Public Health England

age UK

Ageing in coastal and rural communities

Exploring the factors underlying health inequalities for older men, older people from ethnic minorities, and older LGBTQ+ people

Foreword

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Older adults are an asset to society regardless of their background, identity or where they live. When given the right opportunities and support, people in later life continue to live full and productive lives. Over 85 year olds are the fastest growing age group in the UK, with numbers expected to double to 3.2 million by 2041(Public Health England, 2019b). The opportunity to ensure all older adults enjoy a fairer, inclusive, meaningful, healthy and active later life should be seized.

The conditions in which people are born, grow, live, work and become older, influence their opportunities for good health. Our first report, Health Inequalities for Older Populations in Rural and Coastal Areas, told us: older men may be less likely to engage with community networks and services in rural areas and experience social isolation; older LGBT+ communities, may experience marginalisation; and an evidence gap was identified for other older inclusion health groups, including minority ethnic groups who are represented in very small numbers and may lack the social and community support found in urban centres(Public Health England, 2019b).

Public Health England, together with Age UK, has produced this report to explore the causes of health inequalities for older men, older people from ethnic minorities, and older lesbian, gay, bisexual, trans and queer+ (LGBTQ+) people in coastal and rural communities. It provides qualitative evidence on the experience of people from different backgrounds and communities and it shows the variety of issues that raise difficulties and inequalities for these groups as they grow older. The report is intended to help those working in coastal and rural communities (and beyond) to understand the issues affecting older people in these three groups, and to identify how they can take place-based action to address the causes of health inequalities that affect them.

This work is complementary to the Chief Medical Officer's work on coastal health which is in progress, the government's ambition for everyone to have 5 extra years of healthy life by 2035 and to narrowing the inequality gap. Public Health England's commitment and work on identifying and tackling health inequalities has been a priority and will continue as we work with partners on healthy ageing and the levelling up agenda over the coming years. I am delighted that this report is the result of a fruitful collaboration with the voluntary and community sector, led by PHE's Healthy Ageing team and with the support of the Health and Wellbeing Alliance. I hope this report will inspire yet more collaborative progressive work so that the ambition to make healthy ageing accessible to all is realised.

Executive summary

This report explores the causes of health inequalities for older men, older people from ethnic minorities, and older lesbian, gay, bisexual, trans and queer+ (LGBTQ+) people in coastal and rural communities.

It's designed to help those working in coastal and rural communities (and beyond) to understand the issues affecting older people in these three groups, and to identify how they can take place-based action to address the causes of health inequalities that affect them. We envisage this report may be of particular interest to:

- Leaders within health and wellbeing boards
- Policy makers and commissioners within local authorities, local health bodies and Integrated Care Systems
- Other local funders, including businesses and charitable funders
- Voluntary, Community and Social Enterprise (VCSE) sector organisations

Health inequalities are defined as unfair and avoidable differences in health across the population, and between different groups within society. The Covid-19 pandemic has laid bare the extent and impact of health inequalities across our communities and intensified the urgency of addressing their causes. In addition, the 'levelling up' agenda has drawn attention to the need to address the differences in experience and outcome faced by different communities across England.

This study builds on *An evidence summary of health inequalities in older populations in coastal and rural areas*[1]. Its focus is on coastal and rural communities, but our findings will be relevant to those working in other settings: in particular the rural fringes of urban areas, areas with smaller ethnic minority communities, touristic areas, and so on.

The evidence for this study was drawn from three sources:

- A review of the literature on the health inequalities/causes of health inequalities experienced by the communities of interest to this research
- Interviews with VCSE workers who are experts in the field(s) of health, care and support
- Interviews with older people from the groups of interest in this study

It also draws on Public Health England's Place Based Approaches (PBA) toolkit, and in particular the Population Intervention Triangle, against which we set out areas for action.

1. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/824723/Health_Inequalities_in_Ageing_in_Rural_and_Coastal_Areas-Full_report.pdf

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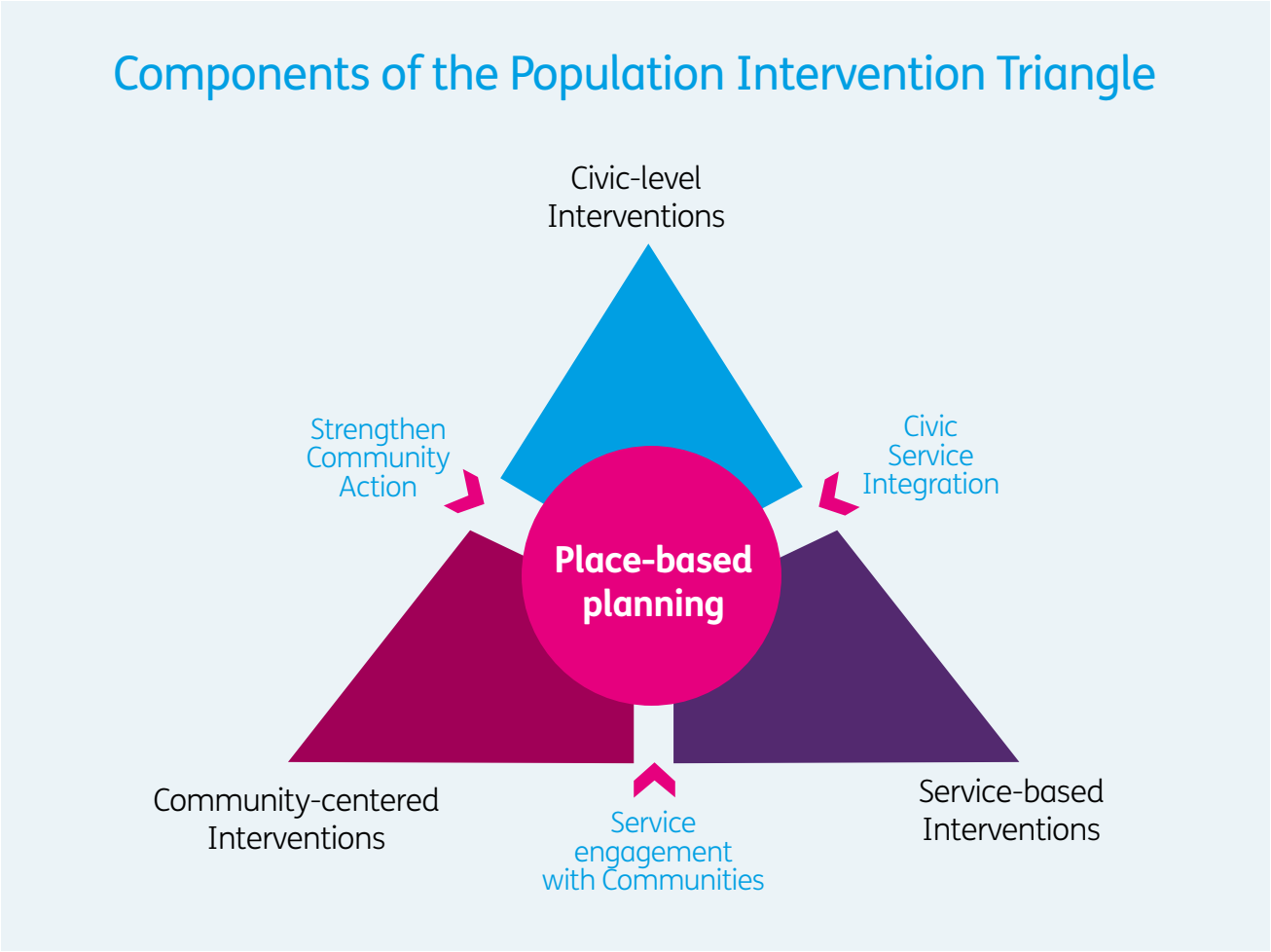

PHE (2019) Place based approaches to reducing health inequalities

Findings and action needed

We identified a number of common themes across all the groups of interest to this research, in both coastal and rural areas:

- Many older people speak positively about where they live, feel a sense of place, and recognise health advantages to living in their areas, but community workers were able to identify more challenging aspects to these settings
- Many of the older people we spoke to are working in later life, and recognise the benefits this offers in connecting them to their communities
- The VCSE sector already knows and supports people from the groups of interest to this study
- The impacts of austerity and of the recent Covid-19 pandemic are keenly felt by VCSE organisations and groups working with the groups of interest to this study
- A lack of data on these groups makes it hard to take action

These themes inform the recommendations we make in this study.

The **five issues** which need action across all groups are:

1. **Loneliness and social isolation:** particularly for some groups of older men, including older carers and men who are insecurely housed; and for both older LGBTQ+ people and older people from ethnic minorities, who often struggle to identify peers in their local areas
2. **The digital divide:** the rapid digitalisation of services is a potential driver of inequalities
3. **A lack of support networks among people who move to rural and coastal communities:** people may need additional support to identify appropriate services and to build social networks in new communities
4. **Gaps in public transport provision:** public transport provision can be patchy, and does not always take people to the places they want to go, as a result people rely heavily on their cars in rural (and to a lesser extent coastal) communities
5. **Gaps in support for carers and people with dementia:** there are gaps in the provision of appropriate and accessible support to meet people's specific needs

We identified **six core approaches** to action that address the three groups of interest in this study, although we **must tailor the specific actions taken to the differing needs of each group (and the sub-groups within them).**

1. **Gather data:** improving data collection, working with communities to build trust and understanding around data gathering, and resourcing VCSE organisations to gather and share evidence
2. **Work with the VCSE sector:** resourcing them and building their capacity to provide services, share their insights, and advocate for the needs of the groups of interest to this study (and sub groups)
3. **Support the development of peer-led services:** map assets and gaps in peer-led provision and support its development with seed funding and capacity building, especially for groups at particular risk of social isolation, loneliness and poor health outcomes
4. **Flex to allow work across geographies and groups:** enable community groups and organisations to work across geographies and generations, particularly when working with very small minority groups within communities; explore the potential of digital connection (while being mindful of the digital divide)
5. **Involve people rather than consulting them:** enable people to fully participate in identifying the issues that affect them, as well as in developing and delivering solutions
6. **Make access easy:** make accessing services easy by delivering them in the places where people already go – social prescribing has a major role to play, given the key role played by GPs, but there's also potential to reach out through:
    - Workplaces
    - Community hubs
    - Faith organisations
    - Farming community hubs such as agricultural markets (in rural communities)

In relation to older people from ethnic minorities and older LGBTQ+ people, the challenge is to avoid a 'numbers game' in which smaller communities can end up marginalised. While place-based responses which provide an integrated response to issues are likely to be helpful, we recommend deliberate attention to the needs of these groups. In particular, approaches must take into account how people within these communities understand the 'places' in which they live.

Issues for specific groups

We identified the following causes of health inequalities among **older LGBTQ+** people:

- The lasting impact of experiences with stigma, discrimination and abuse, especially on if/how older LGBTQ+ people engage with health and care services
- Ongoing experiences of stigma, discrimination and abuse in some health and care services
- A need for peer-led support and services, including around caring responsibilities and dementia
- Challenges in continuing to travel distances to access specialist support as they age
- A need for tailored support around planning for later life, including at the end of life

We identified a specific concern in relation to older LGBTQ+ people living in rural areas:

- Funding restrictions may limit the potential to develop intergenerational projects to reduce isolation and tackle stigma

In coastal areas we heard that:

- Older LGBTQ+ people may experience an increase in stigma, discrimination and abuse during peak tourism seasons

We identified **four considerations for older LGBTQ+ people:**

1. Provide support to those affected by historic trauma, including mental health support sensitive to the circumstances of older LGBTQ+ people – potentially through training staff who work in mainstream mental health services
2. Address discriminatory attitudes among health and care staff by accessing specialist training
3. Provide ongoing support to address discriminatory attitudes and support inclusion – this is to address year-round stigma in places where local populations are in flux (often due to tourism)
4. Provide tailored support around planning for later life, including at the end of life

We identified a number of issues affecting **older men**:

- More older men in these areas are living alone and ageing without children; they may be particularly affected by social isolation and lack of access to sources of care and support, due to gaps in paid provision and a lack of people to provide unpaid care
- More men are lonely and/or socially isolated and may lack access to appropriate sources of social support that works for them

In coastal areas, we heard that:

- Older men who move to coastal towns in retirement may find themselves removed from loved ones and networks, including options for unpaid care
- Single men moved by their inland councils to cheaper coastal areas are now ageing in these places and are at particular risk of isolation and loneliness
- Single men living in houses of multiple occupation (HMOs) are now ageing and unable to move to more appropriate accommodation
- Coastal towns have a pull factor for rough sleepers, but they may find the winters are harsher than expected

In rural areas, we heard that:

- Older men within the farming community may have specific support needs as a result of the circumstances of their working lives, and may prefer to access support from within that community in later life
- Older male carers may not be supported by existing carers' services
- The closure and changing nature of pubs may contribute to older men's loneliness and social isolation
- Transport challenges can exacerbate older men's loneliness and/or social isolation
- GPs are the lynchpins of service coordination and responding to older men's health needs

We identified **five considerations for older men** that recognise the need to pay particular attention to sub-groups who face additional risks of poor health outcomes:

1. Support men living alone and ageing without children – starting with mapping the number of men in these circumstances and planning to give them support with social connection and care needs
2. Support male carers: recognise their needs within both carers' services and other services for older men
3. Value community spaces for men: provide support for local pubs and ensure men's voices are heard when developing community spaces
4. Support men in coastal areas who are inadequately housed
5. Support men from the farming community, for example through outreach at agricultural markets

We identified a number of issues affecting **older people from ethnic minorities:**

- Older people from ethnic minorities feel acutely aware of being in a minority
- Ethnic minorities should not be treated as a homogeneous group, but they often feel that their experiences are approached in this way
- 'Consultation fatigue' and experiences of being 'done to' or 'ticking a box' may contribute to older people from ethnic minorities feeling strong mistrust for statutory bodies and services
- The VCSE sector already understands and supports older people from ethnic minorities
- Language and difficulty accessing translation are barriers to accessing services
- Places of worship can be important for some people from ethnic minorities, but they don't reach everyone
- Older people from ethnic minorities need culturally appropriate services and resources, including in relation to:
  - Food and diet
  - Exercise and physical activity
  - Caring and dementia
  - End of life and burial

In coastal areas we discovered that:

- Older people from ethnic minorities who are working in, or retired from, the tourism and hospitality industries within coastal towns may have specific needs

In rural areas we discovered that:

- Older women from some ethnic minority communities may feel particularly isolated
- Formal health services can be a relatively safe space for some people from ethnic minorities
- Older people from ethnic minorities may experience particular challenges around rural transport

We identified **four considerations for older** people from some ethnic minority communities:

1. Avoid homogenising older people from ethnic minorities – recognise the particular experiences of:
    - People of different ethnicities
    - The differences in experience of those who grew up in England and those who moved to England
    - The differences in experience of those who live in the community in which they grew up and those who have moved from other parts of the country
    - The differences in experience of those who speak English and those who don't
    - The differences in experience of those who share the same religion or religious background as the majority community, and those who don't
2. Provide support with language and interpreting
3. Work with faith communities to provide routes to services, develop culturally appropriate offers, etc.
4. Provide culturally appropriate services, with particular reference to the need to cater for:
    - Diverse diets, and cultural requirements around food and drink
    - The need for older adults who don't speak English or who have English as a second language to get opportunities to meet others who speak their language
    - Different cultural attitudes and expectations around care and support – providing culturally appropriate information around care needs and support services
    - The need for access to women-only spaces for exercise, e.g. swimming
    - Cultural needs around the end of life and burial

Priorities requiring national action

While this report focuses on place-based interventions, it's important to note that progress in some areas will require shifts in national policy too, in particular there is a need for:

- Action to address gaps in broadband infrastructure
- Action to address gaps in housing supply, and particularly housing suited to the needs of an ageing population
- Action to mitigate the impacts of austerity, including on local authority budgets and VCSE sector funding
- Action at a national level to address gaps in research

Place-based approaches

However, there's much that can be done in places, at all levels of the Population Intervention Triangle (PIT) framework – including civic-level, service-level and community-centred approaches. We've also identified a need for action to close gaps in the 'seams' between the different areas of the PIT, in particular through strengthening links between VCSE and community activity with the civic and service levels; shifting towards greater co-production with marginalised communities; and gathering better data together.

We hope that this report provides food for thought and ideas for action to those wishing to address health inequalities through place-based approaches.

Acknowledgements

This project would not have been possible without the range of organisations and individuals who provided us their time, knowledge and experiences.

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We would like to thank Public Health England for their support and the members of the Advisory Group who guided and advised at key points along the way.

Thank you to Kate Jopling and Chloe Reeves for their hard work and dedication on this project.

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VCSE health & wellbeing alliance

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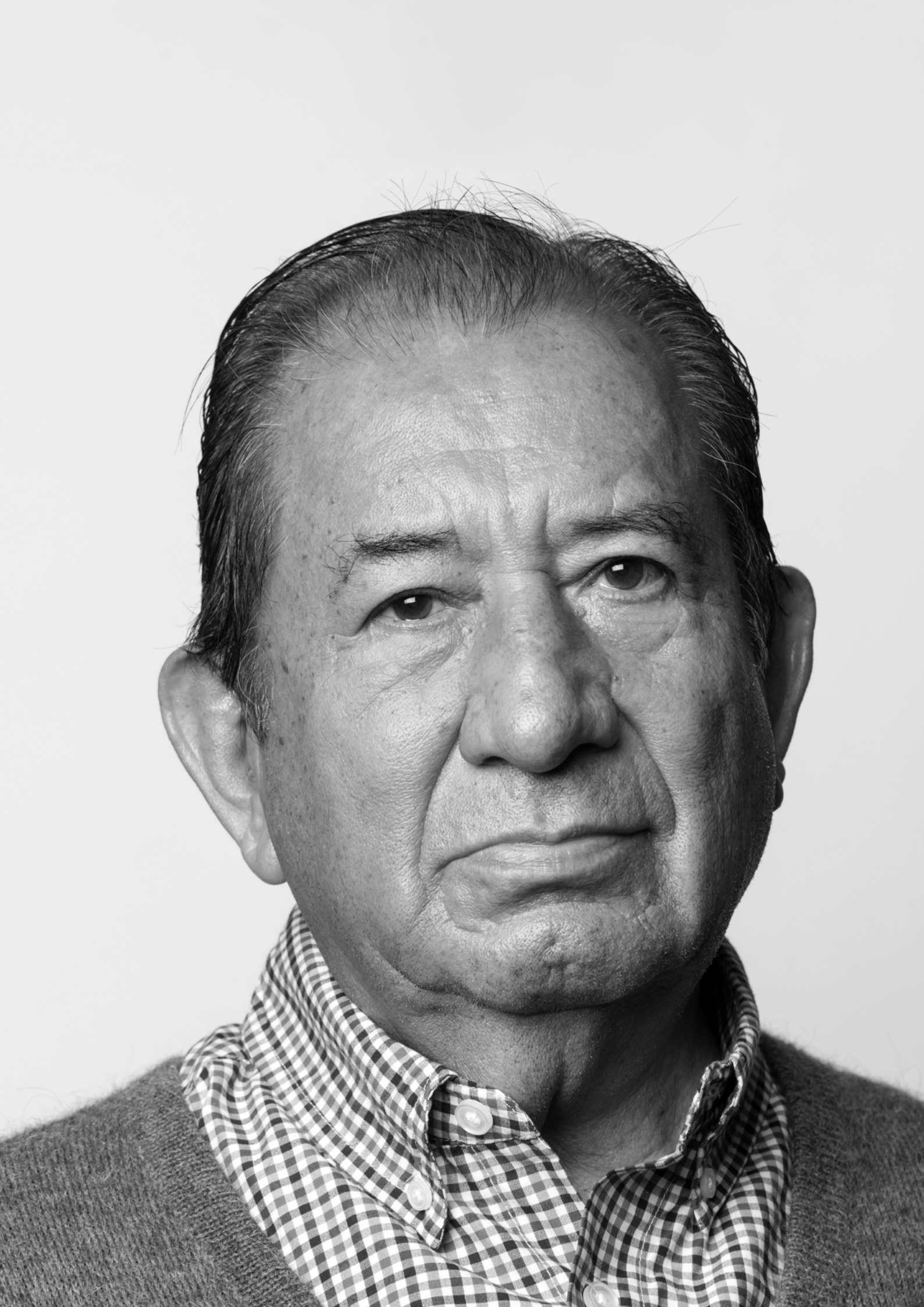


1. About this report

This report explores the causes of health inequalities for older men, older people from ethnic minorities, and older LGBTQ+ people in coastal and rural communities.

