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Care for Older People in Multigenerational Families: a Life Course Analysis across Four Generations

Professional Care and Family Care across Time

The quality of care for older people has been highlighted as a significant issue as the population ages. In the *Ready for Ageing?* report, it is suggested that society is 'woefully' unprepared for an ageing population, which will see the percentage of over 85s more than double from two percent of the population at 1.4 million in 2010, to five percent at 3.5 million in 2030 (House of Lords, 2013, Office for National Statistics, 2012). Social care for older people has been underfunded (AgeUK, 2014; Glendinning et al, 2013; Walker, 2012) and pensions have continued to be inadequate, disadvantaging women in particular (Ginn and Arber, 2000; McKee and Stuckler, 2013). Younger family generations are a vital part of the support system for older people. Relationships between generations influence how care decisions are made, but the complexity of these negotiations are often overlooked in social policy. This paper explores how care and support are worked out for older people between informal and formal sources of support in five four-generation families.

The families in this study have lived through one hundred years of changes in social policy affecting care for older people. Support sources for older people have been in a state of flux between private, public and voluntary spheres. These changes have had an impact on how older people and their families organise support. Whilst workhouses were abolished in the 20th century, the concept of institutionalisation of older people persisted. The development of a wider welfare state from the 1940s saw the introduction of the National Health Service, providing free universal care. But funding for long-term care was relatively neglected, with an assumption that older people would be cared for by family, or in institutions (Howse, 2007).

During the 1980s, there was a significant shift towards community care for a number of reasons, including: deinstitutionalisation, scandals of poor quality institutional care, reducing costs and increasing efficiencies, and a drive towards a mixed economy of welfare. Community care however, was resisted by feminists because of the pressures this would place on women who care (Dalley, 1988; Ungerson, 1987). Pension changes also created social dependencies in the older population (Townsend, 1981). The amount of welfare given to the older population became increasingly lower than the income of the working population. The equivalent of pensions in Victorian England more closely resembled the income of the working population than it did in the latter part of the twentieth century (Thomson, 1984).

From the early 1990s, the personalisation approach sought to give older people and their carers 'choice' and 'voice'. Older people who are assessed by the local authority as

needing care in the UK are offered a personal budget where they receive direct payments, selecting and purchasing care for themselves, or the local authority buying services for them. However, real choice may have been undermined, as it has so far only been a minority of older people able to take advantage of direct payments (Care Quality Commission (CQC), 2010; Yeandle et al, 2012). The direct payment system may not reflect how older people prefer to work out care for themselves. Welfare activism made demands for disabled people to be respected as autonomous citizens (Williams, 2000). This claim for autonomy has been interpreted by governments as older people having consumer rights to care, rather than their right to care as citizens (Williams, 2010).

There has been a lack of quality care and support that reflects older people's needs and preferences. The 'independent living agenda' highlights the choice of older people is to continuing their independence by living in their own home (HM government, 2008). Yet the supply of specialist sheltered housing needs to be improved to support older people with more complex needs to continue their independence. Despite the greater demand, only five per cent of older people live in retirement homes (Davies, 2014). Thus, attempts at personalising care may have fallen short as the flexibility and diversity of resources required for older people to continue independence have not been met.

Carers are becoming increasingly recognised for the contribution they make as well as their need for support in doing so. In 2001, a question about carers appeared in the UK census for the first time (Yeandle and Steill, 2007). Yet Williams (2010) highlights that much of this attention on carers has been driven by highlighting the financial contribution that carers make to society. Estimates suggest that the value informal carers provide was approximately £87 billion in 2007. In comparison, an estimated £82 billion was spent on the National Health Service in the same year (Buckner and Yeandle, 2007).

Negotiating Care for Older People in Four-Generation Families through Time

Older people may decide the best way to look after themselves in relation to the circumstances of their family. As Finch (1989) highlights, family members feel a moral obligation to care. Rather than using external laws and rights, individuals have their own sense of obligation and assess 'the proper thing to do' depending on each other's circumstances. Finch and Mason (1993) later discarded the term 'obligation' in favour of 'negotiation' to convey the way in which individuals work out commitments between them. The ethics of care perspective has been particularly helpful in interpreting this negotiation process as it suggests that morality may reflect sensitivity to others rather than finding the one right action to meet a situation (Williams, 2004).

