

Preparing for later life in Norfolk

**What over 55s are doing
and what help they need**

October 2025

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Registered office: Suite 6, The Old Dairy, Elm Farm, Norwich Common,
Wymondham, Norfolk NR18 0SW

Registered company limited by guarantee: 8366440 | Registered charity: 1153506

Email: enquiries@healthwatchnorfolk.co.uk | Telephone: 0808 168 9669

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Who we are and what we do

Healthwatch Norfolk is the independent voice for patients and service users in the county. We gather people's views of health and social care services in the county and make sure they are heard by the people in charge.

The people who fund and provide services have to listen to you, through us. So, whether you share a good or bad experience with us, your views can help make changes to how services are designed and delivered in Norfolk.

Our work covers all areas of health and social care. This includes GP surgeries, hospitals, dentists, care homes, pharmacies, opticians and more.

We also give out information about the health and care services available in Norfolk and direct people to someone who can help.

At Healthwatch Norfolk we have five main objectives:

1. Gather your views and experiences (good and bad)
2. Pay particular attention to underrepresented groups
3. Show how we contribute to making services better
4. Contribute to better signposting of services
5. Work with national organisations to help create better services

We make sure we have lots of ways to collect feedback from people who use Norfolk's health and social care services. This means that everyone has the same chance to be heard.

Summary

This report is part of a three-year project run by Healthwatch Norfolk for Norfolk County Council Adult Social Care. The project looks at how people aged 55 and over are preparing for later life, and how health and social care services can support them to stay independent for as long as possible. Norfolk has an older population than the national average, and demand for social care is expected to rise, so it is important to plan for the future.

We carried out focus groups and a survey across the county to find out what people expect from later life, what steps they are already taking, and what help they would like. We heard from a wide range of people, although women and those living around Norwich were over-represented.

Most people we spoke to had negative expectations of later life, often linking ageing with decline, poor health, loss of independence and limited support from health and care services. Many were worried about long waiting times, feeling dismissed by professionals because of their age, and experiencing what they saw as ageism in health services. Money worries and the rising cost of living were also major concerns. Some people did describe positive expectations, especially around family life, hobbies and social connections, but these were less common.

When it came to preparing for later life, most people said they were eating healthily, staying physically active, making a will, and keeping socially connected. Fewer people had set up a lasting power of attorney, adapted their homes, or used technology to support independence. People with long-term conditions and disabilities were more likely to adapt their homes or use technology, but often found it

harder to maintain social connections. People from minority ethnic backgrounds faced particular barriers with pensions and wills, often due to having spent less time in the UK.

When asked to prioritise, people felt the most important preparations were staying active, eating well, and keeping socially connected. Many were reluctant to set up a power of attorney, often due to lack of trust, confusion about what it involves, or the belief it is expensive. Others were motivated by personal stories from friends or family, showing that peer experiences have a big influence on decisions.

Most people welcomed the idea of taking more responsibility for staying independent, but they stressed that not everyone can prepare alone. Some lack money, confidence, health, or social networks, and would need more support. People wanted balanced services that encourage independence but still provide help where needed. They also wanted clear, timely, and non-patronising information about preparing for later life, available in a mix of formats—leaflets, websites, and local drop-in sessions—and provided in places people already use, like GP surgeries, libraries, supermarkets, and community centres.

People said the main types of help they wanted were: affordable opportunities to stay active, ways to stay socially connected, practical support with adapting their homes, more accessible information, and support for carers. Community centres and local groups were seen as vital but underused resources, and many people valued intergenerational activities rather than being placed only in “older people’s groups.”

Our findings suggest that most older people want to prepare well for the future, but need the right support and information to do so. Services should make the best use of community resources, recognise the needs of different groups, and address people’s concerns about ageism in health care.

Recommendations

- Provide clear, practical, and non-patronising information about preparing for later life, including pensions, wills, home adaptations and lasting power of attorney. Use leaflets, websites, and local advice sessions, with reminders at different ages (55, 65, 75).
- Expand affordable, age-appropriate physical activity opportunities and provide advice for those with health conditions or disabilities.
- Support social connection through community hubs, Men’s Sheds, intergenerational projects, and better promotion of local assets.
- Increase awareness of help with home adaptations and assistive technology, including practical demonstrations.
- Promote “supported independence”—peer support and professional guidance—rather than expecting people to manage alone.
- Tackle ageism in health and care by training staff and ensuring fair access to treatment.
- Improve access to financial and legal advice, especially for ethnic minority communities and those with fewer resources.

