood environment is to carry out every day needs and valued activities. The research will be conducted in two stages. The purpose of Stage 1 is to get feedback from local residents about the research approach – this is what I am looking for help with today. The results of Stage 1 will then help to inform Stage 2, which is the main study.

What is expected from you?

You are invited to take participate in a small discussion group. During this I will be asking for your feedback on the research project and the methods that I am hoping to use. I would also like your opinions as to the best way to carry out the research and to recruit local participants into the main study, in particular to make sure all groups are represented. Your feedback is very valuable and will help to inform the direction and scope of the main study and to help ensure that I am considering the things that matter most to people.

How much of your time will participation involve?

The group discussion will last 1 hour and is a one-off event. Refreshments will be provided.

Do you have to take part?

No, your involvement is completely voluntary and you do not have to take part. Furthermore, if you decide to take part but change your mind you are also free to leave at any time and you do not have to provide a reason.

What will I do with the information?

Your feedback will be used to inform the direction of the main study and the results will be published in my PhD thesis, along with scholarly publications and academic presentations. The results may also be shared with policy makers and service providers and used to contribute towards the 'Age Friendly Environment' evidence base. I am happy to provide you with a copy

of any of these future outcomes if you would like to provide me with your contact details.

How will information you provide be recorded, stored and protected?

The material and data from the workshop will be stored securely. Group discussions will be digitally recorded and transcribed. False names will be used to make sure that no-one can be identified. Any personal information such as contact details and consent sheets will be stored separately in a locked office. It will be retained for ten years and will then be destroyed by confidential shredding.

Funding Information:

This research was funded by the Health Research Board SPHeRE/2013/1. The Health Research Board (HRB) supports excellent research that improves people's health, patient care and health service delivery. The HRB aim to ensure that new knowledge is created and then used in policy and practice. In doing so, it supports health system innovation and creates new enterprise opportunities.

Who should you contact for further information?

You may contact me at via email at hannah.grove.2016@mumail.ie or via post at Geography Department, Rhetoric House, Maynooth, Co. Kildare, Ireland.

If you experience any concerns for yourself or others following participation in this discussion, the organisation below can offer support:
ALONE: working with older people who are in crisis situations and need extra support to age at home. Contact details: Telephone: 01 679 1032
Email: enquiries@alone.ie Address: ALONE, Olympic House, Pleasants Street, Dublin 8

If during your participation in this study you feel the information and guidelines that you were given have been neglected or disregarded in any way, or if you are unhappy about the process, please contact the Secretary of the Maynooth University Ethics Committee at research.ethics@nuim.ie or +353 (0)1 708 6019. Please be assured that your concerns will be dealt with in a sensitive manner.

Limits to confidentiality:

It must be recognized that, in some circumstances, confidentiality of research data and records may be overridden by courts in the event of litigation or in the course of investigation by lawful authority. In such circumstances the University will take all reasonable steps within law to ensure that confidentiality is maintained to the greatest possible extent.

Thank you for taking the time to read this information sheet,

Hannah Grove

Appendix 7. Stage 1: Consent Form

Consent Form

1) I have read the information sheet provided and agree to participate in the group discussion. I understand that I may withdraw my consent at any time.

_____ _____

Name (printed) Name (signature)

2) I would like to be kept informed of the research project: Yes ☐ No ☐

Please provide your contact details and state your preferred method of contact if you have selected yes to 2):

Email Address: _____

Address: _____

Telephone: _____

Preferred Method of Contact: Email ☐ Address ☐ Telephone ☐

My Contact Information:
Hannah Grove
Email: Hannah.Grove.2016@mumail.ie
Address: Department of Geography, Rhetoric House, Maynooth University, Co. Kildare, Ireland

My Supervisor's Contact Information:
Professor Jan Rigby
Email: Jan.Rigby@nuim.ie
Address: Department of Geography, Room 2.20, Iontas Building, Maynooth University, Co. Kildare, Ireland

Thank you for participating in this study, Hannah

Appendix 8. Stage 2: Social Group Details

This table includes details about the community centres and social groups that participants were recruited from.

Study Area	Community Centre Type and Details About Specific Group	Participants
SA1	Community Centre • Older Adult retirement group involving bingo	3
SA1	Dementia Day Care Centre • Day group for people with dementia including activities, lunch, a garden, and outings	2
SA1	Community Centre • Women's Craft Group • Men's Group	4 (2 from each group)
SA1	Family Resource Centre • Public Speaking Group	1
SA1	GAA Club (Irish Sports Club) • Active Ageing Retirement Group involving a range of activities, trips away and outings	5
SA2	Community Centre • Active Ageing Exercise Group	5
SA2	Senior Citizens Centre • Social group for 'socially isolated' older people including activities such as Yoga and Bingo	8
SA2	Community Centre • Bingo afternoon • Film Club afternoon	3
SA2	Resource Centre • Senior centre where a variety of activities for older adults are provided	1[12]
		Total = 32[13]

[12] Participant volunteers at the centre but was recruited through the older adult group.