Negotiation processes could span across multiple individuals. Another demographic consequence of population ageing is that multiple family generations may live many

more years together (Bengtson, 2001). The focus of this study is on families with four generations, that is, families with living great-grandparents. Research across four-generation lineages remains relatively unexplored in the UK, with some notable exception (Brannen et al, 2004), tending towards an emphasis on dyadic relations such as those between grandparents and grandchildren. By examining intergenerational relationships, it is possible to see how and whether older people work out care, need and support in relation to multiple family members. Furthermore, generational differences in preferred support arrangements can be analysed.

Thus the key question this paper addresses is:

How do older people work out care, need and support in four-generation families within the current policy context?

By examining four-generation families across the life course, I find that families organise professional sources of support for older generations according to sustained close supportive relationships, which entails creating a balance between autonomy, privacy and support. This means selecting different strategies and combinations of family and professional care from the options that are available to them. Families need to have the resources to negotiate a system which is fair to them, and where needs are met, which is specific to each older person and the relationship they have with different family members.

The complexity of understanding care, need and support in multigenerational families across the life course, historical and generational times required an in-depth qualitative analysis. Taking fewer detailed cases is a more effective way of appreciating twists and turns through time, assuming individuals and family groups negotiate, reconstruct, reflect and identify with different discourses. Therefore the intention was to recruit a small number of four-generation families.

There is a significant diversity in the way that care works out between the five case study families. I present a typology of care moving from more independent living towards greater dependency. Geography is a vital consideration for families as they work out in practical terms how best to organise care and support. Thus, for each family I highlight the geographies of care. In the final section, I show how care and support arrangements for older people fluctuate across time, reflecting movements between independence and dependence.

Methodology

A 'timescapes' approach was taken to understand how individuals work out support in relation to policy changes and intergenerational family relationships. Such an approach examines the ways in which social processes may be shaped by time (Adam, 1998). For

example, family relationships may change depending on the time of day, week, year and celebrations. I considered how these relationships and support across generations shift across an individual's life trajectory, policy changes, cohorts and the temporal experience of being a generation e.g., grandparent. Policy and relationship changes across time may influence the resources that are available to carers and those they care for.

Interviews were conducted both retrospectively and prospectively. Two families (the Wilkinsons' and Parkers') were revisited after less than a year. It would have been preferable to revisit all the families involved after a certain time period to see how their situation had unfolded. However, given the restrictions on time and resources it was not possible to do such an analysis for all the families involved.

Moreover, the interview design in this study has adopted a combination of both oral and biographical interpretative methods. Whilst the interviewee was free to construct with minimal intervention through a biographical interpretive approach, they were also asked more specific questions in relation to what they had said, drawing on an oral history approach (Bornat, 2008). In doing so it was possible not only to reveal interviewees' perspectives, but also to gain more knowledge about relevant topic areas that were of greater importance to them.

Vignettes were also used to elicit information on how family members felt support could best be organised for frail older people in multigenerational families, separating personal experiences from normative expectations (Finch, 1987).

The following vignette was posed to interviewees:

Mark and Jessica are a married couple. They both have very hectic working lives. They also have a 23 year old daughter called Michelle. She has two small children. Mark's mother, Maureen, lives alone. Arthritis is making it difficult for her to move, and she has started to show signs of dementia. Mark, Jessica and Michelle are worried about how Maureen will cope. However, Maureen does not like the idea of leaving her own home. She moved to 'Grassholme' when she was 38 and she is now turning 90. She feels very comfortable where she lives, and has friends and neighbours living close by.

Should something be done? What should they do?

The vignette was framed as a family issue, primarily for the third and second generations rather than for the older person themselves. This is reflected in the responses.

Five four-generation families were recruited from cities, suburbs and towns in northern England. These were the Wilkinson, the Buckingham, the Newis, the Thwaite and the Parker families. There were a total of 17 interviews: including five great-grandmother generations (first generation), five grandparents (second generation), five parent

generations (third generation) and two child generations (fourth generation). The sample is mostly composed of female interviewees, with 15 females and two males. Within the families, there was only one living great grandfather who declined to take part in the interviews. The Thwaite family contained two generations of single parenthood.

Across the sample there were some differences in the ages of generations. The oldest great-grandparent was 98, whilst the youngest was 73. The age of generations did not fit neatly with the idea that growing older results in a linear decline in health. Some of the older great grandparents needed less support than the younger ones. The following family trees illustrate family relationships, age and occupational status.

(Figures 6-10 here).

NVivo was used to analyse the data, within families, across the different families, and across different generations. This reflected the aim of understanding how care might shift across generations as well as whether it differed from family to family. .