Why we looked at this

A three-year project to understand older people's experiences of social care

This report details some of the research and engagement done as part of the second year of a three-year project that Healthwatch Norfolk have been commissioned to carry out, by the Adult Social Care Department at Norfolk County Council. The UK population is ageing quickly, and Norfolk has an older population than the UK average (24.8% of the population is over 65, compared to 18% of England's population as a whole, Norfolk Insight 2025). The overall aim of the three-year project is to look at areas of current high demand for social care from people 65 and over, and areas in which demand is expected to rise. We want to understand older people's experiences of services, in order to help Adult Social Care and other services plan services which respond to people's needs and wants.

The project in year 2 was looking at three main themes, one of which is about how people in Norfolk are preparing for later life, and how services in Norfolk might support them to do so better.

Preparing for later life

Statements about the importance of prevention in health and social care have often been made by politicians and professionals in the sector. In relation to the ageing population, the Chief Medical Officer's report of 2023 discussed the importance of the prevention of disease for prolonging people's healthy lifespan, and helping them be independent for as long as possible (Whitty, 2023). The Chief Medical Officer argued that ill health and disability in older age are not inevitable, and that measures to delay and prevent disease and disability can prolong the proportion of our lives that we spend being healthy and independent, and minimise the amount of time we spend living with ill health.

He also noted that there are inequalities in how fast people age biologically, with some ageing much faster due to the social and economic environments that they live in, with those in areas of deprivation likely to have a shorter healthy lifespan. Those living in the most deprived ten per cent of areas in England have

a life expectancy of 51.9 years in good health, while those in the least deprived ten per cent of areas have a life expectancy of 70.7 years in good health (Whitty, 2023, p. 6).

Prevention needs to take many forms, some of which will be taken on by health services, and some by local and national government. What is often termed 'primary prevention', which reduces people's exposure to things which will make them unwell in the long run (for example, by reducing poverty or improving air quality), tends to be the responsibility of government. 'Secondary prevention', meaning measures to slow down the early stages of disease (for example, by running health checks to detect heart disease or cancers as early as possible) is usually taken on by the NHS. The recommendations from this research theme will therefore be targeted both at Norfolk County Council and health services in the county.

Experts in this field often argue that prevention efforts need to focus on the causes of frailty and illness, and on how illnesses develop over time (Arnold & Holden, 2025), rather than starting from the interventions that services are currently set up to provide. In this regard, estimates suggest that only about 20 per cent of people's health outcomes are determined by health care, with 40 per cent determined by socioeconomic factors (such as education, job status and social networks) 30 per cent determined by health behaviours (such as diet and exercise), and 10 per cent by physical environment (such as housing and its location) (Norfolk and Waveney Integrated Care System, 2025, p. 6).

A prevention approach has several advantages for people and society. It can reduce illness, extend people's healthy life expectancy, and how long they live overall. It can also help people avoid having to stop work early, providing economic benefits for them and the economy. From the point of view of health and social care services (and the taxpayers who fund them), it is also usually cheaper to prevent illnesses than to treat them when they arise, and prevention can lead to reduced demand on over-stretched services (Arnold & Holden, 2025).

The benefits and importance of a prevention approach have been recognised in Norfolk, and health and social care bodies have strategies in place to try to increase prevention efforts. Adult Social Services' current five-year strategy, running from 2024-2029, is called "Promoting Independence", and the first part of the strategy is called "Benefiting from prevention and early help" (Norfolk County Council, 2024, p. 10). As the strategy document argues, "Prevention is about

supporting residents' health and wellbeing by offering support as soon as possible to avoid them becoming unwell, losing their independence, or needing more care in the future". The strategy also notes that the department is seeing a rise in demand for services, alongside a challenging financial situation, which may be another reason why prevention is a priority.

The prevention aspect of the strategy focuses on a range of factors, including: to make information easily available that will allow people to plan for their future, to target advice and support at people who can benefit from early help, and to connect people to range of support that allows them to stay independent (ranging from help with gardening, to residential care, to volunteering opportunities). It also has a focus on carers, aiming to make sure that they are identified and supported, and helped to plan for the future with support.