[13] Two additional participants were not recruited through community or social group (one was via a Public Health Nurse and the other was through the sheltered housing complex they lived in).

Appendix 9. Stage 2: Invitation Letter

INVITATION TO TAKE PART IN A PHD RESEARCH PROJECT

I am a PhD student looking for people aged 70 and over living in the [redacted] area to take part in a research project.

I am interested in whether your local neighbourhood supports you to do the things that are most important to you for a good quality of life.

What will this involve?

- An Interview - I will ask you some questions about how you interact with your local environment, where you go on a daily basis, and what activities are most important to you. I will also explore whether you have any barriers that might make doing the things that are most important to you more difficult.
- A Mapping Exercise - I will then provide a map of your local neighbourhood and will ask you to think about where you go and where you do not go. Together we will draw your 'activity space' on the map.

This will last about an hour in total.

- A 'Go-along' Interview - If you are happy and able to do so, I will also ask you to show me in an interview 'on the move', some of the areas in your local environment that are important to you, or where there may be some issues or barriers that make everyday life more difficult.

If you would like to take part in the study, please get in touch – my contact details are provided below.

Many thanks,
Hannah

Email: Hannah.Grove@mu.ie | Tel: 083 865 5063

This research is part of a PhD project at Maynooth University, funded by the Health Research Board (HRB)

Appendix 10. Stage 2: Information Sheet

(Page 1 of 2)

Information Sheet

My name is Hannah Grove and I am a research student in the Department of Geography at Maynooth University. I would like to invite you to take part in a research project looking at the ***everyday experiences of older adults, focusing on whether individual's local environments support a good quality of life***.

Before you decide whether to take part it is important for you to understand why the research is being done and what it will involve. Please take the time to read the following information carefully and ask questions about anything you are not sure about.

What is the purpose of the study?

The aim of this research is to explore the experiences of older people that are living at home, and to identify how supportive or unsupportive their neighbourhood environment is to carry out every day needs and valued activities that are important to people for a good quality of life.

What is expected from you?

We will meet for approximately one hour to carry out an interview. This will comprise of two parts:

- An Interview – I will ask you some questions about how you interact with your local environment, where you go on a daily basis, and what things are most important to you. I will also explore whether you might have any barriers that make doing the things that are most important to you more difficult. I will then ask how your local environment could better support you to maintain these activities as you get older.
- A Mapping Exercise – I will then provide a map of your local neighbourhood and will ask you to think about where you go and where you do not go. Together we will draw your 'activity space' on the map.

If you are happy to do so, you will also be invited to take part in a 'go-along' interview as a separate activity. As part of this, I will ask you to show me some of the areas in your local environment that are important to you, or where there may be some issues or barriers that make your everyday life more difficult. This can be carried out straight away after the main interview, or we can arrange to do this on a separate date.

Do you have to take part?

No. Your involvement is completely voluntary and you do not have to take part. Furthermore, if you decide to take part but change your mind you are also free to stop at any time and you do not have to provide a reason.

What will I do with the information?

Your feedback will be used to inform the local 'Age Friendly Environment' evidence base, and will be presented to policymakers and service providers. The results will be published in my PhD thesis, along with scholarly publications and academic presentations.

How will information you provide be recorded, stored and protected?

The material and data from the workshop will be stored securely. Interviews and go-along interviews will be digitally recorded and transcribed. False names will be used to make sure that you cannot be identified. Any personal information such as contact details and consent sheets will be stored in a locked office. It will be retained for ten years and will then be destroyed by confidential shredding.

Funding Information:

This research was funded by the Health Research Board (SPHeRE/2013/1).
The Health Research Board (HRB) supports excellent research that improves people's health, patient care and health service delivery. The HRB aim to ensure that new knowledge is created and then used in policy and practice. In doing so, it supports health system innovation and creates new enterprise opportunities.

Who should you contact for further information?

You may contact me at via email at hannah.grove@mu.ie or via post at: Geography Department, Rhetoric House, Maynooth University, Co. Kildare, Ireland.

If you experience any concerns for yourself or others following participation in this discussion, the organisation below can offer support:
ALONE: working with older people who are in crisis situations and need extra support to age at home.
Contact details: Telephone: 01 679 1032 Email: enquiries@alone.ie
Address: ALONE, Olympic House, Pleasants Street, Dublin 8

If during your participation in this study you feel the information and guidelines that you were given have been neglected or disregarded in any way, or if you are unhappy about the process, please contact the Secretary of the Maynooth University Ethics Committee at research.ethics@nuim.ie or +353 (0)1 708 6019. Please be assured that your concerns will be dealt with in a sensitive manner.

Limits to confidentiality:

It must be recognized that, in some circumstances, confidentiality of research data and records may be overridden by courts in the event of litigation or in the course of investigation by lawful authority. In such circumstances the University will take all reasonable steps within law to ensure that confidentiality is maintained to the greatest possible extent.

Thank you for taking the time to read this information sheet.

Appendix 11. Stage 2: List of organisations that did not take part and reasons for this

This table provides a details about the organisations that did not take part and reasons for this.