Unfortunately the costs of care were not discussed extensively by interviewees, possibly because interviewees were conscious of being judged as 'uncaring' or as if financial concerns determined their decisions more than love or obligation. It would have been useful to have explored this issue further, however it was perceived that interviewees did not want to be pressed about this issue.

Findings

The findings below reveal the complex ways in which care for older people is worked out with family members.

Home-Based Family Care

Receiving only family care is relatively uncommon (Yeandle et al, 2012), but it was a possibility in the case where care needs were low. Care for Sarah Wilkinson (G1) was based on family care only. Sarah was the oldest interviewee at 98 (and 100 on the second visit), yet she did not have significant health problems. However, she was frail, had occasional falls, and struggled with household tasks, therefore Sarah needed some support.

However, to manage family care, family members had to work around geographic arrangements. Sarah (G1) alternated between her daughters' homes every three months. The daughters, Mary Wilkinson (G2, age 70) and Deborah Wilkinson (G2), lived 200 miles apart. Both daughters drove half the journey, meeting at a service station, and Sarah (G1) changed over to live with the other daughter. The house in which she was

interviewed was owned by her daughter, second generation Mary (G2) and son in-law Paul Wilkinson (G2, age 73). The house was located in a village of high socioeconomic status approximately 10 miles from a northern city. Daughter of Mary and Paul (G2), third generation Rebecca (age, 49) also lived in the house. Rebecca's sister Katrina (G3, age 46), husband Ben (G3) their daughter Kelly (G4, age 6), and Ben's son Tom (G4) lived in a house five miles away. Figure 1 illustrates where each of the family members live.

(Figure 1 here)

In addition to providing accommodation, Mary (G2) Sarah's daughter did "99.9% of the cooking [and cleaning] for Paul (G2) and I and my mum" (Mary Wilkinson, G2), although Paul (G2) mentioned that he also cooked for Sarah (G1) and Mary (G2). Sarah (G1) paid Mary and Paul (G2) a small amount to contribute towards household costs. Rebecca (G3) also spent time with Sarah (G1). Thus rather than providing no support at all, care practices reflected the negotiation between generations in response to the geographical constraints.

The motivations for family care, despite geographical challenges, was that it was often seen as the best form of care. There was a sense of satisfaction from younger generations that older generations could rely on their family to be there for them. Family care could be a way of reciprocating care that had been provided in the past (Brody, 1981; Silverstein et al, 1995). Katrina Wilkinson (G3) firmly believed that what her parents had done for her should be reciprocated in return.

Katrina Wilkinson: I couldn't have done what I've done if it hadn't have been for my grandparents doing what they've done to start off with, and then my parents struggling like mad to give us the sort of great grounding that they have done. So you can't just sort of be right-I'm off now. See you later. (Third generation, age 46)

However, older generations often did not want their children to take responsibility for their care. When working out care for themselves, all generations clearly considered the situation of their family members. Whilst family members valued and gave support to those in need, in practice, family support could be a 'burden' (although this was not necessarily the way carers saw it). They often did not want the younger generation to care for them. Some preferred a professional carer rather than asking a family member to travel a significant distance to see them. As Rita Buckingham (G1) put it "I don't think it's fair. I think it breaks families up". Older and younger generations may have different stakes in a relationship, which impact on their perception of the ways in which different one another should be involved in each other's lives (Giarrusso et al, 1995; Hoff, 2007),

Moreover, family care only could reduce the autonomy of cared for older generations. Sarah Wilkinson (G1) felt independent, but simultaneously felt her autonomy was under threat from her daughters.

Sarah Wilkinson: I think I rely on myself as much as anything...I'm never in trouble you see (laughs)....Both the girls (daughters Mary and Deborah), they're both marvellous, they look after me...They don't realise, but they do treat me like somebody going to school... they will treat you as though you don't know what you're doing. (First generation, age 98)

Thus, despite a strong adherence to the notion that family care is best, there was also a strong moral sense about not being a 'burden' on others. Moreover, choosing family care only had the potential to quash the voice of older generations. Ethics of care underpinned relationships. Being responsive to another meant negotiating the right thing to do, but the findings indicated that there is a strong possibility that an individual's own perception of doing the right thing for a family member may conflict with how that family member wished to be cared for. Family members weighed up how to have trustworthy relationships with one another, which meant creating a balance of respecting both their own needs and needs of others (Williams, 2004). It was felt by those in need of care that professional support could lighten the load on younger generations, which is explored in the following sections.