Norfolk and Waveney's Integrated Care System (NWICS) also focuses on prevention as part of its 'Ageing Well Strategic Framework' (Norfolk and Waveney Integrated Care System, 2025). Given the broader remit of NWICS, its strategy, led by public health, covers measures that can be taken by both local government and NHS services. Noting that healthy life expectancy in Norfolk is lower than the national average (at around 62.7 years for males and 62.4 years for females) and that it has decreased in recent years (p. 2), the strategy document emphasises the urgency of helping people to stay healthy and independent for as long as possible.

The strategy looks at addressing three stages of ageing, the first two of which are most relevant for our research. The first is a "preparing for later life phase", where the focus is on preventative activities which extend healthy and independent life. The second is an "active ageing phase", in which the focus is on the period between being active, and becoming frail. The focus in this phase is on trying to reduce the impact of long-term conditions on everyday life, to postpone frailty, and to prepare one's environment and personal networks. It would also involve targeted support to people at risk of poor health and disability.

Both the social services strategy and the NWICB strategy emphasise the importance of engaging with members of the public when implementing these strategies, and the work in this project theme aims to contribute to that effort. Our objective has been to understand what people who are currently either not in receipt of any formal social care services, or only receiving low-level support (such as using equipment or attending community groups), are doing to

prepare for later life, and to stay independent for as long as possible. We also wanted to know what support people in Norfolk would like, to help them to prepare better. We hope that the findings of this research will allow services in Norfolk to take into account the views of members of the public, as they target their prevention efforts.

How we did this

To understand what people across Norfolk were doing to prepare for later life, and what services in Norfolk could do to help them to stay independent for as long as possible, we wanted to achieve both depth of insight, into the complexities of how individuals prepare for later life, and breadth of insight across the county. We therefore used a combination of qualitative and quantitative methods.

For the qualitative part of the research, we decided to use two-hour focus groups to gather people's views. These would allow us to pose a series of questions to small groups of people, to be discussed in some depth. These would help us to probe not only what people were doing to prepare for older age, but also why their choices made sense to them in the context of their everyday lives, what their motivations were, and what kind of help or encouragement would allow them to do more.

Given that there was likely to be a range of approaches to prepare for later life, the group format also allowed us to discuss the different possible activities of preparing for later life through comparing different participants' strategies. It also allowed us to see what kinds of arguments and examples could persuade people to change their habits. Once the focus groups were complete, we used the results of the groups to write a survey questionnaire to be distributed across the county, in order to get a broader view of people's preparations.

We organised seven focus groups around Norfolk, and recruited participants aged 55 and over for these sessions, trying to capture a range of different voices. Given the intensive nature of qualitative methods, it was not possible to capture the full range of voices in the county, but we tried to capture people who:

- Live in different areas of the county
- Live in both urban and rural areas
- Have different levels of income, but prioritising areas of social deprivation
- Have different fitness levels
- Are of different ages

NCC also asked us to try to capture the voices of minority ethnic groups who were in concentrated geographic areas. With these aspects in mind, we organised the focus groups which are summarised in the following table, along with the recruitment methods:

Focus group location	Recruitment method
ACORN centre, Great Yarmouth	Through the ACORN Centre
Great Yarmouth Library	Engagement with people exiting exercise classes at Yarmouth Marina Centre
Norwich Millennium Library	Online adverts and promotion through Norwich GP surgeries
Swaffham Assembly Rooms	Engagement with people at community events in Swaffham
Discover Downham	Promotion through Men's Sheds
West Earlham Community Centre, Norwich	Promotion with the help of Norfolk Polonia
Hanseatic Union, Kings Lynn	Group organised by the Hanseatic Union

Table 1: A summary of focus group locations and recruitment methods.

The list of questions for these groups was developed partly on the basis of a list of areas that NCC wanted to find out about, as well as the results of a desk review of research on people's perspectives on preparing for later life. We also looked at recommendations from statutory and voluntary organisations about what people ought to do to allow them to stay independent for as long as possible.