It's designed to help those working in coastal and rural communities (and beyond) to understand the issues affecting older people in these three groups, and to identify how place-based action can be taken to address the causes of health inequalities that they face.

Many of the findings will also be of interest to those working with older people from these groups in other geographical areas, in particular those working in areas that share characteristics with rural and coastal areas, such as the rural fringes of urban areas, areas with smaller ethnic minority communities, touristic areas, and so on.

Health inequalities are defined as unfair and avoidable differences in health across the population, and between different groups within society. Health inequalities arise because of differences in the conditions in which we're born, grow, live, work and age. These conditions influence our opportunities for good health, and how we think, feel and act; this shapes our mental health, physical health and wellbeing.

Public Health England recognises that there are multiple dimensions at which health inequalities operate. We find inequalities in health linked to:

- Socio-economic status and deprivation, for example unemployed people, those on low incomes or people living in deprived areas (this could include poor housing and poor education as well as unemployment)
- Protected characteristics: for example, age, sex, race, sexual orientation or disability
- Vulnerable or 'inclusion health' groups: for example, vulnerable migrants; Gypsy, Roma, and Travellers; homeless people and sex workers
- Geography: for example, urban or rural areas

Action on health inequalities requires improving the lives of those with the worst health fastest. (Public Health England, 2019a.)

Our starting point

Previous work commissioned by Public Health England set out to explore the dynamics of health inequalities among older people living in rural and coastal areas. (Public Health England, 2019b.) The report *an evidence summary of health inequalities in older populations in coastal and rural areas* found there was a paucity of literature relating to health inequalities among older adults in these communities, particularly in coastal areas.

This report was commissioned by Public Health England to follow up on that work and attempt to fill some of the gaps in evidence identified by that review. The groups that this study focuses on are older men, older people from ethnic minorities, and older LGBTQ+ people. These were groups for whom the previous review identified both gaps in the evidence base and concern around unmet need. We refer to these as the "groups of interest to this study".

This study focuses on the issues affecting these groups of interest specifically in coastal and rural communities. While some of the issues described are unique to coastal and rural settings, many also affect older people living in urban and inland settings. However, they may do so in different ways – living in a coastal or rural setting may mean that these issues are experienced differently, or may be amplified or exacerbated. We also explore how solutions may need to differ in these settings.

Definitions

Ethnic minorities: We use this term, in line with the most recent Government guidelines[2], to refer to a wide diversity of communities, encompassing people from many backgrounds who belong to different minority communities. The term encompasses people from a range of ethnicities, countries of origin and cultural backgrounds, including white minority populations. We sought information regarding Gypsy, Roma and Traveller communities within this research, but we were unable to find evidence of challenges specific to these communities in these types of geographical area. As discussed later in the report, we recognise that terminology can itself be problematic, as it can minimise important distinctions in the experiences of different individual minority communities. Where we quote other organisations or literature other terms may be used.

Lesbian, Gay, Bisexual, Trans, Queer+ (LGBTQ+) people: We use this term to describe people who identify with a wide range of gender identities and sexual orientations. Again, we recognise that this term can be used to homogenise the experiences of a diverse group, within which there are divisions. In particular, we recognise that attitudinal shifts towards the acceptance of diverse sexual orientations have progressed further than those towards trans+ people. Where we quote other organisations or literature other terms may be used.

Rural areas: These are usually defined as areas which fall outside settlements with more than 10,000 resident population (PHE 2019b).

Coastal areas: Any coastal settlement within a local authority area whose boundaries include UK foreshore, including local authorities whose boundaries only include estuarine foreshore. Coastal settlements include seaside towns, ports and other areas which have a clear connection to the coastal economy (PHE 2019b). While coastal cities were not within the scope of Public Health England's *An evidence summary of health inequalities in older populations in coastal and rural areas,* we have included contributions from the outskirts of some coastal cities within this study.

Older people: we use this term to refer to people aged 50 years or older.

Some key facts

- Nearly 10 million people live in rural areas in England (LGA 2017), and older people comprise a large and growing segment of the population of rural and coastal areas (PHE 2019b)
- The population of those aged 65 years and over will grow by around 50% in rural areas between now and 2039, with negligible growth in the population aged under 65. This will increase the ratio of older to younger people (ONS 2018)
- Rural areas are projected to experience some of the largest increases in the proportion of one-person households containing an older person (ONS 2020a)
- Smaller seaside towns have a much higher proportion of older people – 34% of their population is older than state pension age, compared to just 25% in larger seaside towns, 23% in rural areas and 19% across England as a whole (DCLG 2011)

2. https://www.ethnicity-facts-figures.service.gov.uk/style-guide/writing-about-ethnicity

Policy context

The Covid-19 pandemic has laid bare the extent and impact of health inequalities across our communities and intensified the urgency of addressing their causes (Public Health England, 2020a). In addition, the 'levelling up' agenda has drawn attention to the need to address the differences in experiences and outcomes across different communities across England.

While health inequalities across urban areas have received considerable attention in the media, there has been longstanding interest in the health inequalities that impact rural and coastal communities, with ongoing research programmes on the topic.

There is a growing recognition of the strength of taking a place-based approach to addressing health inequalities, in recognition of the multiple and complex causes of inequality.

However, without a nuanced understanding of why health inequality exists among particular groups, there's a risk that population-level responses may fail to reach some of those who face multiple disadvantage; such responses may, in the worst case, exacerbate inequalities for these groups.

Place-based approaches

This review is intended to inform those who wish to take a place-based approach to addressing health inequalities in their local area. Place-based approaches recognise that to make a significant change to health outcomes at a population level, it's necessary to not just treat disease, or the causes of disease, but to address the wider determinants of health, and to consider the impact of psychosocial and protective factors that operate in a given 'place'. Place-based approaches recognise that the levers for action on health inequality are not held by one single agency; the best approaches draw on the assets and capabilities of all actors in a place, including health and care services, communities and civic bodies.

This report is intended to equip those taking a place-based approach with the tools to identify causes of health inequality among the groups of interest to this study, and to suggest actions that can be taken to address these issues.

We envisage this report may be of particular interest to:

- Leaders within health and wellbeing boards
- Policy makers and commissioners within local authorities, local health bodies and Integrated Care Systems (ICSs)
- Other local funders, including businesses and charitable funders
- VCSE sector organisations

At the end of this report we explore the implications of our findings for those seeking to address health inequalities in place, drawing on the frameworks set out in Public Health England's PBA toolkit (Public Health England, 2019a).

The PBA toolkit has been designed to help local places develop plans for reducing health inequalities (which they are required to produce under the NHS Long Term Plan). It's designed to support collaborative, cross-system action. The PBA toolkit supports places in identifying the strategic, system-wide action that has previously worked to reduce health inequalities at a population level, and how this can be applied in their community. It provides tools and resources, including maturity indices to help local systems to: identify the strength of their partnership arrangements; achieve a shared and evidence-based understanding of the health inequalities in their locality; jointly agree priorities; and plan action and ways of working.

Place-based approaches to addressing health inequalities are important because they allow a comprehensive response to the myriad causes of health inequality. They move away from piecemeal responses that act only on certain aspects of inequality. They allow a response to

the individual behaviours and actions that affect health that's sensitive to the context in which these take place. Place-based approaches also support the allocation of resources to address inequalities across the system. Place-based approaches are already being developed to address health inequalities in many places and across organisations, including local authorities, sustainability and transformation partnerships (STPs), ICSs and Clinical Commissioning Groups (CCGs).

The shift towards place-based working has been further cemented by the publication of the White Paper on Health and Care which envisages a shift towards the integrated planning of health and social care at the levels of system, place and neighbourhood. It also envisages new ICSs playing a key role in strategic decision making (DHSC, 2021). The King's Fund provides a helpful breakdown of the different levels at which health systems are expected to operate:

System: the level of the ICS, typically covering a population of 1-3 million people. Key functions include setting and leading overall strategy, managing collective resources and performance, identifying and sharing best practice to reduce unwarranted variations in care, and leading changes that benefit from working at a larger scale such as digital, estates and workforce transformation.

Place: a town or district within an ICS, often (but not always) co-terminous with a council or borough, typically covering a population of 250-500,000. This is where the majority of changes to clinical services will be designed and delivered, and where population health management will be used to target interventions to particular groups. At this level, providers may work together to join up their services through alliances or more formal contractual arrangements.

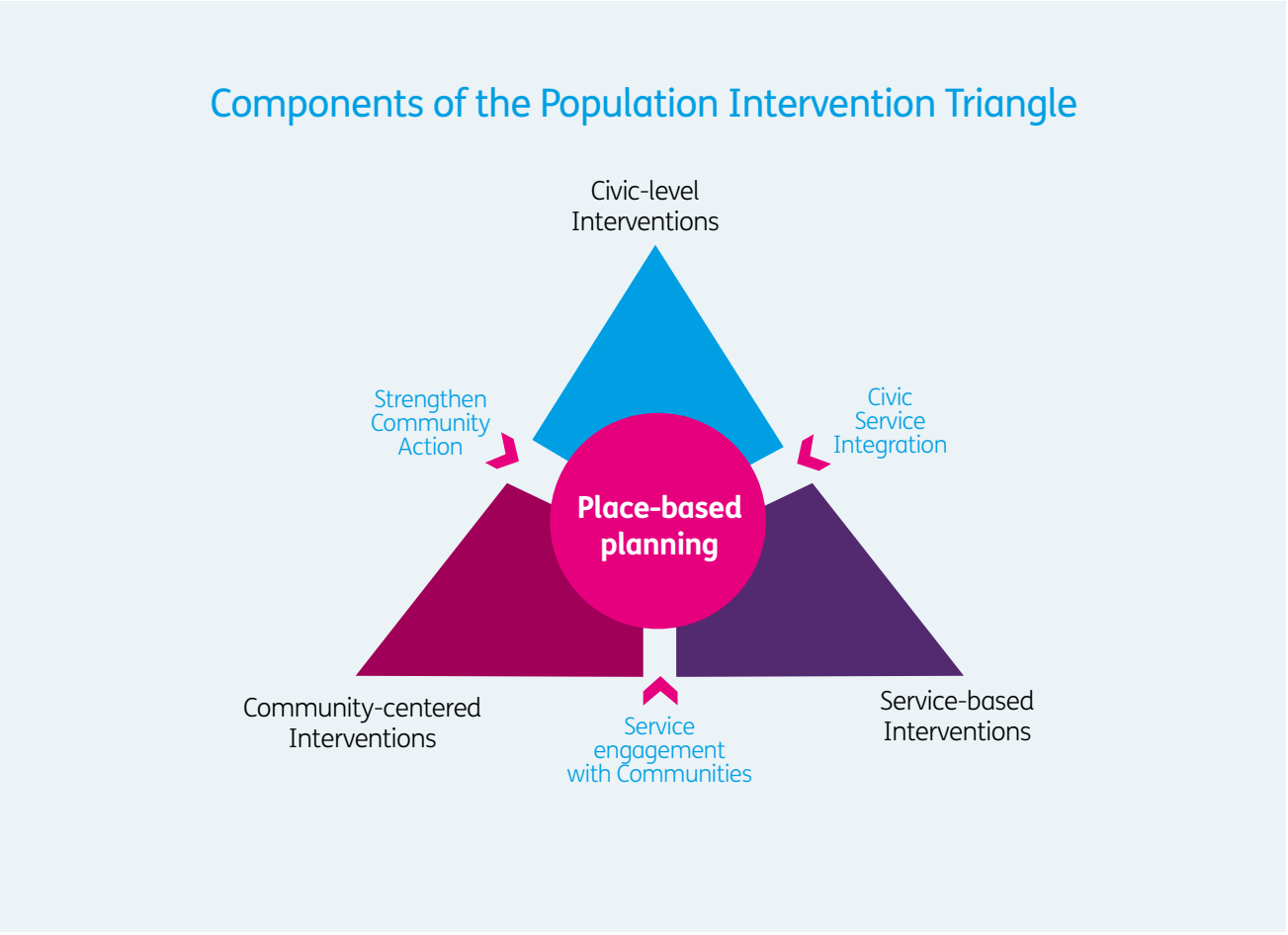
Neighbourhood: a small area, typically covering a population of 30-50,000, where groups of GPs and community-based services work together to deliver co-ordinated, proactive care and support, particularly for groups and individuals with the most complex needs. Primary care networks (PCNs) and multidisciplinary community teams form at this level. (Charles, 2020)

The population intervention triangle (PIT)

The PIT is a key framework within the PBA; it sets out the different levels at which health inequality interventions might take place. It demonstrates that effective action on health inequalities can happen at any level, but that we have the greatest chance of producing a sustainable impact on health inequalities when actors within a place commit to systemic, collaborative action across all levels.

The PIT framework also recognises the need for action along the 'seams' between different levels to ensure an effective place-based response, as it's at these seams that the population groups at most risk can fall through the gaps. The PIT is intended to support cross-organisational working and to help organisations understand where their own interventions fit within a wider place-based approach. It's designed to help focus attention on the need to identify where seams between levels of action can be strengthened.

We have used the PIT framework to think about where action is already taking place, and where further action is needed.



PHE (2019) Place based approaches to reducing health inequalities

Methods

This study was completed by Chloe Reeves and Kate Jopling, independent consultants working for Age UK. Age UK are members of the VCSE Health and Wellbeing Alliance; the authors drew on the expertise and insights of the wider alliance.

We conducted this study in the context of the Covid-19 pandemic, but intended to draw on insights originating from before the pandemic to inform action beyond the immediate response and recovery. Inevitably, however, the context affected what we were told.

We drew the evidence for this study from three sources:

- A review of the literature on the health inequalities/causes of health inequalities experienced by the groups of interest to this research
- Interviews with VCSE workers who are experts in the field(s) of health, care and support
- Interviews with older people from the groups of interest to this research

A "task and finish" advisory group of experts from Public Health England and its partners, and from across the VCSE Health and Wellbeing Alliance, oversaw the study and the development of this report.

The literature review involved a rapid assessment of recent literature on the health inequalities/causes of health inequalities experienced by older LGBTQ+ people, older men, and older people from ethnic minorities living in rural and coastal areas. The review included academic papers, health and social care guidance, and grey literature. Due to the paucity of literature available, we included sources published after 2010, with an emphasis on literature published within the last five years. We focused on literature produced in England, but included sources from outside England where these were commended to us as relevant to the English context by interviewees or members of the advisory group.

We originally envisaged that this study would be rooted in a review of literature. However, as the bibliography indicates, this was extremely limited. The study therefore depended on the work and contributions of VCSE organisations, groups, staff and volunteers. While we made considerable efforts to access knowledge about the groups of interest from resources such as Joint Strategic Needs Assessments, we had to adapt the research methodology in response to the paucity of information.

We made a request for contributions through VCSE networks and newsletters, including but not limited to the VCSE Health and Wellbeing Alliance, and National Voices. These requests generated additional literature (primarily grey), but also illuminated the extent to which the sector's knowledge of the subject is tacit rather than explicit – it's not written down, but held in the heads of community workers.

We therefore undertook to interview and/or correspond with a number of both paid and volunteer community workers. These were a self-selecting group who came forward as holding notable experience and expertise of working with and supporting the communities of interest to this research. We spoke with community workers from seven English regions. Their contributions (primarily spoken, but also written) proved invaluable to this research.

	Rural	Coastal
Spoken contributions	X6	X5
Written contributions	X1	X1

To supplement the evidence from the literature and our interviews with professionals, we carried out interviews with older people from the groups of interest in this study. The limitations of the scope and size of the study meant that the sample was not intended to be representative. Instead, we designed our interviews to explore and illuminate the issues coming out of the wider study.

Our aim was to interview 12 individuals: four from each of the groups, with a split across rural and coastal areas. However, the organisations supporting this work identified additional interviewees, bringing the total sample to 17. Because one of the main categories is exclusively male, while other categories also included men, the sample is majority male.

Category	Rural	Coastal	Age range
Men	X3	X2	66-73
LGBTQ+	X1 queer woman X1 gay man	X2 gay men	62-72
Ethnic minorities	X 2 women X 3 men	X2 women X1 man	50-69

We recruited interviewees through the organisations supporting this work. We also recruited a small additional number through an agency. They come from coastal and rural areas across a range of English regions. We offered interpretation services to support interviewees for whom English was a second language.

We conducted interviews by telephone and Zoom; they took the form of a semi-structured interview covering each individual's perception of life in their community, their health and wellbeing, their experience and understanding of support available in their community, and their wishes and aspirations for support both now and in the future.

The methods used for recruitment and the interview process naturally limited the breadth of the sample, meaning we were unable to reach:

- Those not in contact with any services or support networks
- LGBTQ+ people who were uncomfortable with their identities or fearful of being 'out'
- People with hearing loss

We found that recruiting interviewees was particularly challenging in the context of the pandemic. Many of the small community organisations most familiar with these individuals were heavily stretched in their capacity, and were also keen to be sensitive to the personal challenges faced by older and more vulnerable service users. Consultation fatigue was another concern (this is discussed in more detail in our findings).

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- LGBTQ+ people who were uncomfortable with their identities or fearful of being 'out'
- People with hearing loss

We found that recruiting interviewees was particularly challenging in the context of the pandemic. Many of the small community organisations most familiar with these individuals were heavily stretched in their capacity, and were also keen to be sensitive to the personal challenges faced by older and more vulnerable service users. Consultation fatigue was another concern (this is discussed in more detail in our findings).

Interviewees participated on condition of anonymity. We identify LGBTQ+ individuals using self-selected terms to define their gender identity and/or sexual orientation. We haven't identified the individual ethnicities of interviewees from ethnic minorities. While we acknowledge that this risks playing into the homogenisation of people from diverse backgrounds, it represents a compromise forged to offer people additional anonymity in a context of some distrust and fear. The sample included people from a range of ethnic backgrounds and countries of origin, including both Black and Asian older adults and people from white minority communities. The sample also included some people who were born in England and some who weren't, and individuals who didn't speak English as a first language (some of whom participated through an interpreter). Men who agreed to be interviewed in relation to their experiences as older men did not disclose their ethnicity or sexual orientation. Due to the challenges faced in recruiting participants, we included some participants who lived in larger settlements (e.g., market towns) within rural counties under the rural category.

As a result of these challenges, our interviewees tended to be younger. Although many had faced challenges and had experience of accessing support from the health system and from other sources in the community, these were largely well-managed. All our interviewees lived in the community (rather than in a care setting or in supported housing); some lived alone and some with a partner, or with a partner and children. Participants recruited through the agency were not necessarily in contact with services, but tended to be from more affluent sections of the community. As would be expected given the age of our participants, the majority of our interviewees reported living with at least one long-term condition, although these were often well-managed.

Considerations

In subsequent sections we present our findings on the factors underlying health inequalities among the groups of interest to this study.

It is important to note that the lack of data and other high quality evidence to inform this review places significant limitations on the certainty with which any of these findings can be stated. In particular, in the absence of comparative data, it's difficult to identify which issues are unique to the experiences of these groups in these settings/geographies specifically, as opposed to issues that affect all older people in those groups, or all older people in those settings/geographies.