Home-Based Family Care Supplemented With Professional Help

Whilst all the frail older people took different care options (with some opting for professional support such as home care and sheltered housing), family care continued to be significant across different support patterns. By sharing support, family members avoided 'burdening' individuals with sole responsibility, and ensured that the older person is cared for. How individuals thought care should be shared between professional and family differed.

Edith Newis (G1, age 90) lived in the city centre in a student area of the city. Jean and Ann (G2) lived on the outskirts, approximately six miles away. Helen Newis (G3, age 36) had once been a central figure in the family support network, helping her mother Jean (G2, age 65) and father Joe (G2, age 67) who had health problems, but had moved away. Whilst Jean and Joe (G2) supported Edith, they did not have the capacity to care for Edith alone, partly due to a combination of Joe's ill health and geographic distance. Jean's sister Ann (G2) and Ann's husband Kevin (G2) were also involved in caring for her in addition to professional carers. Figure 2 illustrates the Newis family living arrangements.

(Figure 2 here)

By sharing care between family carers and professional carers, older people and their families are able to continue with existing arrangements for longer, without the need for institutional care. As Helen Newis (G2) described it "As long as she's happy and we've got the care in place, my sister and I come [to Edith's house] quite often". Professional care could also offer a different dimension of support. Edith Newis (G1)

thought of the professional carers who visited on a regular basis as friends. Formal carers offered emotional support, , as well as offering practical and personal care, which removed Edith's concern of troubling her family with health issues.

Edith Newis: I talk to my girls of course, the one I do talk to is Sally. She's the matron... Yes she's very good at listening...She does not... patronise you at all... I wouldn't talk to other people saying 'oh my mouth or my shoulder hurts'... they don't want to know!...But Sally will listen. And Lisa the carer, she's good....I have a regular one every morning but one. And she's the best of all is Lisa. We're really friends. (First generation, age 90)

Here Edith (G1) makes a clear distinction between what non-familial support can offer compared to support from family. Support from professional carers could provide care responsive to specific practical needs, and provide emotional support that was not embedded in complex family relationships. (This was also the case for Edith's granddaughter Helen Newis [G3] who was unable to leave the house very and felt she could talk to her regular carer).

With these arrangements, Edith Newis (G1) felt that she was independent, and not placing too much pressure on her family. As with Sarah Wilkinson (G1), some family care could seem like the 'norm', creating the feeling of being an independent person. In Edith's case, living in her own home allowed more autonomy. However, professional care could be poor quality, not meeting the needs of older people.

Edith Newis: I might have a different one for tea, and for night call. It's higgledy piggledy. They keep setting you one time [to come to the house and turning up later]...They don't give them enough time. There's so much that needs to be done....They shouldn't let them see people without knowing some very basic cooking. (First generation, age 90)

Family care in your own home with professional care could allow those with greater chronic health problems to be supported whilst keeping their independence. With some professional support, family were able to manage caring with other commitments. As the different types of care and support could be split between family and professional sources, it meant intergenerational relations could continue to be balanced.

Sheltered Accommodation with Family Care

Another possibility was more professional care supplemented with family care. In the Thwaite family, all four generations lived within a couple of miles of one another, making support for Gladys Thwaite (G1, age 85) easier. Gladys lived in sheltered accommodation in a small bungalow on a council estate almost on the main street of a busy market town in the countryside. The bungalow was once council owned, but was now owned by a not-for-profit, housing association for supported living. Tracey Thwaite (G2, age 67) lived alone approximately one mile away from Gladys (G1). Katy

Thwaite (G3, age 40) lived approximately one mile away from Gladys (G1) on a council estate with her partner Chris. Katy lived on the other side of town from Tracey (G2). Michelle Thwaite (G4, age 23) shared a flat with a friend, just over a mile from the market town, where Gladys, Tracey and Katy live. The close living arrangements that were common in past times continued to enable family care for Gladys (G1) in the present. Figure 3 illustrates their close living arrangements.