The focus groups covered four main topics. They started off by asking people what they expected older age to be like for them, given that what people are doing to prepare for older age is likely to be informed by these expectations. They then asked people what the most important preparations for later life were, asking them to come up with a list of the top three preparations, both as a way of spurring discussion, and to try to produce findings that could help NCC and other services to prioritise support strategies. During these discussions, the facilitator also asked what participants had already done to prepare, and what their reasons were for undertaking, and not undertaking, different preparations.

We then asked participants what they thought of the move by NCC to encourage and support people to stay independent for as long as possible, asking them to list what the possible advantages and pitfalls of this approach might be. Finally, we asked them what kind of support they would like from services to help them to prepare better. In each of the sections, we asked first for people's opinions without prompting, but then provided a list of prompts to aid the discussion and make sure that it covered all relevant forms of preparation and sources of support.

The data from the focus groups was transcribed using an Artificial Intelligence service called rev.com. Transcripts were coded using a qualitative analysis software package to capture all of the topics that participants discussed. These codes were then organised into themes, which formed the basic structure of how the findings from these focus groups are reported in this document.

A preliminary analysis of the focus group findings was then undertaken, and this informed the preparation of a survey questionnaire, covering similar main themes to the focus groups. It had a slightly greater emphasis on people's attitudes towards establishing a lasting power of attorney, given many focus group participants' reluctance to establish one. It also asked in more detail about how people would like information about preparing for later life to be provided, which had often been a main theme of discussion in the focus groups. The questionnaire included a mixture of closed multiple-choice and open-ended questions.

The survey was made available online, on the Smart Survey platform. It was promoted through:

- The Healthwatch Norfolk website, newsletters and social media
- GP Footfall websites and other primary care IT platforms
- Targeted Facebook adverts for people in the appropriate age groups
- Patient Participation Groups in GP surgeries
- Health and Wellbeing Partnerships across the county
- Volunteer co-ordinators at Norfolk's acute hospitals
- Various voluntary sector organisations' email lists, social media and websites
- The NCC website and providers email list

The survey was also promoted in-person at the following venues:

- Sheringham Salvation Army community café
- Northrepps Cuppa Care event

- Alive Foodbank, Norwich
- Sprowston Dementia Café, Norwich
- Gorleston Library

Respondents were entered into a prize draw to win £10 shopping vouchers as an incentive to take part.

Once the data was received, it was analysed using Smart Survey's own analysis functions, along with Microsoft Excel. The data was analysed both to uncover overall trends, but also to look at the results according to different demographic characteristics (such as age, gender, ethnicity and so on). We also checked the data against our qualitative findings to understand to what extent these were representative of the broader population of Norfolk.

Ethical considerations

This project was not put before an ethical scrutiny committee, because according to the Health Research Authority (HRA), it does not constitute formal research, and therefore does not require ethical scrutiny (see the HRA decision tool here: <https://www.hra-decisiontools.org.uk/research/>).

Care was taken to secure informed consent from all people participating in this research. Participants were told what the information would be used for, how long it would be kept before it was deleted, and that they would be able to withdraw their consent to participate at any time before publication of the report. People were made aware that all responses would be anonymised, and any identifying information removed before it was mentioned in the report. The data was stored in password-protected hard drives, and hard copy survey responses were stored in a locked drawer at the Healthwatch Norfolk offices. The data collected will be deleted at the end of the project, and participants were made aware of this. People participating in the focus groups were signposted to appropriate services after the session ended, to help them to find support with any issues they had raised.

Who we heard from

The charts below summarise the demographic characteristics of people who responded to the survey for this report. As the charts show, the age group we heard from most was 65–74 year olds, who were 42 per cent of respondents (or

98 people), followed by 55-64 year olds (30 per cent, or 72 people), 75-84 year olds (25 per cent or 59 people), and people 85 and over (three per cent or seven people).

Significantly more women (71 per cent, or 173 people) completed the survey than men (28 per cent, or 67 people). This is substantially above the gender balance of the population of Norfolk as a whole, which is 51 per cent women and 49 per cent men. In terms of sexuality, 87 per cent of respondents (or 209 people) identified as heterosexual. This is slightly less than the figure for Norfolk as a whole (89 percent, Census 2021, cited in *Safer Norfolk Plan 2025 to 2028, 2025*), although 5 per cent of respondents selected 'Prefer not to say'.

A significant proportion of respondents had a long-term health condition (40 per cent or 95 people), 15 per cent (or 35 people) had a disability, and 11 percent (or 26 people) had both.