However, these were the issues that individuals living in those contexts, and organisations working with individuals in those contexts, identified as particular to them. In many cases they drew on their own experiences of living and working in different communities, including in urban and inland areas, at other times in their lives.

While some of the challenges identified in this report will also arise for people in urban and inland contexts, there are likely to be differences in their nature and sometimes their severity. In the case of older LGBTQ+ people and older people from ethnic minorities in particular, the smaller population sizes of these communities create challenges for individuals in finding peers, and for organisations in providing support at a viable scale. As a result, the potential solutions to these challenges may differ in rural and coastal locations – with a greater emphasis needed on broadening the inclusivity of mainstream provision and less emphasis on developing specialist services.

However, these challenges are highly likely to be replicated in areas such as the rural fringes of urban areas, areas where ethnic minority communities are small, touristic areas, and so on. And similar solutions may be needed.

We identify the need to improve the evidence base in relation to the groups of interest to this study as an urgent priority.

2. Findings: Overarching themes

In the following sections we set out our findings on the factors underlying health inequalities among older men, older people from ethnic minorities and older LGBTQ+ people in coastal and rural areas.

First, we consider a number of overarching themes that emerged across all groups of interest to this study. It's important to note that the biggest challenge across all three groups is that without specific and focused attention their needs can be overlooked. In the case of older people from ethnic minorities and older LGBTQ+ people, this is often because these communities are affected by a 'numbers game', where they're too small to register across broad assessments of community need. In the case of older men, the lack of a gendered perspective on the challenges of ageing – both in terms of identifying which groups may need support and identifying what support may be needed – can lead to men missing out.

Community organisations reported challenges, but many older people accentuated the positive

The paucity of literature and data available means that our findings were necessarily largely informed by the perspectives of those we talked to. While the community organisations we spoke to were quick to identify the challenges faced by people in their communities, there was a tendency among the individual older people we spoke to accentuate the positive. This was often in the face of significant experiences of challenge, including prejudice and discrimination.

Older people spoke of a sense of place

It's important to note that while many of interviewees recognised some challenges related to their local areas, they were overwhelmingly positive about the communities in which they live and perceived significant advantages of living in coastal or rural areas.

"It's close to provision and the walking and I find living by sea very therapeutic"

Man – Gay – 72 – Coastal area

"When we first came here, we thought, 'Isn't it nice?' People have got time to talk to you. Or we felt that they did. [...] I love the big sky that I have here. It's not over built up. There is room. There is space."

Man – 67 – Coastal area

"I like to live here, to be honest with you. I just adapt really well. I've been working since I've been here, and I like it, to be honest."

Woman – 59 – Ethnic minority background – Coastal area

"The main thing I would say that I like is that I've got family that live fairly close by me. So, if you were to say that is one of the reasons and the fact that I would say it is a safe area to live in. So, if you were to combine those two factors it gives you peace of mind. It makes you feel fairly secure and safe"

Woman – 65 – Ethnic minority background – Coastal area

"I like the weather. The weather is certainly milder here than it is in other parts of the country. I love the accessibility of things like the seaside, I love that. It's a nice area for other amenities."

Man – 69 – Coastal area

For people who had moved into these areas, this viewpoint was often expressed as being in contrast to areas in which they had previously lived.

"It is amazing that first I came out here, I settled down automatically and I felt more comfortable here than I felt in London."

Man – 63 – Ethnic minority background – Coastal area

"Compared to big cities, it is much better than, for example, in London, where I lived for three years, because here, every wish, every need is satisfied, and I'm well looked after. Because I was unemployed and I was homeless since March, and I was also cared for."

Man – 60 – Ethnic minority background (via interpreter) – Rural area

"I moved to [rural town] 12 years ago, and it is a small town in [county], and well it's the first time I've ever lived in a small town so it's been quite challenging for me in lots of ways, but also really nice."

Woman – 59 – Ethnic minority background – Rural area

People identified friendly and supportive communities as a particular advantage of living in coastal and rural areas.

"So, there are very friendly people living here, and these people also are very helpful. And also, during lockdown, many places were closed, but people spoke to each other, they took part in each other's life."

Man – 60 – Ethnic minority background (via interpreter) – Rural area

"I know virtually all my neighbours by first name. And they're a very sociable lot. And they range in age from relatively young to people who are older than me. And that's good, because people will stop and chat and all the rest of it. So, there's a certain degree of sociability about the place."

Man – Gay – 67 – Coastal area

"Well, I could ask the neighbours. They're all pretty friendly. We've met probably most of our immediate neighbours. I could go and knock on the neighbour's doors."

Woman – Queer – 62 – Rural area

"Most of the people from the local community have been really welcoming."

Woman – 61 – Ethnic minority background (via interpreter) – Rural area

In coastal areas that attract tourism, we heard that people take pride in living in a place that others find desirable to visit.

"What makes it even better is there are lots of other people there as well enjoying the same thing and it's very pleasant. I wouldn't change it for anything."

Woman – 65 – Ethnic minority background – Coastal area

"In some ways I think we get the benefit of the fact that there are probably more restaurants and pubs in a seaside resort than there are in an inland town because of the tourists that come here."

Man – 69 – Coastal area

In rural areas, people talked about a sense of space and access to the countryside – noting that this had been a particular advantage during the pandemic.

"I like the fact that it's rural and I like the fact that it's in the hills if you like. Nearer to God. We get more extremes of weather. It's colder in the winter, we get more snow than lower areas and we get more sun in the sunshine. When it comes out it's here first and I really like that. The local council I think are very good. They provide lots of good facilities."

Man – 66 – Rural area

"For me, a town is pain, really. I hate towns. I don't like a lot of people around me. So, I'm quite happy where I am."

Man – 73 – Rural area

This sense of place is potentially an advantage in working with older people in coastal and rural communities, because it suggests that people from the groups of interest to this study will understand interventions that centre on places.

It was notable that people living in coastal areas – by and large small to medium-size towns – perceived few gaps in services, but community workers recognised more gaps, particularly in relation to vulnerable individuals.

"I walk to the top of my road and there's a bus stop. Hundred meters to the left is a railway station. It may be that we were very selective when opted to live here."

Man – 67 – Coastal area

Older people spoke about the health advantages of living in rural and coastal areas

Many of the older people we spoke to took proactive steps to look after their health and recognised that features of their local area helped them to do this.

"It's a good walking area and I think that's very healthy for people, walking, good fresh air. So, I think that's one of the great benefits of it."

Man – Gay – 72 – Coastal area

"Following the lockdown, I've started riding my bike on the seafront."

Man – 67 – Coastal area

"I generally keep good health. I have an underlying health condition, a chronic heart complaint, which I take medication for. It doesn't really impact on my lifestyle at all. I like to exercise and get out and about."

Man – 69 – Coastal area

"There is a group down here [name of support group]. And they are directed mainly at mature people. And on a Friday I would join their class because they had an excellent instructress."

Man – 67 – Coastal area

"I try as much as possible to get out every day. I try and walk between one and three miles a day. But sometimes it's just impossible, but I do try and walk as much as possible."

Man – Gay – 67 – Rural area

People who move to new areas may not have support networks in their new communities

A key theme in our discussions with both community workers and older people was the need to avoid homogenising the groups of interest to this study. Later in this report we discuss the need for a granular and nuanced approach, particularly in relation to LGBTQ+ and ethnic minority communities. However, a contrast that was relevant across all the groups of interest related to the experiences of those who had lived in rural or coastal areas for long periods (and in particular during their earlier adult lives), and those who have moved to these communities more recently and later in life.

People who had lived in these communities all their lives often had deep roots in the community and were surrounded by family. Those who were more recently arrived were often separated from family by distance; their closest relationships were with people living in the areas where they had previously lived.

"Our best friends still live in [previous urban setting]. We do have a bunch of friends down here. If we were to describe our closeness to those groups of friends, they still remain in [previous urban setting]."

Man – 67 – Coastal area

"I mean, the neighbours are super friendly and nice, but we left our support community when we left the tower block that we lived in, which was a real community."

Woman – Queer – 62 – Rural area

"I love the area I live in, but there's no depth to it. I'm not a member of any clubs. I don't have friends that I go and visit. People don't come and visit me, but that suits me fine. I wouldn't say that I do have any roots here."

Man – 69 – Coastal area

"We don't mix in this community very much at all. We know our neighbours and we speak to them but they are just acquaintances. We don't socialise with them."

Man – 66 – Rural area

"I worry about it in a way I suppose because I've moved from where my family live [...] And so I feel that is going to be lacking in my older age not being around my extended family."

Woman – 59 – Ethnic minority background – rural area

We heard that putting down roots could be a particular challenge in small communities.

"It takes you 20 years to settle into these villages."

Man – 66 – Rural area

For older people from ethnic minority backgrounds or LGBTQ+ older people who had grown up or lived for many years in coastal and rural areas, there was a sense that while stigma and prejudice may remain an issue, it is at least a familiar one, around which they had developed coping strategies over many years. For people who have arrived more recently, building links to support may be more challenging.

Linked to that issue, we heard that people who have moved into new areas may lack information about the support available in their communities.

"I think that if you know your way around the system, the support is out there."

Man – 69 – Coastal area

People in rural (and to a lesser extent coastal) areas rely heavily on cars

A strong theme across all our discussions with older adults was a sense that access to a car/ the ability to drive is an essential feature of rural (and to a lesser extent coastal) living. While most of the older people we spoke to had access to a car, after the age of 70 people are required to renew their driving license every three years. While the number of older drivers has increased in recent years, many will have to give up driving in their later lives; this has been linked to a range of negative impacts (Musselwhite, C, 2016).

We heard from both community workers and older people that a lack of public transport makes this is a particular issue in rural and coastal communities. People told us they often needed to travel to shops and services such as pubs and cafes; leisure services such as gyms and swimming pools, and health services, particularly hospitals. The requirement to travel can be greater for the groups of interest to this study, particularly for older people from ethnic minorities and older LGBTQ+ people, as they may need to go further to access specialist shops and services (such as culturally appropriate food and clothing for people from ethnic minorities, or sexual health services for older LGBT+ people). They may also need to travel across larger geographies to meet peers. Some older LGBTQ+ also choose to travel across larger geographies through a desire to preserve anonymity.

The prospect of giving up driving concerned many of those we spoke to, who described local bus services as inadequate.

"I never use public transport. I occasionally use taxis. I have used trains but buses, I haven't been on a bus in 40 to 50 years."

Man – 66 – Rural area

"I do need to drive, especially where I live because everything is a long walk, and I couldn't possibly walk."

Man – Gay – 67 – Rural area

"If you want to go anywhere bigger than what the High Street provides, if you've got specific requirements, you have to drive. And the bus services are pretty awful, I have to say. If you look up the buses, they go to one place."

Woman – Queer – 62 – Rural area

In line with previous research findings, we heard that driving was considered important for social contact. Many respondents had friendship groups spread across wide geographical areas (Musselwhite, C, 2016). This was especially true of the gay men we spoke to, who described travelling considerable distances to meet with other gay friends.

"Very important. I think I would be extremely depressed if I couldn't drive. [...] It's a lifeline to me in the sense of freedom it gives you."

Man – Gay – 72 – Coastal area

It will be important to consider how to enable more older people to travel without cars. This is likely to require action to improve public transport, both to make it a more viable alternative to car use and to encourage active travel where possible. The community workers who contributed to this study noted longstanding transport issues in rural areas. They highlighted infrequent public transport that finishes early in the evening and doesn't run at weekends as a particular challenge. A number noted that the discontinuation/ decommissioning of local Taxicard schemes has had an adverse effect.[4] They also pointed out that bus routes have reduced significantly during the recent years of austerity, making it increasingly difficult to use them for any timed appointments, such as medical appointments.

4.Taxicard schemes provide subsidised (usually by the local authority) door-to-door journeys in licensed taxis and private hire vehicles for people with serious mobility or visual impairments.

"In more rural villages you may have a bus, if you're super lucky, four times a day, which just about makes it a viable service. Cutting that back to one or two a day means it isn't really viable. You can't line up appointments."

Community worker – Rural area

We should also consider how to help people gain confidence in using alternative modes of transport when they give up driving.

"I imagine if I become infirm and unable to drive, I will use not public transport but private hire to get to places. For me, I don't see access to any of these things as a problem. But I may become a grumpy old man."

Man – 67 – Coastal area

Loneliness and social isolation are strong and recurring themes

Loneliness and social isolation are consistent themes throughout the literature with regard to our three groups (see for example Age UK 2018a; Age UK 2018c; Beach 2019). They also featured prominently in the conversations with community workers and were recognised as an issue by many of the older people to whom we spoke – although most had current networks that sustained them (outside of the pandemic).

"I have some friends living in this area, so that made it a bit easier for me. I have some friends living only a few miles away on the edge of this community. And I also had a dog and it's a great dog walking area and owning a dog is a great way of meeting people and making friends."

Man – Gay – 72 – Coastal area

Experiences of loneliness and social isolation vary within and across the groups, as do both the contributing and mitigating factors. For example: the HIV epidemic affected older gay men hugely, due to the loss of friends and partners (Beach 2019); older men within the farming community benefit from the peer networks, camaraderie and shared purpose of livestock markets (Davies et al 2019); and older people from non-English speaking backgrounds particularly welcome projects that allow them to chat in their own language (Age UK 2018a).

"I've been suffering from depression, which you can understand. [...] I'm not okay, but as I said, they [the doctors] won't do anything. But they have volunteers to call on me. And, they phone me up to talk to, because, of course, the only person I do talk to, is my wife. And there's only so much you can talk to your wife."

Man – 73 – Rural area

Many of the older people we spoke to expressed struggles with loneliness as a result of the Covid-19 pandemic. These concerns were reflected by the community workers who contributed to this research, who were concerned that new and exacerbated loneliness and isolation would cast a long shadow even when things opened up.

"How do we get people out again? They've been inside, with shopping and medication coming to them. They've had their family beamed into their living rooms. How do we get them out now?"

Community worker – Rural area

In subsequent sections we discuss the need to help enable people from the groups of interest to this study to come together with those they consider peers, through specialist organisations and services. However, there's also a place for community-based responses to loneliness that offer practical support in people's immediate local areas.

Rural Coffee Caravan

Rural Coffee Caravan exists to help rurally isolated people in Suffolk access services and information to improve their lives, health and wellbeing, and to bring people together, empowering and strengthening rural communities. They work to alleviate loneliness and social isolation by providing occasions that engender conversations, leading to people feeling more part of their community. The service is free and accessible to everyone.

Villages and communities can book visits from the Rural Coffee Caravan. All that's needed for outdoor visits is permission to park, and space to set out tables and chairs, with easy access for everyone (plus room for social distancing during the pandemic). Indoor visits can also be arranged: for example, in village halls (although these have been paused or adapted during the pandemic).

Rural Coffee Caravan supplies publicity material to be shared in the village and/or community, both digital and printed, and provides free refreshments during their visit. The team and volunteers love to chat, so there's always someone to talk to, and they have a wealth of information, in a range of formats, about local services, facilities and resources. Some villages host the Caravan monthly, and others just two or three times a year.

Rural Coffee Caravan also facilitates a network of pubs and cafes hosting free 'coffee morning' style sessions in their venues. These are called MeetUpMondays and are very popular with people who are less comfortable in village halls (sometimes due to a perception that everyone already knows everyone) and who feel more at home in a 'real life' place. These have proved particularly popular with men.

The Friendly Bench

The Friendly Bench CIC is a social enterprise that aims to tackle loneliness, social isolation and build community cohesion using innovative, purposely-designed outdoor social spaces that reconnect people with their local community.

Specially designed, constructed and adhering to Disability Discrimination Act guidelines, The Friendly Bench™ venues are safe, easily accessible mini community gardens with integrated seating and sensory planting. They are situated within communities, for people to meet, chat, connect with nature, build friendships and a sense of belonging.

"The Friendly Bench™ gives me a real boost, it takes me out of myself, it gives me something to do and more fresh air!" **Steve, 57**

(As quoted in The Friendly Bench 2020)

People in rural and coastal areas often have to travel further to find peers

In our conversations with both older people and community workers, we heard that older LGBTQ+ people and older people from ethnic minorities, in particular, often had to travel further to access services appropriate to their needs, or which allowed them to preserve a desired level of anonymity. As such their sense of the 'local' geography may be wider than that of majority populations living in the same areas.

"I mean, really, for gay life here you have to go to [nearest city]. You have to travel into [nearest city], which is not a great burden or anything."

Man – Gay - 67 – Coastal area

"If it wasn't for the internet, I chat to people on there, but don't go anywhere now because times have changed. And where I used to go, things have closed down. There's nothing much here in [market town] for me."

Man – Gay – 67 – Rural area

While the older adults we spoke to didn't always consider this a major problem, especially those who were able to drive, it had caused issues during the Covid-19 lockdown and was recognised as a potential future challenge.

Many of the older people we spoke to were still working

Many of the older people we spoke to were still engaged in some level of work, often part time. This partly reflects our relatively young sample, but also reflects a growing trend towards working in later life. (ONS, 2018)

"I retired some years ago. And then, from then on, I've done part-time work, social caring, and housesitting, etc. I do all sorts for other people."

Man – Gay – 67 – Rural area

"I have been doing home help for the last ten years now."

Woman – 65 – Ethnic minority background – Coastal area

"I worked past retirement age, because I enjoyed what I was doing, you see."

Man – 73 – Rural area

Others were involved in community activities (e.g. chairing local charitable organisations).

Importantly, we heard that work could be a source of connection with other people from a similar background and an opportunity to make connections with the local community. Unfortunately the pandemic had forced some of the people we spoke to out of their jobs.

"I found people with a similar background in my workplace [working in a factory]."

Woman – 61 – Ethnic minority background (via interpreter) – Rural area

"My colleague knew about [migrant support organisation] and passed me the details."

Woman – 61 – Ethnic minority background (via interpreter) – Rural area

"I lost my job during the pandemic. And I'm out of work."

Woman – 59 – Ethnic minority background – Coastal area

The rapid digitalisation of services may increase existing inequalities and create new ones

The community workers we spoke to repeatedly identified digitalisation of services as a factor exacerbating the inequalities faced by the people they work with. There are a number of aspects to this:

1) The lack of adequate high-speed internet infrastructure in rural areas and coastal towns is relatively well known. For example, the Select Committee on Regenerating Seaside Towns and Communities recently reported that "investment in mobile and broadband infrastructure in coastal communities lagged considerably behind that being made in urban areas and that this was worsening the economic disadvantages already being felt in these communities" (House of Lords 2019).

Community workers noted that these issues have been profoundly exacerbated by the response of statutory services to the Covid-19 pandemic:

"It's bonkers when basic statutory services are working through the internet and you have areas still that can't use it reliably."

Community worker – Rural area

"The notion everyone had broadband is just a myth."

Community worker – Coastal area

"GPs think that because someone contacts them by email then they can do a video consultation. They have no idea how many people are dependent on dongles for their internet or are using their phones - especially if they're in rented accommodation. If they were to do a ten-minute Zoom call, then that could be all of their data for the month. Then they're cut off. We can't assume it's viable for everyone to Zoom all the time."

Community worker – Coastal area

2) Mixed levels of digital literacy, confidence and willingness to use digital technology.

"Many older farmers still prefer pen and paper. It's something they avoid as much as possible."

Community worker – Rural area

"Digital inclusion is probably more advanced in the LGBT community because of the safety of anonymity."

Community worker – Coastal area

3) The loss of face-to-face service provision exacerbates barriers to relationship-building, including with regard to language and trust.

"Language on the phone – people really struggle. They're not digitally included. A Zoom call doesn't bridge the divide. It doesn't work. It's not the same as meeting in person."

Community worker – Rural area

"To really be embedded in communities and build trust, Zoom can't replace face-to-face."

Community worker – Rural area

Older people echoed this sense that the shift online was a source of inequality. Most were very aware of the sharp division between those who were able and those who weren't able to get online.