Organisation and details	Summary of contact and reasons for not participating in research
Stage 1: Exploratory Focus Groups	
Older Adult Social Group	I contacted the organiser for this social group and met several times with attendees, however they declined to take part in the Focus Groups.
Men's Shed Group	I called the organiser of this group several times but did not receive any replies.
Stage 2: Main Study	
ALONE (SA1 and SA2) A national charity that provides services to enable older people to age at home and remain connected to their communities	I sent a letter to the headquarters of the organisation and made several phone calls inviting ALONE and contacts within ALONE to take part in this research project. However, I did not receive any replies.
Travellers Community Development Project (SA1) This is a branch within SA1 of the broader 'Pavee Point Traveller and Roma Centre', which is a national non-governmental organisation committed to the attainment of human rights for Irish Travellers and Roma.	I spoke with one of the leaders of this community group and met with her to discuss taking part. Whilst she was interested in the project and we discussed how we could go about this, at the time of the research, the community had experienced several young male suicides and were in a state of shock and grief. The leader stated that it was not possible to take part at this time and it would not be possible for me to visit their sites.
Men's' Shed Group (SA1)	I spoke with the leader of this group and met them and attendees in person and they were very interested in taking part at that time. However, on a later date when I invited them to participate, they stated that they no longer wished to. They mentioned that they had also been contacted several times by other researchers and were feeling over-recruited.

‘Meals on Wheels’ Contact (SA1) A service that provides cooked dinners to older adults, particularly those who may be socially isolated.	I sent several emails to the lead contact for this and did not receive any replies.
Older Adult Day Group (SA2) A centre which provides both meals and activities for older people living in the community	I contacted the organiser of this group and agreed to meet on a specific date. However, when I arrived, they had forgotten about our meeting. The group was then due to take a break over the summer when recruitment was taking place.
Public Health Nurses (SA1 and SA2)	I dropped letters into the Public Health Nurses in 5 Primary Care Centres (4 in SA1 and 1 in SA2) and called them multiple times. I heard back from one Public Health Nurse. This resulted in the recruitment of one participant in SA2.

Appendix 12. Stage 1: Ethical Approval Letter

MAYNOOTH UNIVERSITY RESEARCH ETHICS COMMITTEE
MAYNOOTH UNIVERSITY,
MAYNOOTH, CO. KILDARE, IRELAND

Maynooth University
National University of Ireland Maynooth

Dr Carol Barrett
Secretary to Maynooth University Research Ethics Committee

22 February 2017

Hannah Grove
Department of Geography
Maynooth University

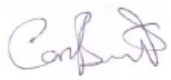
RE: Application for Ethical Approval for a project entitled: The everyday experiences of older adults ageing-in-place in Ireland: to what extent does an individual's neighbourhood environment support the ability to maintain valued activities important for quality of life?

Dear Hannah,

The Ethics Committee evaluated the above project and we would like to inform you that ethical approval has been granted.

Any deviations from the project details submitted to the ethics committee will require further evaluation. This ethical approval will expire on 28 February 2018.

Kind Regards,



Dr Carol Barrett
Secretary,
Maynooth University Research Ethics Committee

C.c. Professor Jan Rigby, Department of Geography

Reference Number
SRESC-2017-017

Appendix 13. Stage 2: Ethical Approval Letter

MAYNOOTH UNIVERSITY RESEARCH ETHICS COMMITTEE
MAYNOOTH UNIVERSITY,
MAYNOOTH, CO. KILDARE, IRELAND

Maynooth University
National University of Ireland Maynooth

Dr Carol Barrett
Secretary to Maynooth University Research Ethics Committee

13 November 2017

Hannah Grove
Department of Geography
Maynooth University

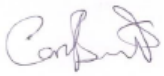
RE: Application for Ethical Approval for a project entitled: 'Does your neighbourhood support a good quality of life?' Perspectives from older people 'ageing in place' in Dublin

Dear Hannah,

The Ethics Committee evaluated the above project and we would like to inform you that ethical approval has been granted.

Any deviations from the project details submitted to the ethics committee will require further evaluation. This ethical approval will expire on 30 November 2019.

Kind Regards,



Dr Carol Barrett
Secretary,
Maynooth University Research Ethics Committee

c.c. Professor Jan Rigby, Department of Geography

Reference Number
SRESC-2017-092

Appendix 14. Stage 2: Consent Form (Standard)

Consent Form

1) I have read the information sheet provided and agree to participate in the group discussion. I understand that I may withdraw my consent at any time.