In terms of ethnicity, a large majority of respondents identified as White British – 94.7 per cent of respondents, which is the same proportion as in Norfolk as a whole.

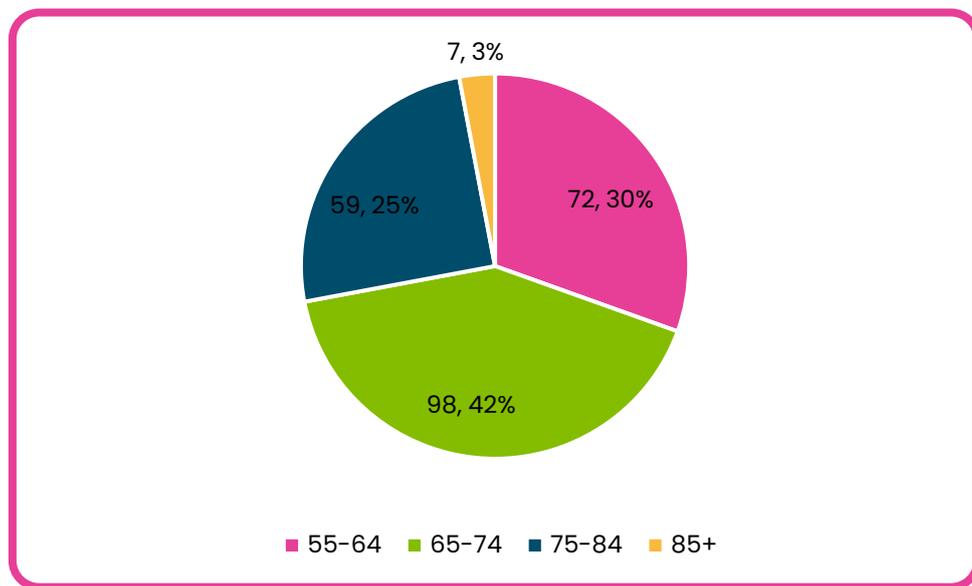


Figure 1 - Pie chart displaying the distribution of age ranges within the survey population. Total responses for this question numbered 237.

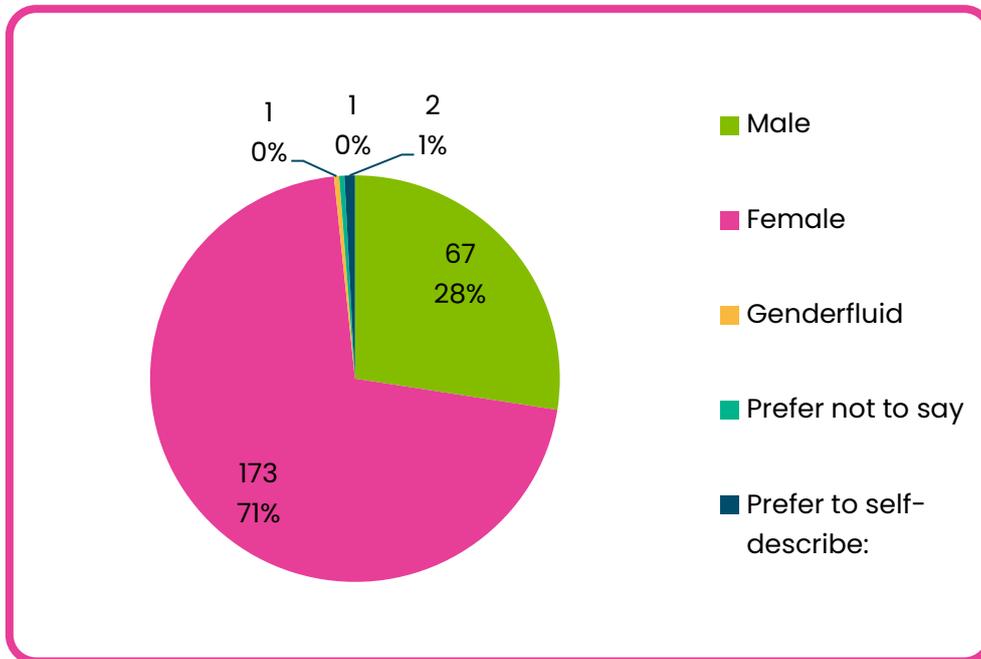


Figure 2- Pie chart displaying the distribution of gender statistics within the survey population. Total responses for this question numbered 244.