"They do encourage you now as well to do a lot of things online. Your correspondence, I mean, with the medical profession. And that's not easy for a lot of people. I can get by but only just. What about all those other people out there that are a lot older than me and wouldn't know one end of a computer to the other let alone if they needed medical attention? They do tend to push that now. They are pushing it more and more and more and I think it's harder for older people."

Woman – 65 – Ethnic minority background – Coastal area

"I don't know how to use the internet 100%. I am a little bit afraid of it."

Woman – 61 – Ethnic minority background (via interpreter) – Rural area

"The groups don't bother now, it's all done online. It's all done on your mobile phone, are you up, or this or that, or the other. It's all done with that, it's just unbelievable how things have changed so much."

Man – Gay – 67 – Rural area

"I think you're missing a huge dimension in your life if you're not conversing with what's available to you, out there, electronically. I think that's a big area that elderly people could benefit more from, being alert to what you can actually do on the internet."

Man – 69 – Coastal area

"[IT skills are] very important now because you virtually can't do anything without it. I mean I'm not saying that I'm very good at it, I'm not, but I can get by."

Woman – 65 – Ethnic minority background – Coastal area

Older people who are online described the significant benefits this brought them. Many said it is their first port of call for information needs; some use local forums and apps to help them remain connected to their communities.

"I'd go on my computer, onto Google, and I'd Google it up and ask and then take it from there. If there's a telephone number or a contact or an address I could write to, I'd do that, go down that road. And ring them and write off the information."

Man – Gay – 67 – Rural area

"I don't feel that I couldn't find advice if I wanted it. I think I'd use the internet to find advice. To find where I might go. Also, there's quite a few support groups. There's a Facebook page called Nextdoor, which is about your area."

Man – 69 – Coastal area

"We've got... In [town], we've got some of neighbourhood apps."

Woman – 59 – Ethnic minority background – Coastal area

"On Facebook, we have a local community group which I tag into. It warns you about anything going wrong in the area."

Man – 66 – Rural area

Some of those we spoke to had taken proactive steps to get online, or to find support to improve their IT skills. This was identified as a priority area for future investment.

"I go to the library here in [market town]. I'm trying to improve on my computer skills."

Man – Gay – 67 – Rural area

The VCSE sector already knows and supports people from the groups of interest to this study

As the bibliography indicates, the development of this research report depended on the work and contributions of VCSE organisations, groups, staff and volunteers.

While not all of the older people we spoke to were in touch with VCSE organisations, a minority relied heavily on these organisations for practical and social support. These organisations were meeting needs that couldn't otherwise be met by communities.

In particular, for people from an ethnic minority backgrounds and LGBTQ+ older people, the VCSE sector supplied the only provision specific to their needs in the community. It was only VCSE organisations – and often very small ones – that were seen as having the specialist knowledge required to provide sensitive support.

Key themes in our conversations with community workers were the flexibility, responsiveness and consistency of VCSE sector support and provision.

"People mistrust so much. It's a slow process to build up confidence so they can tell me their story and we can bring them in slowly at their own pace. They may not make contact for months and they slowly think about whether they want to engage or not. You can't give someone a card with a generic office number – relationships with named people matter."

Community worker – Coastal area

"We are bridging so much and have been throughout the pandemic. With the best will in the world the council and the NHS could not be as fleet of foot as we are."

Community worker – Coastal area

However, they also had significant concerns about sustainability as we move toward a post-pandemic world:

"A lot of people are losing jobs now because it's been so difficult with funding. We are the only ones embedded in these communities. If we go, then we can't just be replaced. It will take years to rebuild."

Community worker – Rural area

"People are tired, you know? We're finally hearing about the toll the pandemic has taken on NHS staff and we sometimes hear social care mentioned, but no one seems to realise that we're on the frontline too. And we're plugging gaps - we're at the really sharp end of things. It's important and we love being there, but it's exhausting."

Community worker – Coastal area

The effects of austerity continue to be keenly felt by VCSE organisations and groups working with people from these groups

Another strongly recurring theme, mentioned by every one of the community workers who contributed to this study, is the impact that years of austerity have had on the VCSE sector. This was frequently cited alongside the current challenges – particularly financial challenges – posed by the Covid-19 pandemic:

"Services have been cut to the bone. Everyone likes to talk about inclusion and reducing inequalities, but we were struggling before Covid. We're needed more than ever, but only just surviving."

Community worker – Coastal area

Community workers also noted that levels of unmet need had increased over the recent years of austerity, with more and more people being referred to them by statutory services that would previously have met their needs directly. We also found examples within the literature: "The [Hastings Men's] Shed would like to report that at this moment of austerity and local government cutbacks we are having more and more people being referred to us from Social Services with various problems to come and enjoy our workshops. The voluntary Trustees are not 'trained' to look after their personal needs so we have to insist they bring a carer along" (Hollands 2019).

A lack of data on these groups makes it hard to make progress

As noted in the Public Health England research An evidence summary of health inequalities in older populations in coastal and rural areas (2019b), there's a paucity of evidence focusing on older LGBTQ+ people, older men, and older people from ethnic minorities who live in these settings.

This lack of evidence is a source of frustration within these communities, and is something a number of the community workers we spoke to felt statutory bodies could do much more to address:

"There's a lack of data from within the BAME community. We need it to secure funding, but don't have the funding to secure it. What do commissioners expect us to do?"

Community worker – Rural area

"Services and organisations say they are LGBTQ+ friendly, but they still don't collect data on sexuality or gender identity. They say 'oh no, that's very personal' or try to be overly politically correct. We do a lot of work with people to make sure they have the confidence and skills [to ask these questions and collect this data]"

Community worker – Coastal area

However even where data is requested, individuals are not always comfortable in disclosing information about their identities – whether in relation to ethnicity or sexual orientation or gender identity. Therefore action is needed alongside data collection efforts to build trust with communities around confidentiality and how data will be used.
These issues are discussed further in subsequent sections.

3. Findings: Older LGBTQ+ people

General themes

Experiences of stigma, discrimination and abuse have a long-lasting impact on if/how older LGBTQ+ people engage with health and care services

As noted above, the older LGBTQ+ people to whom we spoke were relatively comfortable in their identities. They reported having experienced relatively little prejudice and discrimination through their lives as compared to some of their contemporaries. They were also, universally, out to, and accepted by, their families. Our interviewees reported a reasonably high degree of acceptance of their identities within their local communities, with many reflecting positively on how attitudes had moved on in their lifetimes.

"I think it got easier as I've got older because society has changed, there's so many gay related issues on television now, people are much more comfortable with the gay issue."

Man – Gay – 72 – Coastal area

"I have to say I was fairly closeted for a long time. But it hasn't really made a huge difference. I mean most people say, so what? It's very much the attitude."

Man – Gay - 67 – Coastal area

However, they recognised, and community workers reflected, that these experiences were by no means typical among LGBTQ+ people, and especially older people. Some of those we spoke to reflected on the advantages that they perceived as coming from being able to 'mask' one's sexual orientation, or 'passing' in certain circumstances. Importantly, though, passing is less of an option for some older LGBTQ+ people, for example some trans people, and also in some circumstances – for example when in receipt of care services in the home, in a care setting or toward the end of life.

"I don't think they would see a pink label on me as I walk through the door and I wouldn't bring up the term, the idea of sexuality or singleness."

Man – Gay – 72 – Coastal area

"I think as an older queer, you face fewer challenges in being visible. Because as an older woman, you get less and less visible anyway, by the year."

Woman – Queer – 62 – Rural area

Despite these relatively positive experiences, our respondents were still aware of the challenges and pressures that resulted from being in a significant minority within a community.

"That was one of the cons. Are we going to be singled out? But actually, no. I think things have moved on a bit, really."

Woman – Queer – 62 – Rural area

"In a village, everybody knows. And they're all nudging one another. 'There he goes, look.'"

Man – Gay – 67 – Rural area

While our interviewees recognised the progress made towards equality in recent years, it remains the case that many older LGBTQ+ people were born when being gay was effectively illegal in the UK. Some may have hidden their LGBTQ+ identity, the community workers we spoke to reported supporting people who had been 'outed' by organisations or individuals from whom they had sought help in the past. That experience shaped the way they engage with and access health, care (and welfare) services in later life. Other older people carry significant trauma as a result of experiences of prejudice, discrimination and hate earlier in life and may have coped with this without professional support of any kind.

We found a recent review of existing evidence which identified a study that found 18% of older LGBTQ+ people would feel uncomfortable disclosing their sexual orientation to their GP (Beach 2019). There are also studies looking at how prior 'psychological treatment' of older gay men and transgender women earlier in their lives was characterised by physical and mental violence; this shaped other facets of their later lives, including patterns of access to healthcare (Beach 2019).

The community workers who contributed to this study noted a perceived lack of sensitivity to the historic burden of stigma and discrimination experienced by older LGBTQ+ people within statutory bodies' approach to providing LGBTQ+ services:

"Mental health charities aren't the ones to take this forward because of the stigma associations. Or it might be the only peer support group has come out of the sexual health clinic and they insist on putting the logo on the flyers. They need to think harder and do better."

Community worker – Coastal area

A number of community workers noted retirement to be a particularly challenging moment in some older LGBTQ+ people's lives, a time when memories of past traumas can re-emerge:

"People have busy lives and then they retire and traumas resurface... to be older and lesbian or gay or bi... where do you go?"

Community worker – Rural area

Community workers reported emerging concern that experiences of stigma and discrimination, and the feelings associated with these, have been emphasised by the Covid-19 pandemic. In our conversations with older people, we heard harrowing stories of older LGBTQ+ people taking their own lives during the pandemic.

Community workers told us that older gay men who had lost loved ones and livelihoods during the AIDS pandemic were facing particular trauma at this time.

"Gay men who spent all their money when they thought they would die of AIDS, or lost all of their peer group... They didn't expect to be living into old age and haven't got provisions in place, and they've lost people and they feel that and now – what does it feel like to live in another pandemic when everyone is on it and they're protecting jobs and trying to save everyone but it was 'go die' when it was gay people? You wouldn't run to them [statutory bodies] for anything would you?"

Community worker – Coastal area

Gaps in the provision of specialist support for older LGBTQ+ adults who may be dealing with trauma can also be an issue in urban communities. (This trauma may be the result of historic (and/or current) experiences of prejudice, discrimination and hate. Individuals in all communities are also dealing with mental health issues caused by long-term loneliness, isolation and ostracisation) (Beach 2019). However, the challenges of bridging this gap are different in rural and coastal areas, where populations may be too small to sustain specialist services. While it may not be practical to develop specialist support in every community, working with specialist organisations may be one way to ensure that mainstream mental health provision can be made available and adapted to the needs of these groups.

Older LGBTQ+ people can still face stigma, discrimination and abuse in some health and care services.

It is important to note that the older LGBTQ+ people we spoke with reported positive recent experiences of health services (although some had had more negative past experiences) and most had a reasonable degree of confidence in health providers.

"I think my doctor knows I'm gay. I've never discussed it with him, but he lives very close to me and I see him quite a lot, no issues there. I've never met any issues which were I thought... Think about anything to do with my sexual orientation, not at all."

Man – Gay – 72 – Coastal area

"Well, I, personally, have not had any needs that have not been met. And I certainly haven't experienced any prejudice. Whether I would when I try to access them I have no idea."

Man – Gay – 67 – Coastal area

However, the community workers we spoke to told us that our interviewees' experiences were not necessarily representative of all experiences, particularly those of older trans+ people. They said that while there had been progress in some health services, there remained issues in relation to care services and provision for people with dementia and in end-of-life care.

"They're not just films with Colin Firth in – those things still happen."

Community worker – Coastal area

Community workers who contributed to this study noted recent (within the last five years) examples of:

- Older LGBTQ+ people being prayed over by a care worker seeking atonement for their 'sins'
- Health and care staff refusing to acknowledge same-sex relationships
- The loss of a same-sex partner being trivialised by health and care services
- Attempts to prevent someone registering their partner's death using their affirmed gender
- Health and care staff telling older LGBTQ+ people "we don't do that here" when they attempted to express their LGBTQ+ identity

"People think we've come such a long way. We haven't. There are times in our lives when we are very careful about how much we reveal about ourselves, and that's what the older LGBT community grapples with."

Community worker – Coastal area

While stigma and discrimination are not confined to rural areas and coastal towns, the National LGBT Survey found LGBTQ+ people broadly considered larger urban areas safer than smaller towns and rural areas. Respondents to this large national survey described feeling less vulnerable to harassment or abuse from strangers on the street when in a city (Government Equalities Office 2018). And these perspectives were reflected by the older people to whom we spoke, some of whom reported traveling to nearby cities or larger towns to access specialist services, including HIV testing. Community workers with experience of working in urban areas echoed this in their contributions to this study:

"It's difficult in the city, but in the rural surrounds there's even more prejudice and history on someone's history, sexuality and their story."

Community worker – Rural area

All community workers spoke of the need for training for health and care staff, both to address their own biases and to give them the skills and confidence to confront discriminatory attitudes and behaviour from other older adults:

"It's not OK – it's not because residents are old – it's because they're homophobic. Get in there and say something."

Community worker – Coastal area

"It is complex – it's OK to acknowledge that. It's not OK to assume all trans people are young people"

Community worker – Rural area

A survey of LGBTQ+ people aged 18 years and over and living in Greater Merseyside (n=173) identified a need to empower health and care staff and ensure they are more confident about combating discrimination and meeting the needs of LGBTQ+ people. One in four respondents reported that they don't

disclose their sexuality or gender identity to medical or sexual health professionals through fear of a negative reaction or discrimination (Macmillan Cancer Support and Sahir House 2018). We identified a small number of other examples where studies have sought to understand these issues at a local level within the literature. However, one recent review of available evidence notes such training has been required in the NHS for over 20 years. While commissioners generally require diversity training for services, there's currently no quality assurance or national standard for such training (Beach 2019).

Older LGBTQ+ people value peer-led support and services, including around caring responsibilities and dementia

The community workers we spoke to consistently noted that peer-led groups and services have more success in engaging older LGBTQ+ people than other types of provision. Some of the older people we spoke to had experience of accessing support groups specifically for older LGBTQ+ people, including remotely during the pandemic, and felt these had an important role to play in filling gaps in social support. Investing in peer-to-peer support offers an important way of bridging the gap between formal support and individuals coping on their own.

"Because of this [experiences of stigma and discrimination, as explored above] a lot of people don't trust generic services to keep their information confidential. They don't feel confident that they'll 'get it'."

Community worker – Coastal area

"He's starting a social group for older men on Zoom tomorrow. He invited me to join it, so the first time will be tomorrow."

Man – Gay – 72 – Coastal area

Yorkshire MESMAC

Yorkshire MESMAC works with Gay men, Bisexual men, and men who have sex with men (MSM), people living with HIV, young LGB&T people, BME communities, people who misuse drugs, and sex workers across the county of Yorkshire including its rural and coastal areas.

They offer a range of services including sexual health services and testing, counselling and one-to-one support, as well as social opportunities.

MESMAC have an outreach team who work to ensure that people who may not be comfortable accessing services openly are able to access support.

MESMAC support a growing number of older clients. During the Covid-19 pandemic MESMAC helped older gay men living across Yorkshire to come together through social groups held online.

The Phoenix Group

The Phoenix Group is a social group for older gay men, convened by Age UK Wirral. While nearby Liverpool has a relatively thriving LGBTQ+ social scene, Wirral has had little if any provision.

The Group is clear: "All welcome – free of charge – just turn up". No membership is required, no one needs to register to attend, and no personal details are collected. This is essential to encouraging people to come forward and is something commissioners of similar services elsewhere will need to be sensitive to.

Ageless Thanet LGBT 50+ group

The LGBT 50+ group was developed with the support of Ageless Thanet, which is part of the National Lottery Community Fund's Ageing Better programme. Plans for the group were coproduced with local LGBT people, who identified a need for a group for older LGBT people, as they felt that they faced specific issues distinct from those of the wider LGBT community. Before the pandemic, the group held regular coffee mornings; they have also set up 'social strolls' as well as taking part in Margate Pride. While the group focusses on older adults, one of their aims is to facilitate links with the wider LGBT community locally.

Community workers emphasised the need for professionally facilitated specialist support catering to older LGBTQ+ people with care needs, particularly those with dementia. We heard that there can be particular issues for older LGBTQ+ people with dementia. They may face challenges such as being unsure who they've come out to; they sometimes express new identities and orientations as their condition progresses. Community workers felt that there was a need for further research to understand the impact of dementia on people with LGBTQ+ identities as well as for more provision to enable people to receive support among peers:

"People feel uncomfortable within a generic carers' dementia group, because someone might be quite disinhibited, so you know – they want a specific service for that that feels safe."

Community worker – Rural area

"Changing sexuality and dementia is also underexplored. It's difficult for families. More could be done nationally on that one, because if we see it here in [coastal town] then it must be happening everywhere."

Community worker – Coastal area

The need for specialist support for people with care needs was reflected in our interviews with older respondents, who also expressed an interest in care services for LGBTQ+ communities specifically.

"I've often wondered whether there would be a market, for example, for a nursing home for gay people as opposed to being mixed in with other..."

Man – Gay - 67 – Coastal area

Older LGBTQ+ people may benefit from tailored support around planning for later life, including at the end of life

"The life stages older LGBT people go through are different because of their back story."

Community worker – Rural area

A recent review of existing evidence noted that differences in the social networks of older LGBTQ+ people, compared to non-LGBTQ+ people, can contribute to a greater need for formal care provision and support with later life planning, for example due to not having children or being alienated from family members (Beach 2019).

"Covid has revealed how our whole system rests on family members. Many of my LGBTQ group don't have them or have been disowned by them."

Community worker – Coastal area

The community workers who contributed to this study consistently noted the need for tailored services that help older LGBTQ+ people to plan for later life, including end-of-life care and related decisions. Recent research by Marie Curie identified that person-centred support and recognition of partners are critical issues for older LGBTQ+ people at the end of life. (Marie Curie, 2016)

Community workers reported successfully working with local solicitors to develop 'family of choice' workshops for older LGBTQ+ people; developing LGBTQ+-friendly memory clinics; and developing training for staff working in care homes, extra-care housing and other residential settings to understand the LGBTQ+ perspective on concepts like next of kin. They consistently noted that care networks may be different for older LGBTQ+ than for non-LGBTQ+ people, and that health and care professionals must be able to take a potentially unconventional look at what a care network is, and what this means for a health, care or support plan:

"It can take ages to develop living wills, when you're approaching friends and peers rather than family members who might expect that approach more. They don't have biological family systems. There's such a layer of complexity to it. It's not like doing it with a sort of natural person to turn to like an adult child. People didn't have children like [LGBTQ+] people do now. That goes for responding to Covid or falls, or longer-term planning like memory loss and POA [Power of Attorney]."

Community worker – Rural area

The Rainbow Café

Hosted by Brighton and Hove LGBT Switchboard and opened in 2018, the Rainbow Café is a group that supports LGBTQ+ people who live with memory loss or dementia.

Switchboard's research showed that LGBTQ+ people face additional barriers when it comes to dementia, with staff in care settings making the wrong assumptions about someone's sexuality or gender identity. On its own, this can be upsetting, but when someone is also faced with a dementia diagnosis then it can make things worse.

Rainbow Café offers a safe space for LGBTQ+ people living with dementia and their carers, but is also attended by those interested to learn more about dementia and about memory loss.

The café sessions include a mixture of practical activities, conversation and information, such as Q&As with an occupational therapist. Some LGBTQ+ people are estranged from their families or might not want them involved in their healthcare. They may be single and may have a 'family of choice' instead. Information sessions have therefore also looked at support through later care. For example, how one might have a friend recognised as the one's carer in a situation where there is no next of kin; how a friend might register for Power of Attorney; and how someone with dementia might ensure their care needs are directed by a trusted friend.