_____ _____

Name (printed) Name (signature)

2) I would like to be kept informed of the research project: Yes ☐ No ☐

Please provide your contact details and state your preferred method of contact if you have selected yes to 2):

Email Address: _____

Address: _____

Telephone: _____

Preferred Method of Contact: Email ☐ Address ☐ Telephone ☐

My Contact Information:
Hannah Grove
Email: Hannah.Grove.2016@mumail.ie
Address: Department of Geography, Rhetoric House, Maynooth University, Co. Kildare, Ireland

My Supervisor's Contact Information:
Professor Jan Rigby
Email: Jan.Rigby@nuim.ie
Address: Department of Geography, Room 2.20, Iontas Building, Maynooth University, Co. Kildare, Ireland

Thank you for participating in this study, Hannah

Appendix 15. Stage 2: Consent Form (Adapted for Cognitive Impairment)

(Page 1 of 7)

Consent Form

You will be asked to:

Write your name ☐

Answer questions about yourself and about your experiences of your local neighbourhood ☐

1

Carry out a mapping exercise to identify how you use your local neighbourhood ☐

Take part in a go-along interview where you show the researcher areas of your neighbourhood that are important to you ☐

The researcher will:

Record your answers ☐

Put these answers on their computer ☐

3

I understand that:

I am a volunteer ☐

I can stop talking to the researcher at any time ☐

4

Someone can join me to take part if I wish ☐

Your answers will be kept private and people will not be able to identify you ☐

Consent:

I have asked any questions I have about the research and understand the answers □

I am happy to take part in the study □

6

I would like to be kept informed of the research project results ☐

Please provide your contact details and select your preferred method of contact if you have selected yes to 3):

By post ☐ _____

_____

_____

By telephone ☐ _____

By email ☐ _____

My Contact Information:
Hannah Grove
Email: Hannah.Grove@mu.ie
Address: Department of Geography, Rhetoric House, Maynooth University, Co. Kildare, Ireland

My Supervisor's Contact Information:
Professor Jan Rigby
Email: Jan.Rigby@mu.ie
Address: Department of Geography, Room 2.20, Iontas Building, Maynooth University, Co. Kildare, Ireland
Telephone: 01 708 6181

Thank you for participating in this study, Hannah

7

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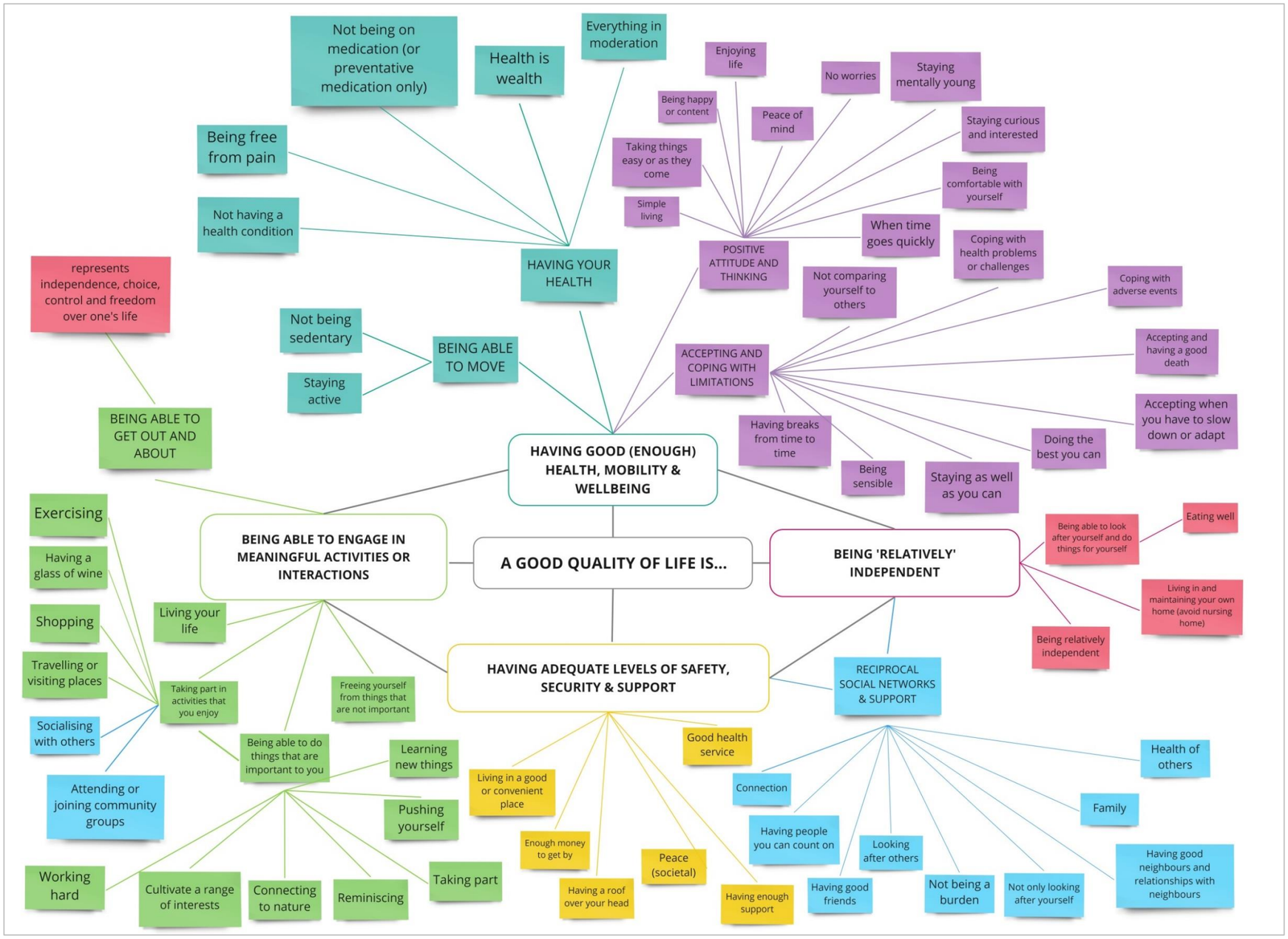
Appendix 16. Chapter 5 Data Analysis: Thematic Map for Defining a Good Quality of Life