(Figure 3 here)

Gladys was 'lucky' (Tracey Thwaite, G2) to find suitable accommodation near to her family. In the Wilkinson family, family care was provided in a multigenerational household. It was thought, particularly by younger generations, that family care would keep the independence of the oldest generation. Gladys's (G1) independence was preserved as the family were able to organise times when they were together and apart. Such organisation was possible as Gladys was protected through being checked on by her 'independent living officer'. The officer regularly visits residents, provides information on local support services, and helps to develop a support package. There is also a 24 hour monitoring service. . This meant that whilst "our lives are all intertwined...they are very very separate" (Gladys, G1). Gladys (G1) felt the balance of independence and dependency was upheld between generations because she was able to live in a separate home with regular contact from her family. When asked about her move into sheltered housing she replied,

Gladys Thwaite: Oh it was a good move it was....Yes, I've got nice neighbours and family's good with me. (First generation, age 85)

However, there was some ambivalence over professional care. In response to the vignette, Gladys (G1) felt that care should be organised between daughters, doctors and a local network of support such as the church. Gladys Thwaite (G1) was fervently opposed to professional carers despite the fact that she lived in sheltered housing. She had used home care but was appalled by the unreliability of the service, and finished with them after one week. She commented how some of her neighbours would find their professional carers turning up late in the day, and leaving them in their night clothes until lunch time. Gladys felt that her informal support network of family, friends and neighbours, and sheltered housing was working for her.

Across the families in the study, family care was also a generational issue, with those more generationally distant, less likely to be possible supporters. This differed in the Thwaite family as third generation was very involved in care for the first generation. Katy (G3) indicated that caring for Gladys was time consuming, and had suggested in the vignette that in general an older person could look more to professional sources for care, thus apparently conflicting with Gladys's perspective. However, there was no evidence that the relationship had become conflicting. As mentioned earlier, Katy (G3) visited Gladys (G1) every weekday but took the weekend off. Gladys (G1) mainly relied on professional support from sheltered housing, but to accommodate for her distrust of professional carers Tracey (G2) and Katy (G3) provided an additional level of care. One

possibility is that Katy (G3) was asymmetrically reciprocating support (Young, 1997). Whilst Gladys Thwaite (G2) had never been a carer for Katy (G3), Katy's (G3) mother Tracey (G2) had in the past been heavily involved in childcare for Michelle (G4) and also supported Katy (G3) through shared living arrangements as an adult. This further demonstrates that care can be inequitable between generations.

Thus, with values of family care and striving to keep independence, sheltered accommodation helped all generations to keep a balance, and was used to negotiate the best possible care solution between generations. Younger generations were able to have time away from caring, whilst Gladys only had to have some professional support.

Institutional Care

At the time of interview there were no older people in institutional care, however there were family members that had recently been in residential care. Institutional care was discussed in considering future care options. All family members thought of institutional care as a last resort. In the vignette response from third generation Louise Buckingham (age 30) below, combinations of family care and home care are clearly preferred over institutional care for family.

Louise Buckingham: I think if I was worried, even if she didn't like it, I think I would get her to not necessarily move out into a home or, I know that would kill my grandma, but try and get somebody... like a home help. (Third generation, age 30, emphasis added)

Institutional care could help older generations to release pressure on younger family members. All family members were concerned with finding the best way to support one another, and this also meant older generations wanted to prevent family members from taking too much of the load. Rita Buckingham (G1, age 76) felt that residential care would be the only option for her if she reached the point in which she could no longer take care of herself. She particularly did not want to move in with her family, and saw value in institutional care. Such a suggestion had already led into conflict with her daughter.

Rita Buckingham: I don't want them to think they have to take me into their homes...If I ever get that I can't look after myself I don't want to do that...Diane (Rita's daughter) just said 'well we'll see'. I said 'no we won't, because I've done my will and I've put in my will I do not want to go and live with Diane'. She said 'you wouldn't dare!' 'Yeah I would!'...They'd have to put me in a home. (First generation, age 76)

Rita (G1) described how "Diane's my eldest daughter, always been closest, always done most for us". Despite this closeness between Rita (G1) and Diane (G2, age 55) they conflicted over how care for Rita could be organised. Rita wished to prevent 'burdening' her daughter with multigenerational living and therefore moving into a care home

would be the 'right thing to do' if she was ill. Diane on the other hand, wanted to make sure her mother was well supported by caring for her herself in her own home, perceiving care homes to offer low quality support. Thus, autonomy, and independence from others may be two different things. As Williams (2002) highlights, autonomy may be realised through dependence. Individuals may need some form of support in order to feel they are living independently.

Professional support for older people varies along a spectrum, ranging from no professional support to 24 hour care, but family care remained strongly implicated in each case. By looking across time it is possible to see how care and support may shift.

Dynamics of Care

As circumstances change, new support patterns are created as family generations renegotiate the best way to organise support. Younger older people in the study were affected by acute periods of ill health which meant new negotiations took place. Rita Buckingham (G1) became seriously ill with meningitis when she was aged 70. She was still able to manage in her own home after returning from hospital. Care, need and support usually flowed most intensely between Rita, Diane (G2), Louise (G3) and Daisy (G4, age 2). However, during her time in hospital, Rita received support from all her family, several children and grandchild, and particularly her neighbour. Figure 4 highlights how the family were dispersed geographically.