Taken from: www.switchboard.org.uk/switchboard-opens-rainbow-cafe-support-lgbtq-dementia/.

Older LGBTQ+ people accept having to travel distances to access specialist support, but this may be more challenging as they age

The older LGBTQ+ people we spoke to lack access to specialist support and to a wider community of their peers in their local area. They are accustomed to being obliged to travel to access support and meet other LGBTQ+ people. However, as this travel is often by car, it may become less accessible as they age.

"The only time I go out in gay life is when I'm visiting cities."

Man – Gay – 72 – Coastal area

"I mean, really, for gay life here you have to go to [nearest city]. You have to travel into [nearest city], which is not a great burden or anything."

Man – Gay – 67 – Coastal area

"I mean, if I get isolated, God forbid, I should end up alone and I was experiencing social isolation, there would be nothing in [rural town] if I wanted to go and join the local LGBT. It would have to be in a bigger place. I would have to travel out to do that."

Woman – Queer – 62 – Rural area

"My social life on the scene is I have two friends in [rural town], and I used to travel over there and stay over with them. We've been all over. I've been on holidays with them. And I go down to London to my cousins."

Man – Gay – 67 – Rural area

"If there's something similar [to the online group] in [nearest city] when lockdown and restrictions are lifted, I will go there and try and meet people."

Man – Gay – 72 – Coastal area

Rural areas

Intergenerational projects can help to reduce isolation and tackle stigma, but may be difficult to establish because of siloed funding

The small size of LGBTQ+ communities in rural areas can make it challenging to create adequate provision for these groups – as a result many older LGBTQ+ people become accustomed to travelling significant distances to reach support, which may become less viable as they age. One potential solution to this is to bring together generations of LGBTQ+ people.

While mixed age groups will not work for everyone, and older people can sometimes feel excluded in such settings, this may be a solution in some areas.

Some of the community workers we spoke to noted that projects – including Rainbow Cafes and Pride events – solely intended to bring together different generations of LGBTQ+ people had led to knowledge sharing and experience building, which in turn had reduced social isolation and loneliness. There were also some reports of reduced local concern about stigma and discrimination. While these intergenerational projects are unlikely to be specific to rural areas, our community workers cited them in reference to rural areas.

"The younger generation is so much more open and that breaks down the traditional younger/older barrier. But the older generations have such a story to tell – and it needs to be told and heard and remembered. It works well – coming together as one Rainbow Community."

Community worker – Rural area

Community workers in areas where there were no intergenerational projects noted how difficult local funding silos would make it to establish something similar.

"We have funding for older people and funding for younger people. We don't have funding to bring younger and older people together."

Community worker – Coastal area

Coastal areas

Older LGBTQ+ people may experience an increase in stigma, discrimination and abuse during peak tourism seasons

While many of the issues faced by older LGBTQ+ people are common to both coastal and rural areas the impact of seasonally changing populations is a particular issue in coastal towns. Tourism is a key (sometimes primary) industry for a number of seaside towns. This means that they may have a relatively stable resident population during autumn and winter months, but a changing and transient population into spring and throughout the summer. Our community workers noted that large numbers of holidaying UK and overseas tourists can considerably change how an older LGBTQ+ person feels about their town:

"Because it's a tourist spot and also gets a lot of foreign students – they don't always get trans older people or even an older gay couple. Where there would be a lot of acceptance in the town and they go to a café and are comfortable and then people say '[a tourist] family came in and they moved the kids away from me'"

Community worker, Coastal area

Recognising the wide-ranging impact of stigma and the fact that this is an ongoing challenge – particularly among older people who can't pass – will be important.

4. Findings: Older men

General themes

More older men are living alone

Across the UK as a whole, we are seeing increases in the numbers of people living alone. In the decade between 2008 and 2018, there was a 6% increase (from 7.5 million to 8.0 million) in the number of people living alone. This was primarily driven by the increase in the number of older men living alone: an increase of 55% for men aged 65 to 74 and 20% for men aged 75 and over. Older people are more likely to live alone than younger people. In 2018, 48% of people living alone were aged 65 and over, and 27% were aged 75 and over (ONS 2019).

"I'm divorced, so I live on my own, but I've got three kids who are in their early 20s and they all work in London. Much of my life revolves around keeping in touch with them and visiting them when I get a chance."

Man – 69 – Coastal area

More older men are ageing without children

The number of aged people 65 and over without adult children is set to rise to 2 million by 2030. The number of women who haven't had children more than doubled in one generation, from 9% of those born in the 1940s to 19% of those born in the 1960s. It's estimated that 25% of women born in the 1970s will not have children. Although the ONS doesn't record data on how many men have children, it's estimated that around 23% of men over 45 are without children (AWWC 2019).

Among the gay men we spoke to, none had children; all were aware that they would likely have to rely on their partners or professional services should they need care and support in future years.

More older men are lonely and/or socially isolated

It's possible to feel lonely without being socially isolated, and vice versa, but both can have a significant impact on physical and mental health, and have similar risk factors. While the proportion of older people who say they're often lonely has remained relatively constant over the last decade, the size of the older population is growing, so absolute numbers are increasing. Based on current population projections, the number of people aged 50 and over living in England who often feel lonely will reach 2 million by 2025/26, unless measures are put in place to prevent it (Age UK 2018b).

While many of the older men we spoke to rejected the term 'lonely' to describe their circumstances, particularly outside of the pandemic context, many described having limited social contacts and limited networks, particularly in their immediate local areas.

"I don't see much of them. Partly, really, because I'm limited to what I can do. Where I can go. I have to protect myself. My health isn't good, so I don't want to get away from the house. I'm hardly able to leave the house. The only time I leave the house, really, these days, is either to the hospital or to the doctors."

Man – 73 – Rural area

"My kids are not here anymore. I don't have close friends. I don't have people I go to the pub with or go for meals with. I've got some friends, but they tend to be further away. In the local community, I don't feel as if I've got any roots."

Man – 69 – Coastal area

"I've hardly got any friends at all. But I don't need. I'm one of those people that doesn't need other people. I'm quite happy with my own company."

Man – 73 – Rural area

Life transitions – and particularly role transitions – are known to be disruptive moments that increase the risk of a person becoming or remaining lonely. When existing social connections are challenged or severed – for example through the break-up of a relationship, emergence of a serious health issue, or retirement – this can reduce opportunities for

'easy' connection and threaten self-identity (Kantar Public 2016). Loneliness is associated with a range of poor health outcomes, including low quality of sleep, increased risk of cardiovascular disease, weakened immune system and, ultimately, higher risk of mortality (Age UK 2018b).

The men we spoke to acknowledged that much of their social contact was related to work, and therefore when they retired this had fallen away, or would be likely to do so when they stopped working:

"I suppose, well, how do you meet people? I mean when I was working I used to work all the time. [...] A lot of my social circle revolves around work... revolved around work."

Man – Gay – 67 – Coastal area

Those at risk of loneliness, including (but not limited to) older people, may struggle to make or maintain social connections with others and as a result experience isolation, sporadic or fleeting social contact and a loss of confidence in their ability to socialise and engage with others. In particular, loneliness among older men may be exacerbated by gender-specific notions associating masculinity with independence and autonomy, which lead to older men being reluctant to reach out to or seek support from others (Willis et al 2019).

The men we spoke to had some awareness of the kinds of help with social connection that might be available to them later in life, but weren't sure whether they would find it helpful.

Activities that engage older men

An ongoing evaluation of an Age UK programme found that while men may not all enjoy the same things, some ways to support older men who are (or may be at risk of being) lonely, are to:

- Provide a supportive environment
- Offer activities with a practical outcome, which generate a sense of purpose among men
- Offer activities that enable men to share skills
- Promote activities in locations where men go, using appropriate language which makes men feel they have something to offer

(Age UK 2018b)

"I don't know that we've got a Men's Shed, but I know about the concept of Men's Sheds because I've got a friend who goes to a Man's Shed in Scotland. I do know about the Men's Shed concept. There was a Walking Football group at one time that I, again I went on the internet and found... I did think, I wonder if I could go back and play football again. I did get in touch. The contact wasn't very good, but at least there was a group there that I knew, if I really, really wanted to, I could do it. Also, I thought I'd quite like to go play chess again and I got in touch with a group that played chess. I never went, I never ended up going. I am, kind of, aware of these things."

Man – 69 – Coastal area

"I think the church has a senior members club, I think. I do go to church occasionally, when church was going, occasionally. Yes, the church has a support group, I think, and one of the pubs used to have a men's group. Not gay men, but just a men's group for people to have a pint and a chat. There were those things, that's all I know of here."

Man – Gay – 72 – Coastal area

"A lot of people around here are into bowls. Many people cycle. I know that's not a social thing. But there's bowls. There's University of the Third Age. There are many churches on nearly every corner down here. And they all have things going on in them. And, yes, there is availability to maintain friendships through that."

Man – 67 – Coastal area

"I went to Silver Screen, which the ODEON was doing cheap films on a Wednesday. And I was approached by, what do you call somebody who arranges things? A convener of a discussion group after the films, and I went there."

Man – 67 – Coastal area

"The only groups that I know of are the walking groups that meet up two or three times a week and they go for walks as a group. That's available to both. Available to men, I am not really aware of any facilities that are specific. If there was I probably wouldn't join in because, again, I am this self-contained person."

Man – 66 – Rural area

Men's Sheds

Men's Sheds are community spaces for men to connect, converse and create. The activities are often similar to those of garden sheds, but for groups of men to enjoy together.

Sheds are whatever the members (or 'Shedders') want them to be. Although labelled sheds, they often aren't sheds at all. They can be empty offices, portable cabins, warehouses, garages, and in at least one case, a disused mortuary. Many don't have premises at all in the beginning and instead form a group that meets regularly for the social connection, company and camaraderie until they can find somewhere to kit out with tools. Many Sheds get involved in community projects too – restoring village features, helping maintain parks and green spaces, and building things for schools, libraries and individuals in need.

Activities in Sheds vary greatly, but you can usually find woodworking, metalworking, repairing and restoring, electronics, model buildings or even car building in a typical Shed. Sheds typically attract older men, but many have younger members and women too. Whatever the activity, the essence of a Shed is not a building, but the connections and relationships between its members.

(Men's Sheds Association 2021)

"Coming to the Shed has given me a feeling of self worth and increased my confidence".

"My spare time was going to waste. Your day goes much quicker when you have nothing to do. Here you meet new people and you get advice or tuition from others. Now I get up in the morning with something to achieve. I enjoy it when I'm doing something positive".

(As quoted in Hastings and St Leonards Men's Shed 2020)

Coastal areas

Older men who move to coastal towns in retirement may find themselves removed from loved ones and networks, including options for unpaid care

As noted above, people who move into a community later in life have a different experience living there than those who've grown up in or spent much of their adult lives in these communities. Community workers told us this was a particular issue in coastal communities.

Each year, tens of thousands of people who have passed retirement age in England move across the country to set up home in a new location. This migration is mainly characterised by movement away from major cities to rural and coastal areas (ONS 2020a). Under the right circumstances, and when undertaken by choice, moving can bring benefits, including allowing people to age in a home that's appropriate to their needs, in an area that meets new aspirations for a post-retirement lifestyle (Pennington 2013).

However, there's a clear association between movement and poor health in older age, with men and women whose health has deteriorated more likely to have moved than those whose health has improved or stayed the same (Wilson et al 2007). Research also suggests that less wealthy people tend to move only when they are compelled by circumstance, such as increased needs for formal or unpaid care, and do so later in older age, as their health deteriorates and their care needs intensify. This leads to poor health and wellbeing outcomes (Pennington 2013).

Some coastal towns that have undertaken population profiles, including Hastings and Hove in the South East, have found a significantly higher percentage of older people living alone than the England average (SESC 2019). The community workers we spoke to noted that older men in coastal towns may become particularly isolated upon the death of a partner, or if their partner develops dementia.

"It's not just a coastal thing, but because people come here to 'retire to the coast' they are even more isolated sometimes when they get older."

Community worker – Coastal area

"We see a lot of older men who are isolated when their spouse or partner dies, and they were maybe [the] more socially-minded one and did all the organising. Of course, there's the bereavement, but there's an isolation; a loneliness too. It can be the same of course when a partner develops dementia".

Community worker – Coastal area

Among the older people we spoke to who had retired to coastal areas, most were still living with a partner. However, they identified concerns about a potential loss of social connection and also a source of care and support in later life should they lose their partner.

Single men moved by their inland council to cheaper coastal areas are now ageing in these places and are at particular risk of isolation and loneliness

There has been a trend in recent years of inland councils resettling people in temporary accommodation in areas where housing is cheaper. These areas are often coastal towns, such as Blackpool and St Leonards-on-Sea (Shelter 2016). While families with school-age children are most adversely affected by these moves (Shelter 2016), older people can also be badly affected, as local networks play an important part in their unpaid care, as well as in mitigating loneliness and isolation (Pennington 2013).

A 2015 Supreme Court judgement made it harder for local authorities to justify out-of-borough placements[5], but they continue to be made and people continue to age in coastal areas, away from their networks and connections. Community workers in coastal towns told us that single men resettled by their originating council are indeed now ageing in these places. They reported these groups to be at particular risk of isolation and loneliness. They are also unlikely to have access to unpaid care.

Single men living in houses of multiple occupation (HMOs) are now ageing and unable to move to more appropriate accommodation

A concentration of HMOs, typically large ones, has emerged in coastal towns, as overseas holidays have become cheaper and increasingly popular. The reduced numbers of holidaymakers left coastal towns with oversupplies of rooms in hotels and guesthouses. Struggling to find customers, many landlords converted their properties to HMOs and made them available to low-income, often single-person households (Viitanen & Weatherall 2014). Community workers that we spoke to told us that these properties had been used to house single men living in coastal communities, who were now ageing in accommodation which was often in poor repair, and not accessible for people with mobility issues (e.g. without lifts). However, pressures on local housing supply meant no other affordable accommodation was available, leaving men struggling.

"The HMOs are cheap. They used to be cheap and cheerful, but there's less cheer when you're struggling with the stairs, paying top whack for metered electric and know you can't handle yourself like you used to. But where can you go? Nothing else is affordable."

Community worker – Coastal area

Some of the community workers who contributed to this study described an emerging picture of property markets in seaside towns being overwhelmed with demand from people seeking to move from urban areas since the start of the Covid-19 pandemic. Some existing HMOs have been sold to families who plan to convert/return the property to a family home. The impact of this emerging trend on low-income HMO residents is not yet known.

Coastal towns have a pull factor for rough sleepers, but the winters are harsher than they expect

Community workers in coastal areas told us that among the most vulnerable men in their community were a group of rough sleepers who were ageing (often prematurely). Coastal towns have a pull factor for rough sleepers due to "fond associations", particularly memories of being a nice place to be. A 2015 report by the charity Crisis quoted one 'local key informant' from a coastal town: "[They say] 'I came here when I was younger, I had the best of times when I was here, my granddad used to bring me here'..." (Johnsen & Jones 2015). Tourism is also a pull factor in the summer months, as rough sleepers can make more money begging in these areas. Another contributor to the Crisis research commented: "They will gravitate towards [Seaside Town] because they know that if they want to go out begging in the summer that people can make £300 a day. Maybe not so much now in the recession, but previous years..." (Johnsen & Jones 2015).

"We don't have enough houses in our area to accommodate everyone and homeless people, we have a few as well. We have a few places where they can go and everything, but we have homeless people in our town, which is not very good."

Woman – 59 – Ethnic minority background – Coastal area

However, community workers who contributed to this study noted that relevant services struggle to flex with this expanded demand. They also report a lack of awareness about how cold the wind chill from the sea can be in the winter. Charities like Warming Up the Homeless in Hastings, Eastbourne and Bexhill have been founded by locals, in part to try and reduce the number of people – often older men – who freeze to death each year. There's little evidence as to the numbers of older men that die on the streets of coastal towns each year, but at least two men in their 50s died in Hastings in 2017 (Bureau of Investigative Journalism 2017).[6] Warming Up the Homeless uses shopping trolleys that have been decorated with fairy lights and are widely recognised locally to distribute "everything needed for warming up our homeless friends" (Warming Up the Homeless 2021).

One local audit of the health needs of the homeless population within coastal towns identified that older health and social care needs (for those aged 50 and older) "will differ on account of premature biological ageing and the reasons for their becoming homeless. It may be appropriate to introduce opportunistic screening specifically for people in this age group in any future commissioned service for the homeless, for example opportunistic screening for cognitive impairment, mobility, urinary problems, and traumatic brain injury" (East Sussex Council 2016).

Older men within the farming community may have specific needs

About 83% of UK farmers are male (Agerholm 2019) and agriculture typically has an ageing workforce. In the UK, around a third of all farm holders are aged 65 and over.[7] In 2016, the median age in the UK was 60, an increase of one year from 2013 and two years from 2005 (DEFRA 2020). In the same year, the median age for farm managers in England was 58 (DEFRA 2016). In 2016 there were 176,000 people working in agricultural holdings in England, in addition to holders and/or managers (DEFRA 2016), but we haven't found data disaggregated by age.

"So, that limits me a bit. The only thing I'm interested in, is in farming. That limits things a bit really, so [the organisation offering support] try to have somebody [as a befriender] who is either in farming, or has been a farmer, or aligned to farming."

Man – 73 – Rural area

Older men in the farming community can face specific challenges in later life. In 2019, Public Health Wales and the Mental Health Foundation collaborated on an action framework to support the mental health and wellbeing of farmers, farm workers, and their families. Their co-produced work found that many farmers are unable to retire because they don't have a pension and rely on income from the farm. They also can't move due to a lack of affordable housing in the local area, building restrictions on farmland, a reluctance to consider alternatives away from the local community, or having

6. Homeless people generally have poorer health and worse mortality than the population as a whole and it is therefore commonly accepted that 'older', in the context of homeless people means those who are aged 50/55 and older (Crane & Warnes 2010).

7. "Farm holder" refers to the person on whose account and in whose name the holding is operated and who is legally and economically responsible for it. "Farm manager" refers to those who ensure the smooth running of a farm or estate by overseeing operations and making business decisions.

caring responsibilities (for ageing parents). One contributor noted, "The 70 and above generation is still farming, as it is the only way of life they know. There is often no get out for the farmer, no backup plan, not really having other options than to continue farming" (Davies et al 2019).

When older men do retire and/or move from their farms, the transition can be difficult:

"They are moving - possibly because of frailty or disability - from a whole way of life to a loss of that. It's not the same as downsizing like many older people do. Loneliness, isolation and a loss of purpose are common...Also I think they have become more resilient and independent over the years, so when they get to the point of needing help, asking for help is difficult."

Community worker – Rural area

Stakeholders in the Public Health Wales and Mental Health Foundation action framework reflected that opportunities to connect should be rooted in a place, and be based on a peer-led approach (e.g., farmer to farmer) (Davies et al 2019). The need for a conversation between peers was emphasised by the retired farmer to whom we spoke, who explained that farming had been his entire life, and having lived a relatively solitary life otherwise, he struggled to find points of connection outside the community. Fortunately, he had managed to find support from a specialist organisation which was providing befriending.

In the literature, livestock markets were identified as a critical source of support, but it was recognised that not all farmers and farm workers attend, especially after retirement (Davies et al 2019). The community workers we spoke to noted the closure of farmers' markets during the pandemic had exacerbated loneliness and isolation within the farming community.

Exploring farmers' experiences of isolation, loneliness and mental health issues

New research led by the University of Exeter and national rural charity The Farming Community Network (FCN) aims to explore how social isolation, loneliness and mental health issues within the farming community are experienced and managed, and how to improve support available.

The research, titled Loneliness, social isolation and mental health in farming communities: An analysis of social and cultural factors, will be conducted by the Centre for Rural Policy Research at the University of Exeter, and is scheduled to conclude in September 2021.