Appendix 17. Chapter 6 Data Analysis: Categories of Social Infrastructure Places by Participant Case

This table shows the different categories of places identified for Chapter 6 and summarises the number of references for each place, as well as how many participants mentioned each place.

	Category of Place	Main Activity	Code	Study Area	Number of references		Number of participants that mentioned the place
1	Main Community Centre		MCC				
1	Community Centre	Attending Social Group or Class (Active Retirement Group)	MCC-01	SA1	24		3
1	Day Care Centre (for PwD)	Attending Social Group or Class (Dementia Day Care Social Group)	MCC-02	SA1	4		2
1	Community Centre	Attending Social Group or Class (Women's Crochet; Men's Group)	MCC-03	SA1	57	**135**	4
1	Resource Centre	Attending Social Group or Class (Public Speaking Group)	MCC-04	SA1	13		1
1	Local GAA Club	Attending Social Group or Class (Active Retirement Group)	MCC-05	SA1	37		5
1	Community Hall	Attending Social Group or Class (Active Retirement Group)	MCC-06	SA2	34		5
1	Senior Citizen's Centre	Attending Social Group or Class (Bingo; Yoga)	MCC-07	SA2	11	**77**	8
1	Community Centre	Attending Social Group or Class (Bingo; Film Nights)	MCC-08	SA2	16		3
1	Resource Centre	Attending Social Group or Class (Volunteering)	MCC-09	SA2	16		5
				Total =	**212**		
2	Other 'Community Centres'		OCC				
2	Contact Centre	Attending Social Group or Class (Attending Church Meetings)	OCC-01	SA1	3		1
2	Community Centre	Now Closed	OCC-02	SA1	2		2
2	Community Centre	Attending Social Group or Class (Attending Computer Classes)	OCC-03	SA1	6		2
2	Shopping Centre	Attending Social Group or Class (Attending Knitting Group)	OCC-04	SA1	5		1
2	Pub	Attending Social Group or Class (Attending Bingo Evenings)	OCC-05	SA1	8	**53**	2
2	Resource Centre	Attending Social Group or Class (Attending Friendship Club)	OCC-06	SA1	2		1
2	Pub	Attending Social Group or Class (Attending Bingo Evenints)	OCC-07	SA1	4		2
2	Arts Centre	Attending Social Group or Class (Attending COPD Prevention Class; Writing Group; Choir)	OCC-08	SA1	10		2
2	Leisure Centre	Attending Social Group or Class (Attending Exercise Classes)	OCC-09	SA1	6		2
2	Church	Attending Social Group or Class (Attending Musical Group)	OCC-10	SA1	7		1
2	Global Company Offices	Attending Social Group or Class (Attending Older Adult Special Events)	OCC-11	SA2	11		7
2	Social Centre	Attending Social Group or Class (Attending Bingo Evenints)	OCC-12	SA2	1		1
2	Leisure Centre	Attending Social Group or Class (Attending Exercise Classes)	OCC-13	SA2	3	**23**	3
2	Leisure Centre	Attending Social Group or Class (Attending Badminton Class; Swimming)	OCC-14	SA2	6		2
2	Pub	Attending Social Group or Class (Attending Book Club)	OCC-15	SA2	2		1
2	Outdoor Based Group	Attending Social Group or Class (Attending Hiking & Walking Group)	OCC-16	OSA	3		1
2	Gym	Attending Social Group or Class (Attending Exercise Classes)	OCC-17	OSA	2	**10**	1
2	Gym	Attending Social Group or Class (Doing Weightlifting)	OCC-18	OSA	5		1
				Total =	**86**		

