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Caring neighbourhoods for ageing well in place

Hannah Grove

Introduction: Ageing in place – home and neighbourhoods as spaces of care

Ageing in place is commonly defined as staying in your own home or community as you age, or 'growing older without having to move home' (Phillips et al, 2010, p 17; Wiles et al, 2012). Across policy and academic literature, supporting ageing in place through the provision of age-friendly environments has become a central objective (World Health Organization, 2007; Buffel et al, 2012; Beard and Montawi, 2015). The home environment holds significant meaning for older people, playing a central role in providing familiarity, stability, and a continued sense of identity in an ever-changing world (Sixsmith and Sixsmith, 1991; Hatcher et al, 2019). This importance is heightened as declining mobility can lead to greater amounts of time spent indoors (Baker et al, 2007). It is well recognised that the condition, quality, and suitability of the home environment are key factors in the overall experience

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of ageing in place (Sixsmith and Sixsmith, 1991; Stones and Gullifer, 2016). Continuing to live at home as independently as possible can present significant challenges for older people as needs and capacities change over time (Hatcher et al, 2019).

The meaning of home extends beyond the physical dwelling to incorporate the surrounding neighbourhood and community. For many older people, a vital aspect of overall 'homeliness' is the ability of the home to act as somewhere you leave, rather than simply a place to reside (Ewart and Luck, 2013, p 41). Being able to leave the home is a fundamental and inherent need, recognising the limits to comfort and security that a home alone can provide (Tse and Linsey, 2005, p 137). The home environment can be a place where negative feelings such as boredom, frustration, worry, and distress can manifest, particularly when leaving the home becomes difficult (Sixsmith and Sixsmith, 1991; Tse and Linsey, 2005). Leaving the home, even on occasion, can provide a distraction from the challenges associated with home life, help to obtain perspective, and offer a more positive outlook upon return (Beard et al, 2009). It can provide a change of scenery and fresh air, in contrast to the stale 'sameness' that some participants associate with being indoors for long periods (Gardner, 2014, p 1252). Benefits to health and wellbeing can be obtained through several pathways, including restorative effects associated with engaging with the natural environments and with being outdoors; social benefits linked to interaction with others; and physical health benefits arising from activity and movement (Alves and Sugiyama, 2006; Sugiyama and Ward Thompson, 2007). In addition, being mobile is closely associated with wellbeing, recognising it as being the physical enactment of freedom and independence (Metz, 2000; Mollenkopf et al, 2011; Schwanen and Ziegler, 2011).

Our health and wellbeing is shaped by the social, physical, and environmental contexts in which we live and age (Marmot, 2015; Vine et al, 2023). In later life, neighbourhoods are especially significant as 'arenas' where health, mobility, social

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relations, and care intersect in complex ways (Gilroy, 2008; Wiles, 2018). High streets, shops, and community spaces function as sites of care, where formal and informal supports can develop through routine encounters and social practices (Conradson, 2003; Newton et al, 2010; Gardner, 2011; Wiles et al, 2012; Milligan, 2014; Fullilove, 2020). Supportive environments can be understood as spatial expressions of care where the physical design, social infrastructure, and everyday practices of care intersect across scales. Neighbourhoods can care by enabling safe mobility, offering places to rest, providing opportunities for social interaction, and fostering a sense of being known and supported beyond the home (Gilroy, 2008; Rowles, 2018). At the same time, neighbourhood environments can fail to care through systemic neglect, through poor maintenance, inaccessible design, or a lack of social infrastructure (Finlay et al, 2019). Neighbourhoods, therefore, are not neutral backdrops, but active in producing wellbeing and belonging, or vulnerability and exclusion.

While leaving the home has the potential to support wellbeing, it can involve challenges, fear, and risk, depending on an individual's personal circumstances and the environments they must navigate. When these challenges are judged to be too great, leaving the home may be avoided altogether (Peace et al, 2011). Ageing in place, therefore, is best understood as an ongoing and dynamic process, involving a balance between environmental demands and individual capacities (Bigonnesse and Chaudhury, 2021). Whether ageing in place is experienced positively depends not only on attachment to home and neighbourhood, but on how well environments can accommodate shifting needs and abilities over time. Ageing well in place is strongly influenced by a person's 'fit' with their environment (Lawton and Nahemow, 1973) and the resources they can draw on to adapt and cope with change (Peace et al, 2011). Depending on the supportiveness of local environments, this process can be far easier for some than for others.