Dr Jude McCann, CEO of FCN, noted: "Through FCN's Helpline (03000 111 999) we regularly hear from farmers and their families experiencing a range of issues which require different approaches and recommendations. We hope this research will help to better understand these experiences and will inform interventions for how to improve the support that is available to those in need."

Updates and the final research output will be available from the Farming Community Network website: https://fcn.org.uk/

Older male carers may not be supported by existing carers' services

Men are more likely to become carers in older age than at other times in their life, usually as a result of caring for their partners. As such, older male carers are more likely to live with the person they are caring for. Carers over the age of 85 are more likely to be men and are the only demographic of carers where men outnumber women (Carers UK 2019).

In 2015, there was a systematic review of barriers and facilitators to accessing formal and unpaid support for male carers in the UK. It found that male carers often felt ambivalent or guilty about asking for help. Their expectations of support were mixed, and previous negative experiences of support influenced help seeking, especially for unpaid support. Insufficient information about available services was frequently highlighted. It also noted male carer attitudes to service use, including lower confidence in services and higher worry compared to females. Positive past experiences and availability of both unpaid and formal support (including gender-specific education) were described as facilitating service access (Greenwood & Smith 2015).

Community workers in rural areas noted that there are very few support groups tailored to the needs and preferences of older male carers. There may be a particular gap around support for older men caring for partners with dementia:

"Services don't seem to be designed with men in mind. We know why Men's Sheds work, but we still think men will attend things like Dementia Cafes and want to chat. A Dementia Pub maybe, or a Men's Shed with a focus on caring, but not a coffee and chat kind of offer."

Community worker – Rural area

"The carers ones [services] tend to be 'come together for a tea and chat'... everything is stretched and the funding is poor. There's no capacity for anything else, but few men come [to them]."

Community worker – Rural area

Chief Cook and Bottle Washer

Chief Cook and Bottle Washer is a short film developed by the Bournemouth University Public Involvement in Education and Research (PIER) Partnership, which is available to view free of charge on YouTube.[8] In the film, a number of male carers over the age of 85 share their insights on being an older carer, how their life has changed since they became a carer, and their key messages for practitioners.

Although not specific to a rural setting, this film was noted by more than one contributor to this study to be a useful resource for those planning, developing, commissioning or delivering responses to the needs of older male carers.

Men at the Margins

A further helpful resource is the short film Men at the Margins, which is also free to view on YouTube.[9] Developed by Bristol University and Age UK, it explores older male carers' experiences of seeking social engagement and combating loneliness in later life, through interviews with both older male carers and researchers.

8. www.youtube.com/watch?v=VWgEaUHs97s
9. www.youtube.com/watch?v=jQye9JoS_Io

The closure and changing nature of pubs may be contributing to older men's loneliness and social isolation

"It did have a pub, at one point, and that was serving food. But whether they actually open again [after the pandemic] I have no idea. I doubt it, really."

Man – 73 – Rural area

The latest ONS data puts the number of pubs in the UK at 39,130 in 2019, reducing by 8,140 since 2009 (ONS 2020b). In 1990 there were 111 pubs per 100,000 people, falling to 73 pubs for every 100,000 people in the UK in 2017 (Foley 2019). Several factors have been suggested for the decline in pubs in the UK, including the 2007 indoor smoking ban, the 2008 recession, rising alcohol prices (due to increased taxation), and socialising at home becoming more commonplace as technology and home entertainment evolve (Lock 2020). Younger generations are also drinking less: 16- to 24-year-olds are less likely to drink than any other age group (ONS 2018).

While some pubs close, many of the pubs that persist are changing in their nature. There's a long-term trend towards people spending more of their household income on eating out and less on drinking out. Pub and bar enterprises are now employing more people serving food than working behind the bar (ONS 2020b).

The Covid-19 pandemic has added to the burden on pubs, with lockdowns forcing them to close their doors. More than 2,000 pubs are estimated to have closed in England and Wales during 2020 (Thatcher 2020). Reported estimates suggest a quarter of UK pubs may not survive the pandemic (Hancock & Asgari 2020).

A 2018 research project by the University of Bristol found men's reasons for going to the pub to be much broader than just drinking alcohol. Men reported wanting to interact with other people, get out of the house, and break their daily routine, as well as enjoy live music. They found that older men still see the pub as a central point in the community, although the rising cost of drinks means more people are drinking at home in isolation. The changing nature of pubs was also outlined, with higher prices, fewer social activities and louder music all identified as making older men less likely to access pubs. Men felt it's no longer acceptable to 'nurse a pint' if you're unable to afford multiple drinks (University of Bristol 2018).

The community workers who contributed to this study noted the important community role of pubs in offering a less formal environment for social interaction, and recognised the need for place-based approaches to nurture and retain pubs that could fulfil this role:

"Pubs as community assets. If you hide away in a village hall then that's not a space that is accessible at other times. If [your support group] meets in a pub, then that's a friendly space that people can access at other times. That's how groups grow and become self-sustaining."

Community worker – Rural area

"Why would you go somewhere with uncomfortable plastic chairs and orange juice, when you could go to a pub with comfortable seating and have a glass of wine? The older generation now is more used to comfort and little luxuries than perhaps the one that came before."

Community worker – Rural area

"The other thing with community halls is once you're in, you're in. You can kind of saunter past [a pub] and be like 'I'm just passing', whereas village halls have high up windows, curtains, layers of doors. You don't know if you're walking into a hundred people or empty chairs."

Community worker – Rural area

"There's no label. It's not mental health, it's not dementia, it's not anxiety, it's not loneliness, it's not knit and natter or anything else that's about doing a particular thing. It's just 'the pub'. You get men at things like church coffee mornings, but they seem to be in couples and go because their wife goes. We find more men go to the pub on their own."

Community worker – Rural area

Pub is the Hub

Wealden District Council, which covers a mostly rural area of East Sussex, has partnered with Pub is the Hub to help local pub operators to diversify, and offer more community spaces to support people who may be at risk of loneliness. This partnership recognises that, in many communities, the pub is an important space for socialising: publicans are often aware of regulars who come in search of company. Many see themselves as the eyes and ears of the community. In rural areas, pubs can be the only community space available, so they have the potential to play a key role in addressing loneliness.

Pub is the Hub is a national not-for-profit organisation that offers support and advice to communities, to help them increase the number of services and activities on offer in local pubs, and to reconnect pubs to their communities. Wealden District Council's Community and Regeneration team puts the Pub is the Hub in touch with local pub proprietors. Its representatives make regular trips to pubs with council officers, to build relationships with publicans and suggest how they might develop their community offering.

As a result, pubs in the Wealden area are now offering theatre nights, libraries, dementia-friendly pubs and computer classes, many of which are delivered through partnerships brokered by Pub is the Hub. These events help publicans to attract new customers, widen the experience for their regulars, and reinforce the pub as a central, vibrant part of community life.

For example, Pub is the Hub linked pubs in Wealden with the Applause Rural Touring Company and production company INN Crowd. With help from an Arts Council grant, they put on performances in several local pubs, with pubs often offering a set menu alongside performances. Many pubs were fully booked for these events which offered the opportunity for people who cannot travel long distances to the theatre to experience professional performances.

Pub is the Hub also linked pubs with the Barclay's Digital Eagles to offer computer classes on weekday mornings. It linked pubs to the East Sussex County Council library service to open mobile libraries in pubs across the district.

Taken from Jopling, K. (2020). Promising Approaches Revisited

For more information: www.wealden.gov.uk/business-support/pub-is-the-hub/

Transport challenges can exacerbate older men's loneliness and/or social isolation

The number of groups and activities taking place within each small town or village is often limited, with older men needing to travel to neighbouring villages and towns, or to the nearest city, in order to access them. A recent two-year study into older men's experiences of loneliness and social isolation identified long driving distances, preferring not to drive at night, and poor access to public transport as barriers to accessing and participating in groups (Willis et al 2019).

"It's well known so that we ignore it now. I wouldn't bother doing new research [about it] you know? But it's a challenge. We don't have council Taxicards anymore - nothing like that - so you have to drive or have money for taxis. You can use the bus to go to town and shop or something, but it only comes twice a day and folk in town don't plan things around our [village's] bus."

Community worker – Rural area

As noted above, high levels of car dependency may put older men who have to stop driving particularly at risk of loneliness and social isolation in rural areas.

"I never use public transport. I occasionally use taxis. I have used trains but buses, I haven't been on a bus in 40 to 50 years.

Man – 66 – Rural area

GPs are the lynchpin of service coordination responding to older men's health needs

In our discussions with older men it was striking that "the doctor's" was cited as a primary source of advice and information around wide range of needs. In several cases the GP was the only potential source of information around support that individuals could think of.

There was a high degree of trust in GP services, although in several cases we heard frustrations about the time it took to get an appointment.

"I must admit, I've got an excellent doctor. Excellent doctor. And, every time, I mean, I phone up, I need something. They put, the girl puts me through to the doctor, if they can, straight away. And, then they sort something out and he gets on to the hospitals, wherever the source of help for me is."

Man – 73 – Rural area

"I've just always started off with the GP, really. Only because I feel that I can probably open up to them a bit more. And they've always sorted me out, one way or the other."

Man – 66 – Ethnic minority background – Rural area

"Probably speak to the doctors if we needed help in the first place."

Man – 66 – Rural area

"We have a fabulous medical centre which has good access. It's good parking, it has all the facilities you need. Normally when I need to use them then they are readily available."

Man – 66 – Rural area

Given this reliance on GPs as a source of information, the roll out of social prescribing services through Primary Care Networks may present a new opportunity to link older adults with sources of appropriate support and connection in the community.

Brightlife Cheshire: Social Prescribing

Brightlife Cheshire provide social prescribing in the rural communities of Cheshire West, funded by the National Lottery Community Fund Ageing Better programme.

Brightlife works alongside NHS link workers providing enhanced support to older people experiencing loneliness and social isolation. It offers personalised interventions linking people into community-based activities, through signposting, supported access, accompanied visits. Men are particularly reticent in coming forward for support but Brightlife evidences numerous case studies, illustrating complex challenges and successful outcomes.

There are three tiers of engagement available depending on how vulnerable the person is, ranging from basic signposting into available services, through to intensive and on-going support including access to peer befriending projects.

5. Findings: Older people from ethnic minorities

General themes

Older people from ethnic minorities feel acutely aware of being in a minority

The older people we spoke to from ethnic minorities had varying experiences of abuse and discrimination because of their background, in their local areas. Nonetheless, it was clear across our conversations that the experience of being in a minority had an impact on people's lives:

"There are not many Bengali people here"

Woman – 69 – Ethnic minority background (via interpreter) – Rural area

"There aren't many black people in, well certainly, not around where we are. And I don't suppose there are, well, in all the surrounding areas really."

Man – 66 – Ethnic minority background – Rural area

"I really struggled to begin with when I came to [rural town] [...] because I lived in [borough] when I was in London which is nearly 85% mixed ethnic groups. And so I came to a small town which was very white, and very English, and I felt like I was one of the only Asian or Black faces in the town, so I did struggle with that."

Woman – 59 – Ethnic minority background – Rural area

"The town I'm living in, I would say there's not many ethnic minority people. We are probably the first family as Asian Bangladeshi background"

Man – 50 – Ethnic minority background – Rural area

"Funnily enough, in this particular area, there are hardly any people of minority ethnicity."

Woman – 65 – Ethnic minority background – Coastal area

"We never had any issues about race or any disputes at all and I was so pleased that the children and the families welcomed me as just a part of the community."

Man – 63 – Ethnic minority background – Coastal area

Some of the people we spoke to had experienced direct and overt racism, while others felt they were accepted in their communities.

"There are really bad people in the evenings if you are out then they shout out and say bad names and swear"

Woman – 69 – Ethnic minority background (via interpreter) – Rural area

"Even though I haven't encountered that much [overt racism], every so often those little pieces, that I have encountered, is there, it's at the back of your mind."

Man – 66 – Ethnic minority background – Rural area

"We are not English people and sometimes they don't know us and they just assume things about foreign people, which is not good. But we can live with that."

Woman – 59 – Ethnic minority background – Coastal area

"I must say then that I fit adequately in the social environment that I think I belong here."

Man – 63 – Ethnic minority background – Coastal area

"It's had no impact on my life whatsoever. Very occasionally maybe the odd inquisitive person, and it is only purely inquisitiveness, they will say where do you come from? Only extremely, extremely occasionally. I've never suffered from any racial whatever you like to call it whatsoever. None, absolutely none."

Woman – 65 – Ethnic minority background – Coastal area

"Where I live, I was the only Black family there in about let's say 50 houses and there was no-one in my area or my street that were Black. My neighbours were very, very nice and neighbourly and friendly."

Man – 63 – Ethnic minority background – Coastal area

Over time, most had identified a small number of others from similar backgrounds and while most were keen to be part of the wider community, they found comfort in being linked to people with a similar experience.

"I have a very nice friend, a wife, well, a husband and wife, who live down the road. They're from Jamaica, Caribbean, they're Black. We live like brothers and sisters. And they help me."

Man – 63 – Ethnic minority background – Coastal area

"It's very few people. I know just two or three people who speak Russian here, but it does not really matter, because I also speak Lithuanian, and also Polish, and I also know a little bit of English."

Man – 60 – Ethnic minority background (via interpreter) – Rural area

Ethnic minorities should not be treated as a homogeneous group

Community workers told us that the terms 'Black, Asian and Minority Ethnic', 'BAME' or 'Bame' [pronounced as a single word] are often used in reference to diverse groups of people with different stories, preferences and opinions. Community workers noted that this tendency creates a risk that those who plan, commission or provide health and care services treat people from ethnic minorities as a homogenous group. It was felt this risk may be heightened within coastal towns, and particularly in rural areas where the number of people from ethnic minority backgrounds may be very small:

"The 'Bame' thing is really dangerous. There isn't one homogenous group. Someone from a West Indian community will have very different cultural heritage, points of reference and preferences to someone from a Polish community."

Community worker – Coastal area

"You are just talking about such small numbers in rural [county]. There's hardly any BAME people, but there are some. It's no surprise they [statutory bodies] find it easier to group everyone together, but then they wonder why things don't work. You see that now with [Covid-19] 'vaccine hesitancy' as people call it. There's no one response. You have to take the time to understand people's individual stories."

Community worker – Rural area

'Consultation fatigue' and experiences of being 'done to' or 'ticking a box' may contribute to older people from ethnic minorities feeling strong mistrust for statutory bodies and services

Every community worker who contributed to this study noted feelings of mistrust when it came to older people from ethnic minorities engaging with statutory services:

"We're forgotten nationally because we're rural and then are forgotten about locally because there is a majority White British population. That means those who are isolated are really isolated."

Community worker – Rural area

"Over the years we've spent a lot of time and energy inviting people to consultation and the outcome is very sparse...then we go through the same thing a few months later. The only real outcome consultation fatigue."

Community worker – Coastal area

"We get a small amount of money to actually support people and for it we have to help the council tick every single box."

Community worker – Coastal area

Community workers also reported a sense of being 'done to':

"They come to these communities with an idea of a problem and a solution, but it's not always a problem the community recognises, let alone a solution they need. A lot of organisations go thinking they can fix something. We don't need fixing, we're OK."

Community worker – Rural area

A particular concern was that the sidestepping of normal consultation processes during the pandemic may lead to a long-term move away from effective consultation. Community workers told us that it would be important to vigorously reassert the need for true coproduction as part of the recovery effort.

"All this optimism about building things back up again [after the pandemic] but what's the use if they just tell people what they're getting instead of asking them what they need?"

Community worker – Coastal area

This sense of frustration was also reflected in our conversations with older people who expressed frustration about a lack of space for diverse voices.

"And this is what I find, that most people feel they know everything, but without knowing anything. But if you go to a city, if you've seen a council meeting, you'll have different people of different views and different perspectives. People bounce off each other. And this is what societies should be."

Man – 50 – Ethnic minority background – Rural area

These strong feelings of mistrust can be exacerbated by health and care workforces that don't reflect the populations they serve:

"You don't see diversity reflected within the health and care workforce, so that doesn't help."

Community worker – Coastal area

"I don't think any of my GPs, when they actually see any of us, they have any differences between us or anything else. But I would feel the backroom staff, they are, I would say, very prejudiced against, I would say, coloured people, my kind of people."

Man – 50 – Ethnic minority background – Rural area

The VCSE sector already knows and supports older people from ethnic minorities

This finding is noted in the 'Overarching themes' section above, but it merits repeating here. Very small, hyperlocal voluntary organisations and community groups often know and already support older people from ethnic minorities. The community workers who contributed to this study noted the time it takes to build relationships and trust:

"You've got to walk alongside people and regain their trust – who better to do that than someone from the community?"

Community worker – Coastal area

"If you go in as a human being then you'll get a lot further than going in as a job title. I think the voluntary sector might be better [at this]. We don't overthink process and how to do things; we often do things because they feel right not because a procedure says it is [right]."

Community worker – Rural area

Some of the people we spoke to had been supported by local VCSE organisations. Some of those were specialist community organisations, focused on the needs of people from ethnic minorities, others were mainstream community organisations that service users felt were inclusive.

The Connect Centre, Wells

The Connect Centre is run by Connect Elim, part of a mainstream Christian church. The Centre's Community Outreach programme aims to support people challenged by complex and multiple needs, including homelessness; unemployment; issues such as addiction or self-harm; mental health issues; relationship problems; learning difficulties or social isolation.

The Centre runs regular daily drop-in services in their centre in Wells and weekly services in towns across Mendip, including Frome and Glastonbury. They offer a range of activities in local communities, and offer case worker support to individuals with complex needs.

GYROS

GYROS supports migrants and culturally and linguistically diverse (CALD) communities across East Anglia, offering information, advice and advocacy on a range of topics, including immigration, rights, education, housing, benefits and debt. It also supports CALD communities in accessing healthcare and other specialist services and provides community events and social opportunities for children and adults.

GYROS' innovative Community Pathways Partnership is a four-year programme funded by the National Lottery Community Fund to deliver multilingual and multicultural information, advice and guidance, through an innovative hub and spoke model, to people from CALD communities across Norfolk and Suffolk. It incorporates 'pop up' provision and digital support.

As part of the partnership, Outreach Community Connectors work with the most marginalised people within CALD communities, supporting them before they reach crisis point, organising community-wide services across the region and facilitating volunteering opportunities.

The aim of the programme is to improve people's access to support and awareness of their rights, and to build wider individual and community resilience. It seeks to increase capacity across the region to respond to the needs of CALD communities and improve the availability of data about those needs.

It's important to note that the organisations that we spoke to that support older people from ethnic minorities weren't necessarily specialist organisations. But many had workers from ethnic minority backgrounds or made other specific efforts to signal their inclusivity.

"I was the only Black person in the [community garden] group around there too. And everyone was very, very nice to me, which I felt okay that I was not discriminated against. And the people that worked around it and know the group, they all knew me and knew my name after the second time."

Man – 63 – Ethnic minority background – Coastal area

"I know much about help, and even if not, then I know I'm sure I will be helped by [community organisation]."

Man – 60 – Ethnic minority background (via interpreter) – Rural area

"I would come to [migrant community support organisation] for support [...] I don't know any other organisations I could go to."

Woman – 61 – Ethnic minority background (via interpreter) – Rural area

However, interviewees reflected that not all VCSE provision was inclusive and welcoming to people from ethnic minorities. The presence of visible peers could be vital in enabling people to feel included.

"They wouldn't necessarily go to that Talking Café that's there for everybody to just come, they'd feel intimidated about that, but they have come to our smaller [ethnic minority-led] support group just to come and chat and eat cake."

Woman – 59 – Ethnic minority background – Rural area

Language and difficulty accessing translation are barriers to accessing services

Every community worker who contributed to this study noted that language and difficulty accessing translation are barriers to older people from ethnic minorities accessing services. And this challenge was reflected in our conversations with older people from ethnic minorities who required translation support, and by others when reflecting on the experiences of their friends and family members.