3	Shops		SHO				
3	Supermarket	Shopping	SHO-01	SA1	9		4
3	DIY Store	Shopping	SHO-02	SA1	4		2
3	Supermarket	Shopping	SHO-03	SA1	1		1
3	Charity Shop	Shopping	SHO-04	SA1	1		1
3	Supermarket	Shopping	SHO-05	SA1	12		4
3	Supermarket	Shopping	SHO-06	SA1	1		1
3	Supermarket	Shopping	SHO-07	SA1	21		6
3	Local Shop	Shopping	SHO-08	SA1	6	**171**	1
3	Local Shopping Parade	Shopping	SHO-09	SA1	6		1
3	Local Shop	Shopping	SHO-10	SA1	10		1
3	Local Shopping Parade	Shopping	SHO-11	SA1	11		4
3	Local Shopping Parade	Shopping	SHO-12	SA1	8		4
3	Supermarket	Shopping	SHO-13	SA1	2		1
3	Large Shopping Centre	Shopping	SHO-14	SA1	77		14
3	Small Shopping Centre	Shopping	SHO-15	SA1	2		2
3	Charity Shop	Shopping	SHO-16	SA2	1		1
3	Local Shop	Shopping	SHO-17	SA2	3		1
3	Local Shop	Shopping	SHO-18	SA2	1		1
3	Artisan Supermarket	Shopping	SHO-19	SA2	2		1
3	Local Shop	Shopping	SHO-20	SA2	1		1
3	Local Shop	Shopping	SHO-21	SA2	1	**40**	1
3	Local Shop	Shopping	SHO-22	SA2	1		1
3	Local Shop	Shopping	SHO-23	SA2	1		1
3	Supermarket	Shopping	SHO-24	SA2	7		5
3	Supermarket	Shopping	SHO-25	SA2	8		3
3	Local Shopping Parade	Shopping	SHO-26	SA2	1		1
3	Local Shopping Parade	Shopping	SHO-27	SA2	13		5
3	Fishing Tackle Shop	Shopping	SHO-28	OSA	3		1
3	Supermarket	Shopping	SHO-29	OSA	3		3
3	Department Store	Shopping	SHO-30	OSA	4		3
3	Large Shopping Centre	Shopping	SHO-31	OSA	1		1
3	City Centre Shopping	Shopping	SHO-32	OSA	43		19
3	Large Shopping Centre	Shopping	SHO-33	OSA	4		2
3	Bookshop	Shopping	SHO-34	OSA	3		3
3	Shopping Street	Shopping	SHO-35	OSA	3		3
3	Shopping Centre	Shopping	SHO-36	OSA	2		2
3	Shopping Centre	Shopping	SHO-37	OSA	2	**90**	1
3	Supermarket	Shopping	SHO-38	OSA	3		2
3	Large Shopping Centre	Shopping	SHO-39	OSA	7		6
3	Market	Shopping	SHO-40	OSA	3		1
3	Shopping Centre	Shopping	SHO-41	OSA	2		2
3	Shopping Street	Shopping	SHO-42	OSA	3		3
3	Clothing Shop	Shopping	SHO-43	OSA	2		2
3	Fishing Tackle Shop	Shopping	SHO-44	OSA	1		1
3	Wool Shop	Now Closed	SHO-45	OSA	1		1
				Total =	**301**		

4	Post Offices		POF				
4	Post Office	Collecting Pension	POF-01	SA1	7	14	1
4	Post Office	Collecting Pension	POF-02	SA1	3		1
4	Post Office	Collecting Pension	POF-03	SA1	2		1
4	Post Office	Collecting Pension	POF-04	SA1	2		1
4	Post Office	Collecting Pension	POF-05	SA2	2	9	2
4	Post Office	Collecting Pension	POF-06	SA2	1		1
4	Post Office	Now Closed	POF-07	SA2	3		2
4	Post Office	Now Closed	POF-08	SA2	3		3
				Total =	**23**		
5	Banks & Credit Unions		BCU				
5	Credit Union	Doing Banking	BCU-01	SA1	4	**4**	1
5	Bank	Now Closed	BCU-02	SA2	2	**3**	1
5	Bank	Now Closed	BCU-03	SA2	1		1
5	Bank	Doing Banking	BCU-04	OSA	1	**3**	1
5	Bank	Doing Banking	BCU-05	OSA	2		1
				Total =	**10**		
6	Hairdressers		HAI				
6	Hairdressers	Getting a Haircut	HAI-01	SA1	1	**3**	1
6	Hairdressers	Getting a Haircut	HAI-02	SA1	1		1
6	Hairdressers	Getting a Haircut	HAI-03	SA1	1	**1**	1
				Total =	**4**		
7	Health-Related		HRE				
7	Hospital	Attending Hospital Appointment	HRE-01	SA1	24	58	9
7	Pharmacy	Collecting Prescription	HRE-02	SA1	1		1
7	Health Centre	Attending Doctor's Appointment	HRE-03	SA1	1		1
7	Pharmacy	Collecting Prescription	HRE-04	SA1	1		1
7	Health Centre	Attending Doctor's Appointment	HRE-05	SA1	1		1
7	Doctor's Surgery	Attending Doctor's Appointment	HRE-06	SA1	10		2
7	Medical Centre	Attending Doctor's Appointment	HRE-07	SA1	8		2
7	Pharmacy	Collecting Prescription	HRE-08	SA1	1		1
7	Medical Centre	Attending Doctor's Appointment	HRE-09	SA1	7		1
7	Medical Centre	Attending Doctor's Appointment	HRE-10	SA1	4		2
7	Medical Centre	Attending Doctor's Appointment	HRE-11	SA2	1	5	1
7	Primary Care Centre	Attending Doctor's Appointment	HRE-12	SA2	3		3
7	Pharmacy	Collecting Prescription	HRE-13	SA2	1		1
7	Hospital	Attending Hospital Appointment	HRE-14	OSA	4	17	1
7	Hospital	Attending Hospital Appointment	HRE-15	OSA	1		1
7	Hospital	Attending Hospital Appointment	HRE-16	OSA	3		3
7	Hospital	Attending Hospital Appointment	HRE-17	OSA	9		5
				Total =	**80**		