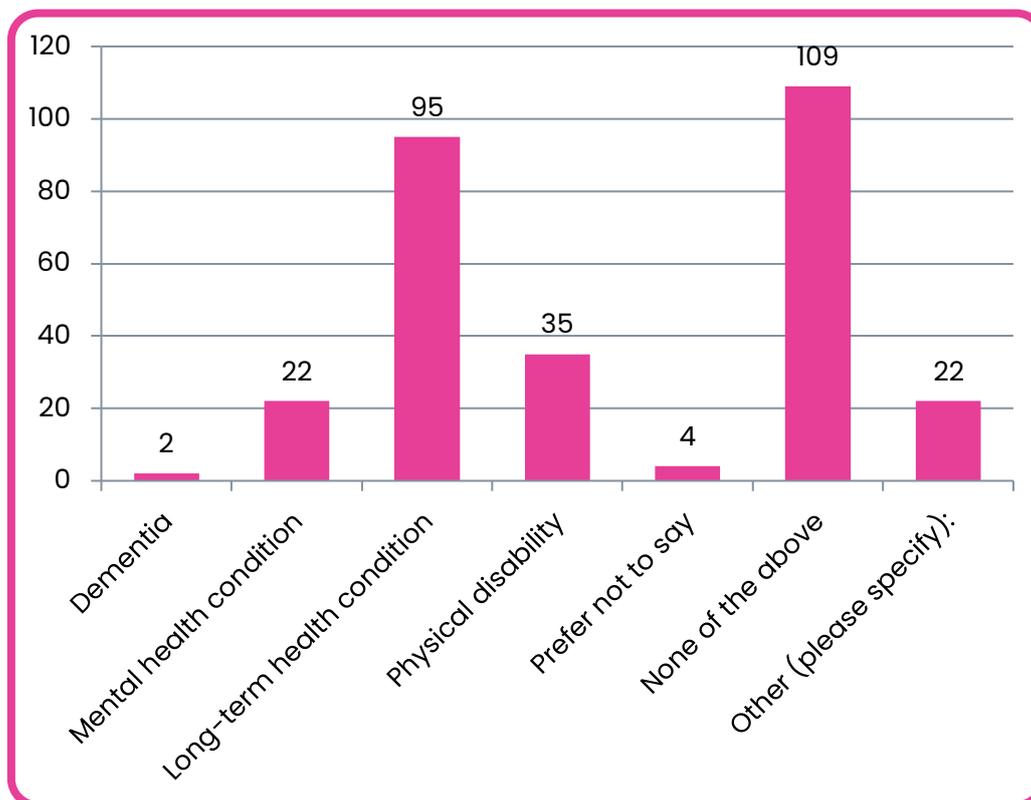


Figure 3 - Bar chart depicting the number of respondents who identified as having a disability or long-term health condition etc. Total responses for this question numbered 237.