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Empirical case study: negotiating care, risk and everyday mobility

Drawing on doctoral research (Grove, 2022), this section presents an empirical case study from qualitative and spatial research conducted with older adults living in the Greater Dublin Area. The wider study employed focus groups, in-depth interviews, mapping exercises, and go-along interviews to explore everyday routes, routines, and places of significance. This chapter focuses on the experiences of one individual, 'Dolores' (a pseudonym), providing a detailed account of how care, risk, and mobility are negotiated in everyday neighbourhood life.

Living alone in an inner-suburban Dublin neighbourhood, Dolores (aged 89 at the time of the interview) was the only participant recruited via a public health nurse and received the most extensive in-home support. This included home modifications such as a stair lift and assistive devices. Dolores lived with multiple health and mobility challenges and relied on a walker when leaving her home. Despite these challenges, Dolores was determined to remain engaged with her neighbourhood. She described a 'good day' as one where she could walk to Mass, approximately 800 metres or 20 minutes from her home. On days when she managed this journey independently, she was 'delighted' with herself. This routine was deeply meaningful to her and illustrates how wellbeing in later life is tied to the ability to carry out specific, valued activities beyond the home. Dolores received formal care through health services and home adaptations, while informal care was embedded in her neighbourhood through supportive neighbours who assisted with shopping, giving her a lift to Mass on Sundays, and checking in with her during adverse weather: 'It is a very friendly neighbourhood and people are so kind, can I open the gate for you, can I get you a message [something from the shop]? And during the snow there I was … There was a queue at my door [laughs].'

Dolores emphasised how fortunate she felt to live in a supportive area, describing herself as 'truly blessed'.

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However, she was careful about what she asked of others, expressing a desire not to be a burden. While she would accept help for what she considered more necessary activities, she was reluctant to seek support for trips she viewed as more discretionary, such as visiting gardens or the seaside: 'I would love to go to the Botanic Gardens, but I don't feel like paying a taxi there and back. My neighbours are great, but I am not going to ask them to bring me to the Botanic Gardens, they are busy working or whatever.'

Dolores' ability to leave home was shaped by a continual negotiation of risk. On any given day, she had to assess how she felt physically, considering her health, energy levels, and mobility, as well as external conditions such as the weather and time of day. She was highly sensitive to windy conditions, which heightened her fear of falling and could be enough to deter her from leaving the house altogether. Features of the built environment further amplified risk for Dolores, shaped in part by previous negative experiences and falls that had undermined her confidence over time. Uneven pavements and poorly maintained footpaths (Figures 5.1 and 5.2) made walking with a walker increasingly difficult. During her go-along interview, Dolores pointed out several locations in her neighbourhood where she had fallen in the past. She described how, more recently, she had lost strength and found it difficult to lift her walker off the ground, making cracked or uneven surfaces particularly hazardous. These experiences heightened her sense of vulnerability and made even short journeys feel riskier. Public transport posed similarly high-stakes challenges for Dolores. Although a bus stop and train station were both within walking distance of her home, inconsistent assistance from bus drivers and inaccessible vehicle and station design had taught her, through experience, that she could not rely on these systems to keep her safe. Dolores described how getting on and off the bus could be particularly stressful when it was busy: 'You couldn't go from town to get off at [my stop] because there would be people standing … how are you

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Figure 5.1: Broken footpaths in the local area, photographed during a go-along interview



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Figure 5.2: Dolores using her walker, photographed during a go-along interview



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going to get your rollator [walker] past all these legs? … So that really is a no-no.' She also highlighted the variability in driver behaviour, explaining that 'some of them are very good, they will lower the ramp … some of them won't bother'. This left her struggling to lift the heavy walker, tap her card, and find a seat before the bus moved off. In these moments, she described being 'afraid of my life of falling because I am not steady on my feet'. Past experiences reinforced these fears. On one occasion, when travelling to hospital for an appointment, Dolores decided to 'chance' the bus because of the higher costs associated with taxis. Although she managed to board and sit on her rollator, the sudden movement of the bus caused her to injure her elbow, which started bleeding. Reflecting on these experiences, Dolores concluded that saving money when compared with taking a taxi was 'not worth ending up in A&E'. Over time, these cumulative barriers narrowed Dolores' world. While she remained appreciative of her neighbours and community, her capacity to engage beyond her immediate neighbourhood had diminished. Central to this experience was the delicate and often negotiated balance between independence and dependence. Dolores expressed a strong desire not to be a burden on others, a finding that resonates with a substantial body of research on ageing and independence (Schwanen et al, 2012; Bell and Menec, 2013; Hillcoat-Nallétamby, 2014). Existing studies show that independence in later life is rarely absolute; rather, it is relational and contingent, sustained through negotiated forms of support and reciprocity (Borglin et al, 2005). Research has shown that older people are more willing to accept help and less likely to perceive themselves as dependent, when they can reciprocate in some way, reinforcing the importance of altruism, mutual aid, and *interdependence* (White and Groves, 1997; Bell and Menec, 2013).