8	Green & Blue Spaces		GBS				
8	Local Green Space or Park	Engaging with Nature	GBS-01	SA1	6		1
8	Waterway	Engaging with Nature	GBS-02	SA1	3		2
8	Local Green Space or Park	Engaging with Nature	GBS-03	SA1	30		7
8	Local Woods	Engaging with Nature	GBS-04	SA1	2	**74**	1
8	Local Green Space or Park	Engaging with Nature	GBS-05	SA1	16		3
8	Local Green Space or Park	Engaging with Nature	GBS-06	SA1	6		2
8	Local Green Space or Park	Engaging with Nature	GBS-07	SA1	8		2
8	Fairy Tree	Engaging with Nature	GBS-08	SA1	3		1
8	Allotment	Engaging with Nature	GBS-09	SA2	5		1
8	Waterway	Engaging with Nature	GBS-10	SA2	10		5
8	Waterway Path	Engaging with Nature	GBS-11	SA2	23		5
8	Dublin Bay	Engaging with Nature	GBS-12	SA2	2		2
8	Waterway	Engaging with Nature	GBS-13	SA2	13		6
8	Local Green Space or Park	Engaging with Nature	GBS-14	SA2	7		6
8	Naure Park	Engaging with Nature	GBS-15	SA2	15		6
8	Beach	Engaging with Nature	GBS-16	SA2	4	**207**	1
8	Local Green Space or Park	Engaging with Nature	GBS-17	SA2	43		9
8	Waterway	Engaging with Nature	GBS-18	SA2	13		6
8	Beach	Engaging with Nature	GBS-19	SA2	16		6
8	Coastal Path	Engaging with Nature	GBS-20	SA2	12		8
8	Village Green	Engaging with Nature	GBS-21	SA2	12		5
8	Local Green Space or Park	Engaging with Nature	GBS-22	SA2	12		6
8	Beach	Engaging with Nature	GBS-23	SA2	8		5
8	Coastal Path	Engaging with Nature	GBS-24	SA2	12		4
8	Allotment	Engaging with Nature	GBS-25	OSA	7		1
8	Rural Village	Engaging with Nature	GBS-26	OSA	15		3
8	Pitch & Putt Course	Engaging with Nature	GBS-27	OSA	6		1
8	Harbour	Engaging with Nature	GBS-28	OSA	2		1
8	Mountains	Engaging with Nature	GBS-29	OSA	29	**72**	8
8	Local Green Space or Park	Engaging with Nature	GBS-30	OSA	6		2
8	Large Green Space or Park	Engaging with Nature	GBS-31	OSA	1		1
8	Large Green Space or Park	Engaging with Nature	GBS-32	OSA	4		3
8	Local Green Space or Park	Engaging with Nature	GBS-33	OSA	2		1
				Total =	**353**		

9	Trip Destinations		TRI				
9	Athlone	Attending Day Trip or Trips Away	TRI-01	OSA	2		2
9	Beara Peninsula	Attending Day Trip or Trips Away	TRI-02	OSA	1		1
9	Belfast	Attending Day Trip or Trips Away	TRI-03	OSA	3		3
9	Bray	Attending Day Trip or Trips Away	TRI-04	OSA	3		3
9	Bundoran	Attending Day Trip or Trips Away	TRI-05	OSA	1		1
9	Cyprus	Attending Day Trip or Trips Away	TRI-06	OSA	1		1
9	Donabate	Attending Day Trip or Trips Away	TRI-07	OSA	1		1
9	Dun Laoghaire	Attending Day Trip or Trips Away	TRI-08	OSA	9		7
9	Galway	Attending Day Trip or Trips Away	TRI-09	OSA	1		1
9	Giant's Causeway	Attending Day Trip or Trips Away	TRI-10	OSA	1		1
9	Howth	Attending Day Trip or Trips Away	TRI-11	OSA	7	**61**	6
9	Killarney	Attending Day Trip or Trips Away	TRI-12	OSA	3		3
9	Lourdes	Attending Day Trip or Trips Away	TRI-13	OSA	3		2
9	Malahide	Attending Day Trip or Trips Away	TRI-14	OSA	4		3
9	Portmarnock	Attending Day Trip or Trips Away	TRI-15	OSA	1		1
9	Skerries	Attending Day Trip or Trips Away	TRI-16	OSA	1		1
9	Spain	Attending Day Trip or Trips Away	TRI-17	OSA	2		2
9	Waterford	Attending Day Trip or Trips Away	TRI-18	OSA	3		2
9	Westport	Attending Day Trip or Trips Away	TRI-19	OSA	1		1
9	Wexford	Attending Day Trip or Trips Away	TRI-20	OSA	10		7
9	Wicklow	Attending Day Trip or Trips Away	TRI-21	OSA	3		2
				Total =	**61**		