"I am quite satisfied with the GP. They give a translator. But in the hospital they don't give a translator every time."

Woman – 61 – Ethnic minority background (via interpreter) – Rural area

Many noted that translation services are especially difficult to access in rural areas, but those challenges are not exclusive to these settings. Some community workers noted that translation services had been easier to access during the Covid-19 pandemic, as translators can be anywhere in the country (or indeed the world). However, no one reported wanting to default to video calls once the pandemic conditions are over, with a number of community workers noting that translation over video is more tiring for everyone involved than face-to-face translation:

"A Zoom call doesn't bridge the divide. It doesn't work. It's not the same as meeting in person."

Community worker – Rural area

The disadvantages faced by migrant women from diverse cultural and linguistic backgrounds who continue to experience a lower standard of English proficiency are well documented (e.g. MacDonald 2013). For some non-English-speaking migrant women, ethnicity and gender may be further compounded as factors by religious and cultural barriers to participation. However, although language barriers continue to be more pronounced for women than for men, community workers supporting older people from ethnic minorities noted the loss of language associated with dementia to be a particular challenge with regard to accessing health, care and support services.

"It's less of an issue for men than women, though dementia is a leveller of course and someone who may have been fluent in English can lose that language."

Community worker – Rural area

Access to formal translation services was noted to be especially important with regard to health and care services:

"People depend on family, but having to sit and be the translator while your mum is going on about the menopause might be really awkward... We also know the patient might get the translation, but they might get what they think Mum needs to hear."

Community worker – Rural area

"Last time my daughter helped to translate, but last time they said they didn't have an interpreter, so I had to show them with my hands."

Woman – 61 – Ethnic minority background (via interpreter) – Rural area

Places of worship can be important for some people from ethnic minorities, but they don't reach everyone

The community workers who contributed to this study noted that places of worship play an important role as physical community hubs for people from ethnic minorities, including older people. This was reflected in conversations with some of the people from ethnic minorities that we interviewed.

"Because there's only one mosque in town and it's the only mosque serving lots of smaller [surrounding] villages, then it's perhaps a more inclusive mosque than you'd get in an urban area. Sunnis and Shiites – who would worship separately in an urban area – come together in an inclusive space. You can hold a health clinic there and reach a lot of people."

Community worker – Coastal area

However, they also reported a sense that those who plan, commission and deliver health, care and support services may overly rely on places of worship as a means to engage with people from ethnic minorities, and may assume that they are networked with whole communities, when in reality they support a proportion of these communities (albeit a large proportion in some areas):

"Thinking about communities who are not religious as individuals, but are sort of culturally religious. The local Catholic church might have a Polish Priest there on a Sunday and much of the community comes together there, but it is hard for those who might not want to go to church but are then left out from the community."

Community worker – Rural area

"I have been to a couple of churches. Because I am the type of person I get up and I want to go to church and see my Pentecostal church or the Baptist church or the Methodist church further down the road. I would just get up and go. I never really selected a church. Although I went to the Pentecostal church near to the town. From there the camaraderie was good, the welcome was good, but the atmosphere wasn't right for me."

Man – 63 – Ethnic minority background – Coastal area

Older people from ethnic minorities need culturally appropriate services and resources, including support for carers of loved ones with dementia

The community workers we spoke to consistently noted the need for culturally appropriate health, care and support services and resources. These must be sensitive to the key cultural beliefs and practices of older people from ethnic minorities'. Older people told us that a lack of peers to mix with within social groups and support services could act as a barrier to accessing services.

"One of the things I've noticed in [rural town] is that mostly the people that are leading all these groups are white English. And I think if you have somebody from one of the cultural backgrounds then people are more likely to engage with it."

Woman – 59 – Ethnic minority background – Rural area

"Those people who have grown up drinking the alcohol and they've got their friends, I haven't mixed with those people to actually suddenly go and mix with those people in ten, 15 years' time, I'm talking about. It's going to be difficult for me to adjust to that. But then if I'm sitting around or having a tea or something with people from my community, I would feel more wellbeing in myself, healthier in myself, rather than trying to fit in with something which is not me."

Man – 50 – Ethnic minority background – Rural area

We heard that accessing culturally appropriate clothing and food was challenging in rural communities, leaving many older people reliant on driving to larger urban centres or receiving deliveries from family members.

"There are a lot of things you can't get in the local shops [...] food and clothing and everything [...] when my son's wife comes she brings the things for a couple of months"

Woman – 69 – Ethnic minority background (via interpreter) – Rural area

"One of the things that I've found noticeably different was that being able to buy foods that I would normally cook. Like you couldn't buy lentils to make dhal easily from the shops around here, you had to go out to seek it out."

Woman – 59 – Ethnic minority background – Rural area

Even though most of the people we spoke to expressed a desire to be part of the wider community and not to remain solely with people from similar backgrounds to them, they felt that the need to have places to connect with their home cultures was significant.

"It feels really, in a way, because you are far away from your country and you live here for so many years now, it feels good just to have that little smell of home in your country."

Woman – 59 – Ethnic minority background – Coastal area

"I do know that there have been some people that have moved to [rural town], and or been moved to [rural town], and couldn't stay here because they felt like there weren't either people that they could relate to, or there weren't mosques. Well mosques being one thing, but food, and culture, and other people similar to themselves."

Woman – 59 – Ethnic minority background – Rural area

"At least you don't feel so lonely in yourself. We have some... At least we have someone who can talk Portuguese like you and who can express the same feelings as you have and everything. I think it's important. It is. Even if it's a small community, it's important for people to know there is someone from the same country in the area."

Woman – 59 – Ethnic minority background – Coastal area

"If I'm sitting with, let's say, five people from my community in a similar age, I don't have to think about the drink issue or the food issue or when the time for prayers."

Man – 50 – Ethnic minority background – Rural area

Some older people also told us that they wanted to be involved in developing culturally-appropriate support structures.

"There were many times I wanted to set up an ethnic minority group, because I realised that they're not only afro-Caribbean, but there's a really strong input of the Asian communities [...]. I was thinking it'd be at the [local community] centre."

Man – 63 – Ethnic minority background – Coastal area

"What I did was I ended up teaming up with some other people that were from other places, and we started first of all forming a group. And then we now put on an annual event which is like a multicultural [rural town], which invites people in [rural town] that are from different countries and cultures to come and celebrate."

Woman – 59 – Ethnic minority background – Rural area

Community workers noted the need for support with 1) food and diet, 2) physical activity and 3) caring, including caring for loved ones with dementia. We also heard from older people about the need for support at 4) the end of life.

1. Culturally appropriate services and resourcesin relation to food and diet:

"The public health team put something together about diabetes and diet. I'm sure it was good information if you ate the food they were talking about, but I said I couldn't share it with people from the community. They probably thought I was difficult."

Community worker – Coastal area

The absence of culturally appropriate services and resources had been keenly felt during the Covid-19 pandemic, especially with regard to food security:

"Food is a big one. The pandemic has made it worse and cut people off from the diaspora even more – travelling to the nearest city to get suitable food is hard or impossible."

Community worker – Rural area

"It's come up a lot with resilience during lockdown. They say, 'If you're Muslim then we haven't got a foodbox for you'."

Community worker – Rural area

2. Culturally appropriate services and resources in relation to exercise and physical activity:

The importance of culturally appropriate opportunities for physical activity was also highlighted.

"We had walking football that was popular, but then a few members of the Black community - with Caribbean heritage - set up walking cricket because they're not bothered about playing football. They like watching it, but they don't really play it. The guys who set up the walking football helped them do it and it's gone really well."

Community worker – Rural area

"If you look at the Muslim community, especially the women's section, it is impossible. For instance, if they wanted to go swimming, for instance, they wouldn't go in swimming with the other men [...] If you go to the cities, you have only-women gyms."

Man – 50 – Ethnic minority background – Rural area

3. The need for culturally appropriate services and resources in relation to caring for loved ones with dementia was an especially strong theme in our conversations with community workers. The community workers who contributed to this study spoke of an urgent and growing need for these to be prioritised:

"The cultural norms around caring are very different, so the support needs to be different too. But this is something that is a growing need because adult children are no longer taking on caring responsibilities like they used to. [Health, care and support] planners need to do something now or it will be such a gap in the near future."

Community worker – Coastal area

"Sometimes there isn't a word in the language for the thing you're talking about. We do find that with dementia sometimes - there is no word to translate to because it isn't something that's talked about. If you don't have a word for it then how can you even begin to seek out support? It's very difficult."

Community worker – Coastal area

4. We also heard about the need for better access to culturally appropriate burial:

"When I die eventually, I want to be buried within my community. That's the final thing that you have in life. But that is not available in my community, where I am at this moment."

Man – 50 – Ethnic minority background – Rural area

Coastal areas

Older people from ethnic minorities working in, or retired from, the tourism and hospitality sectors in coastal towns may have particular needs

The community workers we spoke to noted relatively large cohorts of people from ethnic minorities working in the tourism and hospitality industries within coastal towns. They reported an emerging issue of people now ageing in place after working in these industries for many years. Some of the people who migrated to English coastal towns to work in these industries originally intended to return to their home country on retirement, but now find themselves weighing their options and grappling with difficult decisions about later life. In some cases this was reported to result in family breakdown, with needs arising around social isolation, loneliness and access to unpaid care and support:

"Not planning and the lack of appropriate support sometimes ends up with families splitting and perhaps one going back and the other staying."

Community worker – Coastal area

"It's a major life decision – do you stay or go? One guy told me it was like getting married without talking about whether you want children and then finding out later you had different views... very difficult and sad for everyone."

Community worker – Coastal area

Rural areas

Older women from some ethnic minority communities may feel particularly isolated

Older people from ethnic minorities told us that older women from Muslim communities may experience particular barriers to connection in rural communities.

"There are no Bengalis here. People who have restaurants who are Bengali, they don't bring their families and they come on their own. It is only the men here. They don't bring their families so there are no women to mix with."

Woman – 69 – Ethnic minority background (via interpreter) – Rural area

"The minority community, especially the Muslim community, always suffer when especially the people who are in charge of things in a smaller town don't understand the needs of those people who are especially the women."

Man – 50 – Ethnic minority background – Rural area

"I do feel isolated. Because of Covid as well I feel more lonely and isolated."

Woman – 69 – Ethnic minority background (via interpreter) – Rural area

The lack of culturally sensitive services was a particular issue. It was recognised that most would prefer women-only spaces, but may not access mainstream women-only provision without particular encouragement.

"It would be nice to have a women's group, and to have a way to get out shopping"

Woman – 69 – Ethnic minority background (via interpreter) – Rural area

Access to information about the services and support available in the local area was another important issue.

"How would I know if no-one tells me anything?"

Woman – 69 – Ethnic minority background (via interpreter) – Rural area

Formal health services can be a relatively safe space for some people from ethnic minorities

While some community workers reported negative experiences with healthcare services, the older people from Black and Asian backgrounds that we spoke to mentioned health services as one of the few environments in which they encountered people from similar backgrounds to them.

"There are not many Bengali people here [...] Very occasionally some doctors in the hospital but not very many."

Woman – 69 – Ethnic minority background (via interpreter) – Rural area

"Interestingly I didn't notice that [a lack of ethnic minority role models] in the medical profession, so if you went to the doctors, or hospitals, or anything, you would see those people, but in other institutions you wouldn't."

Woman – 59 – Ethnic minority background – Rural area

"Within our hospital, we had GPs and things like that from our community as well. And there is at the moment as well. That helped within our communities."

Man – 50 – Ethnic minority background – Rural area

The doctor was seen as a trusted source of information and for some was the only recognised source of information about health and care needs.

"I always go to the same GP and I get information from leaflets and otherwise I ask the doctor"

Woman – 61 – Ethnic minority background (via interpreter) – Rural area

"If I have something or any doubt or something like that, I just call the GP and I ask. That's my first resource, is them."

Woman – 59 – Ethnic minority background – Coastal area

Older people from ethnic minorities may experience particular challenges around rural transport

While challenges with transport affect many people in rural areas, community workers noted particular challenges for older people from ethnic minorities. These include the isolation of older women who don't drive and the isolation of older men who don't have the knowledge and confidence to navigate public transport:

"There was a bus service opposite the house, but now it is too far away."

Woman – 69 – Ethnic minority background (via interpreter) – Rural area

"It's difficult for women who have never driven, but it's also difficult for men who can no longer drive but have only ever driven [to appointments and so on] and don't know how the buses work. How do you know when they're coming? How do you pay? Where do you sit? How do you know when it stops? How do you get it to stop? If you're in your 70s and have never done it...wow, just think what that's like, and if English is your second language... Maybe you'd get a cab, but what if you can't afford it?"

Community worker – Rural area

Community workers reported concerns that the reduction in rural public transport during pandemic-related lockdowns will persist as we emerge into a post-pandemic period.

6. Areas for action

The findings of this study indicate a number of areas in which action is needed to ensure that older LGBTQ+ people, older men and older people, from ethnic minorities have the support they need to age well in rural and coastal areas, and that place-based responses to health inequalities are inclusive.

While these actions relate primarily to the rural and/or coastal context, many will also be relevant in some urban and inland areas – in particular rural fringes of urban areas, areas where ethnic minority communities are small, touristic areas, and so on.

Six core approaches

There are a number of themes that were common to all of the groups of interest to this study. Action in these areas could help all three – **although the actions must be tailored to the needs of each group (and the sub-groups within them).**

1. **Gather data**

    - **Action:** Collect data on sexual orientation and gender identity using standard measures such as those developed by the LGBT foundation[10]
    - **Action:** Collect data on race and ethnicity using standard measures[11]
    - **Action:** Provide resource and expertise to local VCSE organisations embedded in their communities, to enable them to capture high quality quantitative and qualitative data about their members/ service users and their needs
    - **Action:** Work with community organisations to build trust around confidentiality and the use of data

2. **Work with the VCSE sector**

    - **Action:** Provide flexible funding to the (often very small) VCSE organisations that work with older LGBTQ+ people, older people from ethnic minorities and those older men who are at particular risk of health inequalities, including older male carers and older men who are lonely and isolated
    - **Action:** Recognise that the VCSE sector is a source of deep insight into the issues affecting key communities, and has trusted relationships, built over many years, with those at risk of experiencing health inequalities. Resource the sector to undertake its vital advocacy for communities and to contribute its expertise
    - **Action:** Support organisations which are of ethnic minority communities, LGBTQ+ older people and older men to build their capacity, and enable them to take a leading role in relation to identifying and meeting community needs
    - **Action:** Provide support to the VCSE organisations working on specific challenges arising in coastal communities, such as men ageing while living on the streets or in insecure or unsuitable accommodation

10. https://lgbt.foundation/monitoring
11. https://www.ons.gov.uk/methodology/classificationsandstandards/measuringequality/ethnicgroupnationalidentityandreligion

3. **Support the development of peer-led services**

    - **Action:** Work with local VCSE organisations to conduct mapping and identify gaps in peer-led services, especially for groups at particular risk of social isolation, loneliness and poor health outcomes
    - Action: Provide easy-to-access pots of seed funding, as well as capacity-building support, to enable older adults from ethnic minorities to develop their own community-led solutions to issues that they identify as important

4. **Flex to allow work across geographies and groups**

    - **Action:** Work with older LGBTQ+ people and older people from ethnic minorities to understand how peers wish to come together across geographies and generations, making sure there's flexibility around eligibility where populations are very small
    - **Action:** Recognise that where communities are small there may be a need to work across geographies to tap into expertise around these communities' needs and appropriate responses
    - **Action:** Consider how digital and remote support networks could support groups that are small in number to come together across areas. Provide additional support in areas where digital infrastructure is poor (including many rural areas) and for groups who may lack access to broadband (including those in insecure housing, or experiencing homelessness)

5. **Involve people rather than consulting them**

    - **Action:** Commit to working with and through VCSE organisations to support the involvement of older people from ethnic minorities and older LGBTQ+ people – for instance making sure they can shape the questions they're asked to address and see the solutions – to avoid 'consultation fatigue'
    - **Action:** Take steps to improve the representation of older people from ethnic minorities within civic bodies, for example by advertising vacancies in governing bodies and associations through trusted VCSE organisations and faith groups

6. **Make access easy**

    - **Action:** Ensure that older people are aware of, and given help to access opportunities. This might include recognising the centrality of the GP as a source of trusted information and advice around health and wellbeing, and working with community-specific organisations to support timely distribution of information. Consider how social prescribing can bridge the gap between formal services and community activities.

About social prescribing

Social prescribing is a way for local agencies to refer people to a link worker. Link workers give people time, focusing on 'what matters to me' and taking a holistic approach to people's health and wellbeing. They connect people to community groups and statutory services for practical and emotional support.

The commitment to roll out social prescribing link worker services across all PCNs was a key plank of the NHS Long Term Plan and the Government's Loneliness Strategy. Social prescribing acts as a bridge between primary care and the activities and support available in the wider community. It's recognised as a key part of personalised care, enabling people to maintain their health and wellbeing and supporting the self-management of long-term conditions.

Given the messages we heard about the central role played by GPs in supporting people from the groups of interest to this study to access wider support, and the importance of VCSE provision in supporting older people at risk of poor health outcomes, there's clearly a strong role for social prescribing.

However action will be needed to ensure that social prescribing services are fully inclusive. In some cases there may be a need for specialist social prescribing/community connector services to ensure that the full range of needs in communities can be met (Jopling & Howells, 2018)

"Our medical practice have these people called 'health connectors' there and it's really good, I think it works really well. And they have this thing called a Talking Café which happens in this community venue that I was telling you about. But one thing that I have noticed about that is that again it is very white English, people that go to that. And I've thought about something similar would be good to invite initially people from other ethnic backgrounds, not to separate the two groups but just to entice people in the first place."

Woman – 59 – Ethnic minority background – Rural area

Five issues to address for all groups

1. Loneliness and social isolation

- **Action:** Ensure men can access opportunities for social connection that:
  - Provide a supportive environment
  - Offer activities with a practical outcome, which generate a sense of purpose among men
  - Offer activities that enable men to share skills
  - Promote activities in locations where men go, using appropriate language which makes men feel they have something to offer (Age UK 2018b)
- **Action:** Support the provision of social groups that bring people together across geographical areas and across generations to ensure that people from small sub-groups among older people from ethnic minorities and older LGBTQ+ people can come together with peers
- **Action:** Encourage mainstream providers of social activity to take specific steps to include older people from ethnic minorities and older LGBTQ+ people, including by using images of diverse older people in marketing materials and engaging staff from minority communities as outreach workers.

2. The digital divide

- **Action:** Ensure that there are offline and face-to-face alternatives for those who are digitally excluded due to poor digital infrastructure (especially in rural communities) and/or precarious internet access, for example people in insecure housing and/or who are dependent on dongles and low data packages
- **Action:** Provide support to develop digital skills – including through partnerships with trusted local VCSE sector organisations

3. A lack of support networks among people who move to rural and coastal communities

- **Action:** Consider how to proactively reach out to people who move into coastal and rural communities in later life, to provide information around local support structures and to help people to develop social networks locally. Potential routes for outreach include:
  - GPs – including via social prescribing services
  - Working with VCSE and faith organisations
  - Working with local employers – especially those who employ migrant workforces (recognising the growing numbers of people working in later life)
  - Digital tools, including neighbourhood apps and forums

4. Gaps in public transport provision

- **Action:** Ensure that the travel needs of older adults are taken into account in planning public transport services, so that public transport gives them access to opportunities for leisure and social connection as well as shopping, health services and work
- **Action:** Ensure local planning strategies take account of the need for good access to amenities including shops and leisure facilities as well as health services, including the need for culturally appropriate shops and services
- **Action:** Work with older people from ethnic minorities and LGBTQ+ communities to understand their travel needs, recognising that they may need to travel further to meet with peers
- **Action:** Ensure that community transport provision is culturally sensitive (for example ensure volunteer driver schemes offer an option to choose a female driver)

- **Action:** Consider how to help older adults who rely on cars to build their confidence and understanding around accessing public transport (for example through 'travel buddy' schemes), especially at the point of driving cessation

5. Gaps in support for carers and people with dementia

- **Action:** Map provision of support for carers, and ensure that the offer is inclusive of:
  - Older men: taking account of the key features of support services that engage men noted above
  - Older LGBTQ+ people: recognising that people may prefer to travel to places outside the area in which they live to preserve anonymity around their identities
  - Older people from ethnic minorities: considering potential needs for language interpretation; women-only support; culturally appropriate food and drink, etc

- **Action:** Map the provision of support for people with dementia, and ensure that the offer is inclusive of:
  - Older men: taking account of the key features of support services that engage men noted above
  - Older LGBTQ+ people: recognising that specialist support may be preferred (even if this involves additional travel) due to the specific impacts of dementia on some LGBTQ+ people
  - Older people from ethnic minorities: considering potential needs for language interpretation; women-only support; culturally appropriate food and drink, etc

- **Action:** In areas where communities are too small to make specialist provision viable, consider how mainstream providers can get training and support from specialist organisations to make their offer inclusive.