Dolores remained determined to leave the home in some form, even when it became increasingly challenging to do so, underscoring how engagement with place remained central

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to her wellbeing and how she conceptualised a 'good day'. Many of the high levels of risk she faced were not inevitable consequences of ageing, but products of careless design, inconsistent service provision, and mobility infrastructures that lacked care and consideration of the needs of older people with health and mobility challenges. This example highlights the need to move away from viewing ageing well in place as an individual achievement, and toward understanding it as a collective, place-based societal responsibility; one that planning, transport, and housing systems play a central role in shaping. The final section of this chapter now considers how neighbourhoods might be deliberately designed and governed as collective infrastructures of care, to enable more inclusive, relational, and socially sustainable forms of ageing well in place.

Designing neighbourhoods of care: implications for policy and practice

Planning systems play a critical role in shaping the everyday environments through which care is enacted, including how easily people can move through cities, access essential services, and maintain social connections within their neighbourhoods (Buffel et al, 2018; Buffel and Phillipson, 2024). The findings presented in this chapter have highlighted the need for planning and ageing policy to move beyond aspirational commitments to age-friendliness, health, and resilience, towards approaches that explicitly recognise care, interdependence, social infrastructure, and accessible mobility as central.

Integrating planning and public health to address inequalities

An explicit '*Health for All Policies*' is required to align planning, public health, housing, sustainability, and integrated care agendas (Greer et al, 2022). Designing neighbourhoods that care for their residents requires coordinated action across planning, public health, housing, and transport, so that decisions about social infrastructure, housing, and everyday

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mobility reinforce public health objectives rather than operating in isolation. Stronger coordination at neighbourhood and community scales can support preventative, place-based approaches to care that extend the period during which people can remain connected within their communities, while also contributing to reductions in persistent health inequalities (Buffel and Phillipson, 2018). Addressing inequality must be central to this integration. Older people's experiences of ageing well are shaped by accumulated advantage and disadvantage across the life course (Dannefer, 2003). Age-friendly, healthy, or resilient city frameworks risk obscuring and reinforcing these inequalities if applied without explicit attention to power and the uneven distribution of resources (Buffel et al, 2023). Planning authorities can use existing health and demographic data to better map socio-spatial inequalities and to recognise that different population subgroups have unequal capacities to benefit from more supportive environments.

Embedding care within healthy place-shaping principles

Planning policy should embed City of Care and healthy place-shaping principles as core components of spatial decision-making, rather than treating them as supplementary or aspirational goals. Long-standing research on healthy urban planning demonstrates that the design of neighbourhood environments, such as walkability, accessibility, and access to social spaces, can have profound implications for health and wellbeing across the life course (Barton and Grant, 2006). Investment in pavements, seating, shelter, legible routes, accessible transport, and local social spaces should, therefore, be understood and valued as essential health-promoting infrastructures. Investments in this type of infrastructure support the development of everyday caring practices, enable interdependence, and reduce the risk of social isolation, particularly in later life (Buffel and Phillipson, 2024). Framing these elements as core infrastructure strengthens the case for

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their prioritisation within planning policy and development decision-making.

Social infrastructure needs to be better recognised as a foundational component of caring and socially sustainable cities. Facilities such as community centres, libraries, health services, places of worship, local shops, and informal meeting spaces are critical sites through which everyday care, social connection, and mutual support are organised (Klinenberg, 2018). Planning policy has a key role in protecting and promoting social infrastructure, yet it is consistently undervalued in developer-led and economically driven planning systems. More could be done through local plan-making to safeguard existing community assets and to ensure that new developments include accessible and inclusive social spaces, recognising the importance of small-scale and informal third places, such as cafés, benches, sheltered public spaces, and toilets, as everyday infrastructures of care (Oldenburg, 1989; Gardner, 2011; Finlay et al, 2019; Yarker, 2021; Buffel and Phillipson, 2024).