10	Eating & Drinking Places		EDP				
10	Café	Eating or Drinking	EDP-01	SA1	1		1
10	Café	Eating or Drinking	EDP-02	SA1	1		1
10	Café	Eating or Drinking	EDP-03	SA1	4		1
10	Pub	Eating or Drinking	EDP-04	SA1	8	**24**	2
10	Pub	Eating or Drinking	EDP-05	SA1	4		2
10	Café	Eating or Drinking	EDP-06	SA1	2		1
10	Pub	Eating or Drinking	EDP-07	SA1	2		2
10	Café	Eating or Drinking	EDP-08	SA1	2		1
10	Pub	Eating or Drinking	EDP-09	SA2	1		1
10	Hotel with Swimming Pool	Eating or Drinking	EDP-10	SA2	2		1
10	Restaurant	Eating or Drinking	EDP-11	SA2	1		1
10	Café	Eating or Drinking	EDP-12	SA2	2		1
10	Café	Eating or Drinking	EDP-13	SA2	1		1
10	Betting Shop	Eating or Drinking	EDP-14	SA2	2	**19**	1
10	Restaurant	Eating or Drinking	EDP-15	SA2	1		1
10	Café	Eating or Drinking	EDP-16	SA2	3		1
10	Pub	Eating or Drinking	EDP-17	SA2	1		1
10	Hotel	Eating or Drinking	EDP-18	SA2	4		1
10	Bar	Eating or Drinking	EDP-19	SA2	1		1
10	Café	Eating or Drinking	EDP-20	OSA	2		2
10	Café	Eating or Drinking	EDP-21	OSA	1	**5**	1
10	Café	Eating or Drinking	EDP-22	OSA	1		1
10	Garden Centre	Eating or Drinking	EDP-23	OSA	1		1
				Total =	**48**		

11	Cultural Buildings		CUB				
11	Theatre	Going to the Theatre	CUB-01	SA1	8		4
11	Cinema	Going to the Cinema	CUB-02	SA1	3	22	1
11	Bingo Hall	Going to a Bingo Night (mentions but dislikes and does not attend)	CUB-03	SA1	1		1
11	Arts Centre	Various Activities / Events	CUB-04	SA1	10		3
11	Cinema - Closed	Going to the Cinema	CUB-05	SA2	2	4	1
11	Cinema - Closed	Going to the Cinema	CUB-06	SA2	2		2
11	Concert Venue	Going to a Concert	CUB-07	OSA	3	39	1
11	Theatre	Going to the Theatre	CUB-08	OSA	9		7
11	Tourist Attraction	Visiting a Tourist Attraction	CUB-09	OSA	2		1
11	Theatre	Going to the Theatre	CUB-10	OSA	2		1
11	Cinema	Going to the Cinema	CUB-11	OSA	2		2
11	Tourist Attraction	Visiting a Tourist Attraction	CUB-12	OSA	3		2
11	Concert Venue	Going to a Concert	CUB-13	OSA	3		3
11	Art Gallery	Visiting an Art Gallery	CUB-14	OSA	1		1
11	Arena	Going to a Concert	CUB-15	OSA	5		3
11	College	Various Activities / Events	CUB-16	OSA	9		5
				Total =	**65**		
12	Churches		CHU				
12	Church	Attending Mass	CHU-01	SA1	2	45	1
12	Church	Attending Mass	CHU-02	SA1	1		1
12	Church	Attending Mass	CHU-03	SA1	2		1
12	Church	Attending Mass	CHU-04	SA1	15		5
12	Church	Attending Mass	CHU-05	SA1	4		1
12	Church	Attending Mass	CHU-06	SA1	2		2
12	Church	Attending Mass	CHU-07	SA1	1		1
12	Church	Attending Mass	CHU-08	SA1	18		5
12	Church	Attending Mass	CHU-09	SA2	16	25	7
12	Church	Attending Mass	CHU-10	SA2	2		2
12	Church	Attending Mass	CHU-11	SA2	4		2
12	Church	Attending Mass	CHU-12	SA2	3		3
12	Hospice	Attending Mass; Volunteering	CHU-13	OSA	12	19	4
12	Church	Attending Mass	CHU-14	OSA	7		2
				Total =	**89**		
13	Libraries		LIB				
13	Library	Visiting Library; Borrowing Books	LIB-01	SA1	4	13	2
13	Library	Visiting Library; Borrowing Books	LIB-02	SA1	9		4
13	Library	Visiting Library; Borrowing Books	LIB-03	SA2	13	13	8
				Total =	**26**		
14	Miscellaneous		REC				
14	Recycling Point	Doing Recycling	REC-01	SA2	2	2	1
				Total =	**2**		

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