(Figure 4 here)

At the time of the first interview Iris Parker (G1, age 73) had just retired and was in good health. Several months later, her health had deteriorated. She had problems with her back which made looking after her great-grandson more difficult. However, Derek Parker (G1, age 75) was also able to support Iris and their great-grandson. Figure 5 illustrates the living arrangements of the Parker family.

(Figure 5 here)

Care networks had to be reconfigured as the health of the older generations fluctuated. The first generations moved to more chronic conditions whilst the second generations often had acute conditions, which meant support needed to change. Flexible professional support could help families adapt across changes whilst keeping independence for older people and their family. In the Thwaite family, two years after the first interview, Gladys's (G1) health had deteriorated. Gladys (G1) used a Telecare system, which offers support by monitoring individuals from a distance using sensors, and was able to get help from a nurse and her daughter Tracey (G2). Sheltered housing enabled Gladys and her family to adapt to these new problems. However, it is questionable as to whether this model of more family care will be sustainable. If

Gladys's health worsens, then the family may not be able to take more responsibility.

Due to the fluctuations in health across older generations, older people and their families often have to negotiate and design new support systems to keep the equilibrium of independence, autonomy and meeting needs.

Discussion

At the beginning of this paper I posed the question 'How do older people work out care, need and support in four-generation families within the current policy context?' Whilst all the frail older people took different care options (with some opting for professional support such as home care and sheltered housing), family care continued to be significant. By sharing support, family members avoid 'burdening' individuals with sole responsibility, and ensure that the older person is cared for. This resulted in the variety of care practices found in only five four-generation families. Care practices ranged from: home-based family care, home-based family care with professional supplement, sheltered housing with family care, and institutional care when older people suffered more chronic conditions. Family carers were more likely to provide emotional support, where professional care could meet the practical needs of older people.

It also emerged that care needs fluctuate with young older people more likely to have acute periods of ill health and the oldest older people with more chronic conditions. Geography was also a key consideration for families which resulted in new care practices. For example, in order to receive family care, Sarah Wilkinson (G1) lived in each daughter's house for three months as they lived 200 miles apart. Arranging care is not a straightforward process, but requires ongoing negotiation on both a long-term and day to day basis.

Care preferences could clash as younger generations wanted to support older generations, and older generations did not want to 'burden' younger generations. Sharing care could mitigate this to some extent. Institutional care was regarded by all generations in this study as the least desirable form of care for their family. This reflected policies of deinstitutionalisation, and public perception of the quality of residential care, and of a perceived abandonment of older family members who move into care homes.

In practice, decisions are made as complex intergenerational family negotiations rather than independently. The findings revealed how these negotiations were guided by ethics of care rather than a consumer choice, as family members did what they believed to be the 'right thing to do' by trusting and being responsive to one another's needs when working out the best way to care (Williams, 2004). When reflecting on care for themselves, a 'burden' was seen as too much pressure on the informal network to provide care. This was particularly the case for the women in the study who were more likely to provide support for more than one generation. Older people preferred to move

into accommodation where they felt their needs were met. An independent living agenda may have been used politically as an excuse not to create sheltered housing (Oldman, 2003). Policy lacks the attention to the ways in which “our neediness, as well as our ability to cooperate to fulfil needs and desires, is at the heart of community and all social organization” (Kittay, 2001:526).

Professional care could be a ‘mixed bag’, with some inconsistency and unreliability. Having a trustworthy source of support may be more important to older people than having a choice (Hardy et al, 2001). To reflect the diversity of older people’s needs, there should be more professional carers who are able to work more flexibly (Yeandle et al, 2006). These findings suggest maintaining independence is complex and that families need support in working out the best way to care. The professional care service should be responsive to bespoke personal needs. It should address gaps in family provision with the aim of providing a holistic network of support for all.

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Figure 1: The Wilkinson Family: Map of Living Arrangements

Figure 2: The Newis Family: Map of Living Arrangements

Figure 3: The Thwaite Family: Map of Living Arrangements

Figure 4: The Buckingham Family: Map of Living Arrangements

Figure 5: The Parker Family: Map of Living Arrangements

Figure 6: The Wilkinson Family Tree

Figure 7: The Newis Family Tree

Figure 8: The Buckingham Family Tree

Figure 9: The Thwaite Family Tree

Figure 10: The Parker Family Tree