Everyday mobility and the ability to move through cities

The ability to move easily, safely, and confidently through neighbourhoods is central to whether urban environments are experienced as caring. Barriers such as uneven pavements, inadequate crossings, lack of seating and shelter, poor lighting, and inaccessible public transport disproportionately affect older people and those with mobility or cognitive impairments, shaping decisions about whether to leave the home at all (Burton and Mitchell, 2006; World Health Organization, 2007). Planning policy should therefore prioritise walkability, accessibility, and comfort as core design principles. Investment in pedestrian infrastructure, accessible transport, and age-friendly street design should be understood as preventative health and care interventions. Relatively modest interventions, focused primarily on more supportive and caring local mobility services, could have significantly enhanced Dolores'

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ability to age well in place. Such interventions require a combination of both physical and tangible infrastructure, but also more intangible aspects of the social environment. These more intangible elements are central to enhancing social sustainability, understood as the capacity of places to support wellbeing, social cohesion, and mutual care over time (Dempsey et al, 2011). However, these dimensions are rarely captured within formal planning evidence bases.

These concerns point toward the importance of proximate urban development patterns, including the principles underpinning *15-minute neighbourhoods*, where essential amenities, services, and destinations are accessible within a 15-minute walk or cycle (Moreno et al, 2021). While such frameworks are often framed primarily in terms of promoting environmental sustainability and carbon reduction, this research highlights their significance for care, social infrastructure, and everyday mobility. Ensuring that essential services, social spaces, and everyday destinations are accessible within short, walkable distances is particularly important for older people and others whose mobility is constrained by age, health, or caring responsibilities (Buffel et al, 2018; Moreno et al, 2021). However, proximity cannot be understood solely in terms of distance or travel time. It must also account for the pace, rhythms, and temporalities through which people move through cities. Research on ageing and mobility emphasises that older people often experience urban environments at slower speeds and through more episodic, relational rhythms, shaped by bodily change, confidence, and the need for rest, social interaction, and familiarity (Lager et al, 2016). Even routes that might be considered objectively 'accessible' can become effectively inaccessible if they are rushed, uncomfortable, or physically demanding, or if they fail to accommodate pauses, lingering, and informal encounters. This highlights the importance of designing proximate neighbourhoods that are not only compact, but also temporally inclusive. Wide pavements, frequent seating, safe crossings with sufficient

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crossing times, sheltered waiting areas, and legible, familiar routes enable older people to move at their own pace and to integrate everyday journeys with social interaction and caring practices. Without attention to pace and rhythm, proximate urban models such as 15-minute neighbourhoods risk reproducing spatial and temporal inequalities, privileging those who are mobile, confident, and time-efficient, while marginalising those who move more slowly or cautiously.

Valuing participation and lived experience as evidence

How care is understood and enacted in later life is shaped by wider social, political, and economic belief systems that define rights and responsibilities at both individual and societal levels (Milligan, 2014). These belief systems influence what forms of knowledge and evidence are recognised as legitimate within planning and policy processes. Planning systems have traditionally prioritised objective, measurable indicators, often privileging professional expertise over lived experience (Hockey et al, 2013). As a result, the subjective, relational, and experiential dimensions of ageing in place, such as how people feel, move, connect, and negotiate their everyday environments, are frequently overlooked. Yet it is precisely these experiential qualities that shape whether neighbourhoods are experienced as caring or supportive. Feelings of safety, familiarity, confidence, and being known within a place play a critical role in sustaining independence and wellbeing in later life (Rowles, 2018). Participatory mapping, in-situ methods such as go-along interviews, and spatial storytelling approaches can help to ensure that policy interventions better incorporate the lived realities of ageing (Carpiano, 2009; Finlay and Bowman, 2017; Grove, 2021). Through person-in-environment interventions, participatory approaches can support older people to identify what matters most to them, recognise existing resources, and articulate where additional support may be needed (Finlay and Rowles, 2021). This aligns

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with broader calls for forms of *collaborative urbanism*, which emphasise co-production and the active involvement of older people in shaping neighbourhood change (Buffel, 2018; Buffel and Phillipson, 2024).

A primary barrier to creating caring cities lies less in the availability of local authority resources than in the values embedded within planning systems and urban development policies. Building on the City of Care framework, originally articulated by Manzo (2023) and further developed by Manzo and Grove (2024), and grounded in an ethics of care centred on public health, community wellbeing, solidarity, empowerment, and social justice, this chapter calls for a reorientation of planning policy that recognises neighbourhoods as collective infrastructures of care. From this perspective, ageing well in place is shaped not only by the quality of housing, but by the supportiveness of everyday neighbourhood environments to enable engagement beyond the home. This understanding reframes older people as active contributors to care through informal practices and everyday mobilities, rather than solely as recipients. Embedding caring city principles in planning and policy requires an acknowledgement of our collective interdependence, the need to address unequal environmental supports, and to broaden what counts as evidence to include lived experience alongside conventional indicators. Together, these shifts invite a reimagining of neighbourhoods as shared spaces of care, which can support human flourishing throughout the life course.

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