Four considerations for older LGBTQ+ people

6. Provide support to people affected by historic trauma including mental health support sensitive to the circumstances of older LGBTQ+ people

- **Action:** Work with specialist LGBTQ+ organisations to access training and guidance so mainstream mental health providers can adapt their services to meet older LGBTQ+ people's needs

7. Address discriminatory attitudes among health and care staff

- **Action:** Ensure that local frontline staff access training programmes developed by LGBTQ+ organisations to support positive practice and shift attitudes within health and care services, including the Pride in Practice standard developed by the LGBT Foundation [12] and Opening Doors' Pride in Care training[13]

8. Provide ongoing support to address discriminatory attitudes and support inclusion

- **Action:** Work with older LGBTQ+ people to develop appropriate visual signals of LGBTQ+ inclusion that are prominent in touristic coastal and rural areas all year around (This could include the use of imagery of older LGBTQ+ adults in marketing and supporting events which promote inclusion throughout the year, including at times when tourists are visiting.)

12. https://lgbt.foundation/how-we-can-help-you/pride-in-practice

13. https://www.openingdoorslondon.org.uk/pride-in-care-quality-standard

- **Action:** Design initiatives to combat anti-LGBTQ+ prejudice and discrimination with the involvement of the full diversity of older LGBTQ+ people, taking account of the differences in experiences between sub-groups such as trans+ people and gay men

9. Provide tailored support around planning for later life, including at the end of life

- **Action:** Work with organisations that work with older LGBTQ+ people to provide tailored support for later life, taking account of the specific needs of:
  - The cohort of older gay men who lived through AIDS who may need support in planning for later lives they may not have expected to reach
  - Older LGBTQ+ people who are ageing without children or lacking family support, who may need help in planning for emerging care and support needs
  - Support for LGBTQ+ people with dementia: for example, by accessing training from the LGBT Foundation's Bring Dementia Out programme[14]
  - Older LGBTQ+ people at the end of life: drawing on learning from Marie Curie around the importance of person-centred care at the end of life, and the importance of recognising people's partners (Marie Curie, 2016)

Five considerations for older men

While not all men living in coastal and rural areas are at risk of poor health outcomes, older men could be left behind, if we do not apply a gender lens to underlying factors of health inequality, such as loneliness and isolation. We have identified several areas in which attention to the particular needs of men will be required.

1. Support men living alone and ageing without children

- **Action:** Gather data on men living alone and ageing without children and map patterns, to ensure adequate provision to meet future care needs of groups more likely to need to access paid care and support services

- **Action:** Target older men living alone and ageing without children through outreach support to make access easy (see above)

2. Support for male carers

- **Action:** Build support for carers into existing provision for men: for example, creating opportunities for male carers to access Men's Sheds by offering respite care alongside sessions

- **Action:** Work with providers of carers' support to ensure their provision takes account of the needs of male carers (drawing on learning around the kinds of activities that appeal to men – see above)

- **Action:** Ensure frontline staff working with older people (e.g. GPs and other health and social care professionals) recognise the growing number of older male carers and are ready to ask men about their caring responsibilities and to signpost to sources of support

3. Value community spaces for men

- **Action:** Recognise the vital role of rural pubs as a community space accessible to men, and use 'place-shaping, powers to support the ongoing availability of accessible community spaces, such as use of the Social Value Act to protect pubs and through initiatives such as "the Pub is the Hub"

14. https://lgbt.foundation/bringdementiaout

- **Action:** Recognise that not all men will find pubs an accessible community space – in particular men from certain cultural backgrounds

- **Action:** Ensure that older men are involved alongside older women in planning community spaces

4. Support men in coastal areas who are inadequately housed

- **Action:** Local housing authorities and planners should take steps to address the standards of existing housing and to improve the availability of new housing to meet this group's needs

- **Action:** Work with VCSE organisations that support these men, recognising their expertise on the needs of these groups and their relationships of trust with them; partner with these organisations to identify and address needs

5. Support for the farming community

- **Action:** Work with community organisations who have an in-depth understanding of ageing and retired farmers and farm workers, both to provide direct support and to enable older farmers and farm workers to connect with their wider communities

- **Action:** Consider how services (such as health and care services, information and advice, and screening) can be brought to the places and spaces where older people from the farming community meet – in particular livestock markets and agricultural events

Four considerations for ethnic minority communities

1. Avoid 'homogenising' older people from ethnic minority communities

- **Action:** Take steps to explicitly recognise the full diversity of older people from ethnic minorities. Ensure that individual older adults are not asked to speak for people from across the spectrum of ethnic minority experience. Efforts to engage with people from ethnic minorities should take account of the experiences of:

    - People of different ethnicities
    - The differences in experience of those who have grown up in England and those who have moved to England
    - The differences in experience of those who live in the community in which they grew up and those who have moved from other parts of the country
    - The differences in experience of those who speak English and those who don't
    - The differences in experience of those who share the same religion or religious background as the majority community and those who don't

2. Support with language and interpreting

- **Action:** Address gaps in interpretation support, recognising that while online tools can be helpful they should not be regarded as a panacea; improving data on ethnic minority populations will be important for assessing levels of need for such services

- **Action:** Ensure that planning for language support takes account of the impact of conditions such as dementia on language capabilities

- **Action:** Improve access to language learning among older adults; providing this in ways that are flexible, sociable and culturally sensitive will be vital to enabling more older adults from ethnic minorities to improve their language skills

3. Work with faith communities

- **Action:** Continue and build upon work with faith communities as a means of reaching older adults from ethnic minorities; however ensure that this is not the only mechanism used to reach out to people in these communities

- **Action:** In rural areas, and smaller coastal areas where there may not be provision for all faith communities, work with local communities to map the faith organisations in nearby towns and cities to which people connect, and build links with them

4. Provide culturally appropriate services

- **Action:** Ensure that the needs of minority populations are not overlooked, for example by ensuring provision takes account of:
    - Diverse diets and cultural requirements around food and drink, through the provision of culturally appropriate food and drink at community events and in health and care services; and recognising this diversity within advice around diet
    - The need for older adults from ethnic minorities who don't speak English or who have English as a second language to have opportunities to meet others who speak their language
    - Different cultural attitudes and expectations around care and support, through the provision of culturally appropriate information around care needs and support services
    - The need for access to women-only exercise spaces, including women-only sessions in gyms and swimming pools
    - Cultural needs around the end of life, and particularly in relation to culturally appropriate burial
- **Action:** Explore opportunities to work with local VCSE organisations to plug gaps in provision

- **Action:** Work in partnership with communities in neighbouring areas to ensure that statutory provision (such as around burials) includes adequate provision to meet cultural needs where populations are small, providing additional support with transport where travel is required.

Priorities for national action

While the focus of this report is on place-based action, it's important to note that effective action on these areas will also require shifts in national policy; in particular there is a need for:

- Action to address gaps in broadband infrastructure
- Action to address gaps in housing supply, and particularly housing suited to the needs of an ageing population
- Action to mitigate the impacts of austerity, including on local authority budgets and VCSE sector funding
- Action at a national level to address gaps in research

7. Implications for place-based approaches

Beyond place

In this section we consider how the areas for action identified above can be addressed through place-based interventions. However, as noted in section 5, progress in many of these areas will also require action at national level.

The PIT framework (see About this report: Place-based approaches) envisages three main types of place-based intervention that can make a difference to health inequalities. These are:

- Civic-level
- Community-centred
- Service-based

These individual approaches must be underpinned by place-based planning, based on strong leadership and effective partnership, as well as a credible shared vision and strategy that sits across the individual interventions. In addition there may be a need for work to strengthen the links or seams between the different areas of action.

While there are a number of areas where action is needed across all three groups of interest, those planning and delivering services will need to tailor the approaches taken to addressing the issues for each group (and their sub-groups).

In relation to older people from ethnic minorities and older LGBTQ+ people, the key challenge is to avoid a 'numbers game' in which smaller communities can end up marginalised. While the integrated response to issues provided by place-based responses is likely to be helpful, it may be that there's a need to consider how these groups understand their 'places.', as we've seen that both individuals and organisations often operate across significant geographies to find peers.

In relation to the needs of older men, there are two key issues: one is to ensure that we recognise and respond to the particular causes of inequality that predominantly affect men; the other is to ensure that place-based responses to the needs of groups like carers are geared to the needs of men as well as women.

Specific and deliberate action is needed to address the inequalities experienced by these groups, to ensure that responses at all three levels of intervention are tailored to their needs.

Civic-level interventions

We've identified a number of areas where civic-level interventions may be needed as part of a place-based approach to addressing health inequalities for the groups of interest to this study:

- **Addressing gaps in data:** civic authorities need to place an emphasis on collecting consistent data across their own and commissioned services in relation to ethnicity, sexual orientation and gender identity, drawing on recognised data standards such as those developed by the LGBT Foundation.[15] This will help to improve understanding of the level of need.
- **Providing social care:** civic authorities need to ensure that in commissioning health and care services they place an emphasis on inclusive provision, encouraging the take up of equality training and accreditation though initiatives such as Pride in Care.[16]

15. https://lgbt.foundation/monitoring
16. https://www.openingdoorslondon.org.uk/pride-in-care-quality-standard

- **Commissioning services:** civic authorities need to explicitly require the services they commission to be inclusive of the full diversity of older adults, for example requiring leisure providers to offer sessions appropriate for older Muslim women. In rural areas where communities may be too small to justify specialist provision, commissioners should provide transport support to allow individuals to reach appropriate support in other nearby areas.
- **Commissioning for social value:** civic authorities need to consider how they can use commissioning processes to promote social value, for example by investing in firms that employ local people from under-employed groups, or which demonstrate strong commitment to addressing inequalities. This should include incorporating mandatory requirements within contracts on social value and looking at how to capture social value for in-house services and activity.
- **Planning:** civic authorities need to ensure that they take account of the needs of older people in all their diversity in planning processes and in the exercise of their place-shaping powers. This will be particularly important in the provision of community space and public transport to ensure that older adults can access opportunities for social connection. This could include using the Social Value Act to protect rural pubs, or investing in community transport initiatives in rural communities.
- **Transport:** transport authorities have a critical role to play in delivering the infrastructure which people need to access basic services and amenities and to maintain social connection. Ensuring that the full diversity of needs among the older population are taken into account will be important, as will working with bodies across sectors to develop innovative solutions to address gaps in provision in small and remote rural communities.
- **Housing:** housing authorities need to plan to meet the needs of older adults, particularly those living alone and without children, and those in insecure and unsuitable accommodation, including older homeless men and older single men housed in HMOs in coastal areas, and older people living in Park Homes in rural areas.
- **Communication and information:** civic authorities need to work closely with communities to support the provision of high quality, accessible information about the support available in their communities. While digital tools such as neighbourhood forums and apps will be helpful in reaching some older people, there will also be a need to provide offline alternatives, including telephone services and face-to-face advice in the places people go (such as GP surgeries, places of worship and farming community hubs like agricultural markets). They should use civic space to convey ongoing messages of inclusivity, for example to create visible signals around LGBTQ+ inclusion to tourists visiting coastal areas.
- **Representation:** civic authorities should take steps to increase representation of a diversity of older adults in key roles, including on local councils, school governing bodies and health authorities. This could include advertising these opportunities through faith organisations and local VCSE organisations with which older people from ethnic minorities have built relationships of trust.

Service-level interventions

The PIT framework highlights how unwarranted variation in services and different patterns of service use can result in inequalities within a place. Service-level interventions seek to address these discrepancies, and even reverse inequalities by targeting additional support to those populations at greatest need.

We've identified a number of areas of opportunity to improve services for the groups of interest to this study, including:

- Working to increase access to services and support by ensuring that people can access these services through trusted intermediaries – in particular through local VCSE organisations and primary care services
- Improving the training of frontline staff, particularly in care and support services, around the inclusion of people from ethnic minorities and LGBTQ+ people, accessing specialist training (as outlined above)
- Taking a cautious approach to the digitalisation of services by continuing to offer offline and face-to-face alternatives, including providing information in places where older people go
- Providing tailored support to underserved groups, particularly those who have caring responsibilities and people with dementia. This could be by commissioning specialist support for older LGBTQ+ people (potentially through partnerships, across geographies where populations are small) and/or helping mainstream providers to tailor their provision by working with older people from ethnic minorities to understand their practical and cultural requirements such as language support and food and drink.

In addressing these issues, and in the absence of hard data on the needs of these communities and what will work to meet their needs, the most effective way to proceed with service improvement will be by coproducing solutions with older people from these communities.

Community-centred interventions

The PIT framework recognises the importance of community-centred interventions, both in place-based communities and across communities of interest. Both will be important in addressing the needs of older people from the groups of interest to this study. Public Health England's recent briefing, Community-centred public health: Taking a whole system approach, sets out 11 key elements of change in developing an integrated approach for community-centred public health. It emphasises a need for action across all levels, from strategic leadership to neighbourhood approaches (PHE 2020b).

The Public Health England guidance recognises a whole family of community-centred approaches necessary to an effective place-based response to health inequality.

Our study's findings suggest that community-centred interventions are likely to be vital in addressing the factors underlying health inequality as experienced by older men, older people from ethnic minorities and older LGTBQ+ people.

The family of community-centered approaches

Source: PHE (2015) Health and wellbeing: a guide to community-centred approaches

Specifically this study identifies a need for action to:

- Help to **build the capacity of VCSE organisations** that work with and for older people from ethnic minorities, older LGBTQ+ people and older men. This is particularly in light of the consequences of the Covid-19 pandemic on demand for these organisations' support and on their funding. These may be specialist organisations that focus on these communities; or community-based organisations which operate inclusively (including, for example, by hiring staff from these communities to offer outreach services).
- **Support the development of peer-led and peer-to-peer support models,** including across geographies and generations in rural communities where populations of older adults from these groups (and the sub-groups within them) may be very small.
- Improve access to s**upport for carers, people with dementia, and people at the end of life** from within these groups, including specialist provision for older LGBTQ+ people with dementia, and support for male carers.
- Provide support to older adults from these groups to **develop their own solutions** to address gaps in local provision, using approaches such as asset-based community development, enabling people to work across the geographies and communities that exist in rural and coastal areas in ways that make sense to them.

We also identified opportunities to make connections across the 'seams' between the different areas of the framework.

Strengthening community action

There is an urgent need to strengthen the linkages between the civic and community levels, with five areas for action:

- As noted above there is a need for civic authorities to **build the capacity of** VCSE organisations that work with and for older people from ethnic minorities, older LGBTQ+ people and older men to. This is particularly important given the effect of Covid-19 pandemic on both funding for these organisations and demand for their services.
- Ensure that people and communities are **supported to engage with the policy-making processes** that affect their lives, taking proactive steps to engage communities in co-production and moving away from processes of consultation in which minority voices can be overlooked or drowned out, especially in rural communities where ethnic minority and LGBTQ+ communities may be very small.
- Ensure that f**unding can be used across geographies and age groups** to support action that addresses health inequalities across communities of place and interest. This action should make sense to individuals from the groups of interest to this study. This could involve supporting intergenerational support for LGBTQ+ people; or enabling older people from specific ethnic minority communities to access culturally-appropriate support in neighbouring areas.
- Work with VCSE organisations and with communities to **develop a stronger evidence base** around the needs and experiences of people from these groups. This should include developing protocols for data collection with communities; using recognised measures; and sharing data with community organisations so that they can directly benefit from this work.
- **Support community-led organisations to engage in commissioning processes,** including actively encouraging collaborative and inclusive bidding. This could mean encouraging organisations to bid on providing mainstream services across rural and coastal communities, or to collaborate with local VCSE organisations working with and for older ethnic minority or LGBTQ+ communities to provide inclusive services.

Service engagement with communities

We identified significant opportunities for services to engage more effectively with communities, often mediated through VCSE organisations with whom marginalised older people have built up trust. In particular we recognised a need for:

- **Building links between primary care, and activities and support in communities** – social prescribing services present a potentially effective mechanism for bridging the gap between the trusted office of the GP and specialist support in the community. However, action is needed to ensure that social prescribing services are trusted by, and accessible to, all members of the community, particularly ethnic minority communities in rural areas. This may require the development of specialist support services.
- **Service providers to work with people from the groups of interest to this study** to identify and understand their needs, building new services through co-design and co-production. This might include ensuring that work with ethnic minority community organisations starts from these communities' understanding of the key issues to be addressed, rather than consulting them on priorities that have been defined by others.

- **Service providers to work with community organisations** to tap into their local networks and relationships and identify how to make public services more accessible and approachable. This might include providing 'pop up' services in community hubs such as places of worship, rural pubs, and, in the case of farming communities, markets and agricultural shows.

Civic-to-service integration

We also identified opportunities to improve civic-to-service integration, including the need to:

- Ensure that commissioning processes explicitly recognise the additional **costs of inclusion,** in particular the need to provide interpretation support; or to offer women-only sessions in leisure facilities.
- Improve **social value commissioning** so that commissioners can choose to work with organisations that provide wider support to the community, including through employing excluded groups, or acting to address inequality.
- Improve **funding processes** to make it easier for providers in both the public and private sectors to work with VCSE providers to deliver public services, including small community-led organisations.
- Support service providers with access to the **best available data** on the needs and experiences of older people and require them to support the development of evidence based around the needs of the groups of interest to this study.
- Encourage better **integration across services,** so that older people can access support through the avenue most comfortable for them: for example through social prescribing services which offer a bridge between health services and community support and activities.

Conclusion

This study has demonstrated that there are a number of areas in which deliberate attention is required to address the potential causes of health inequalities among older men, older LGBTQ+ people and older people from ethnic minorities.

We hope that the areas we've identified will be helpful in:

- Highlighting considerations which particularly apply to these groups but may be overlooked when taking a 'whole population' approach to health inequalities among the general older population
- Highlighting the issues around which action would be needed when taking a place-based approach to inequalities specifically affecting these communities
- We have identified potential for action across all levels of the PIT framework within the PBA toolkit. We believe that all of the audiences identified for this report have a part to play:
- Leaders within health and wellbeing boards
- Policy makers and commissioners within local authorities, local health bodies and Integrated Care Systems
- Other local funders, including businesses and charitable funders
- VCSE organisations.

We should make it a particular priority to strengthen the links between VCSE groups and organisations, service providers and civic authorities. VCSE groups and organisations are already working with, and trusted by, the groups of interest to this study; their insight has been invaluable in informing this report. Leaders in civic authorities and service provider organisations must start their work based on these sources of expertise and insight.

Working together will be vital to develop a shared understanding of local needs and issues as well as in co-producing solutions that work. Early priorities for action will be to identify how to strengthen the 'seams' between community, service and civic-level bodies to address gaps in provision, build capacity and gather better data to inform future work.

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