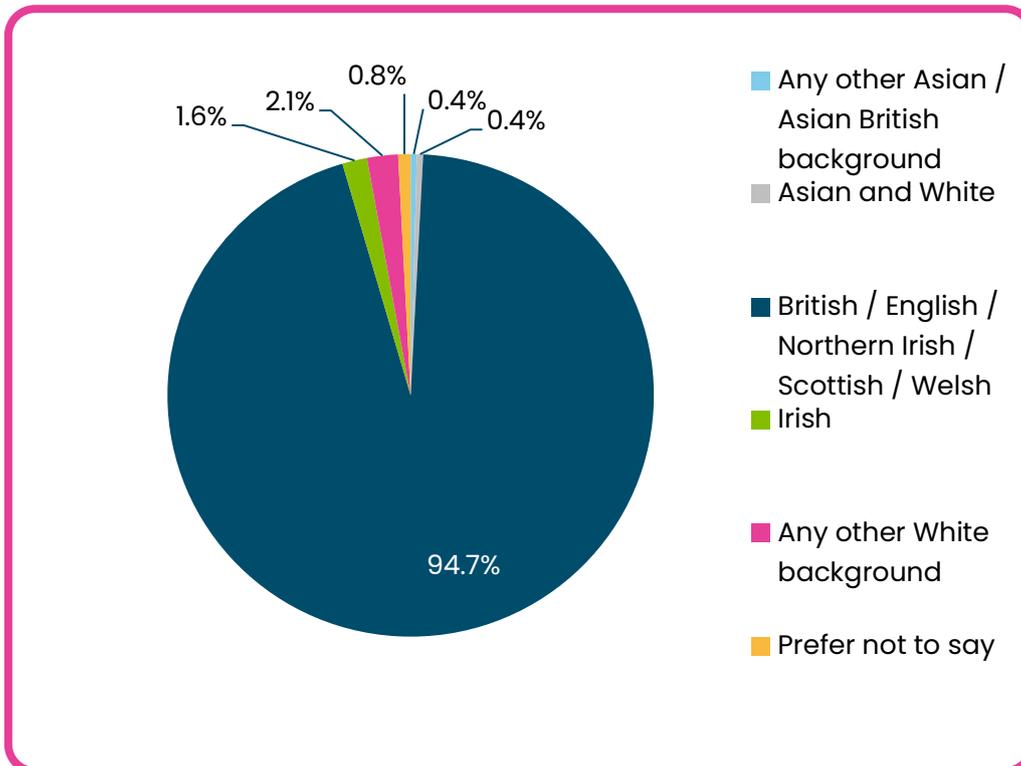


Figure 4 - Pie chart depicting the ethnicity of survey respondents. Total responses for this question numbered 243.

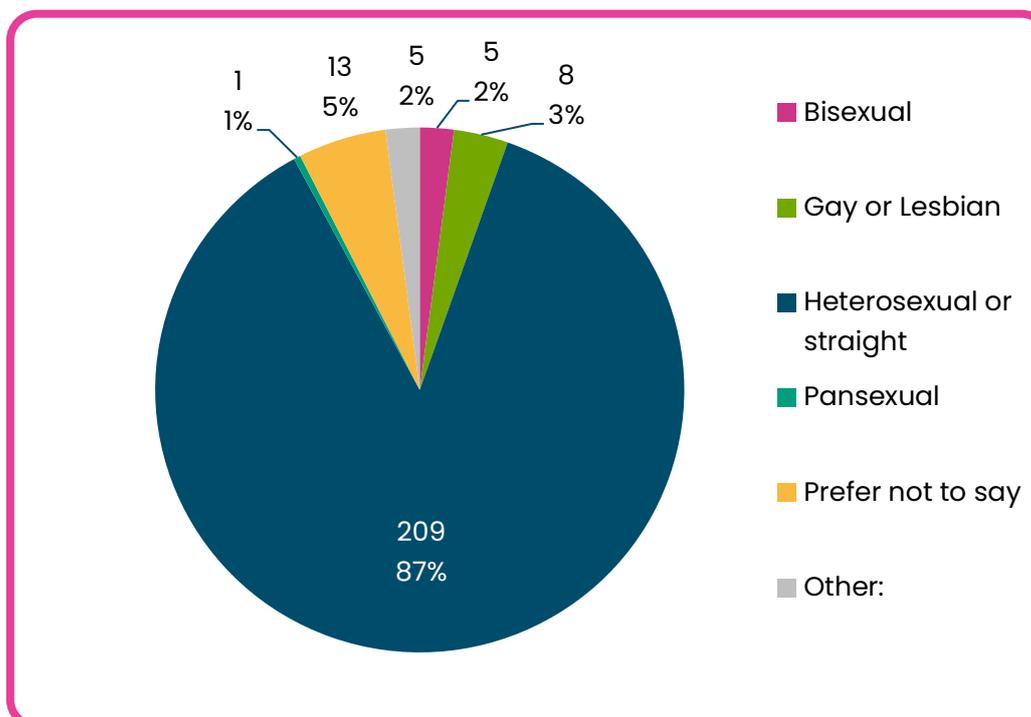


Figure 5 - Pie chart depicting the sexuality of respondents. Total responses for this question numbered 241.

Finally, the heatmap below shows the geographical spread of respondents to the survey. This shows a concentration of respondents in the greater Norwich area, which is to be expected due to the greater population density in this area.

It does, however, not show concentrations of respondents in other parts of the county with denser populations, particularly in Great Yarmouth and King's Lynn.

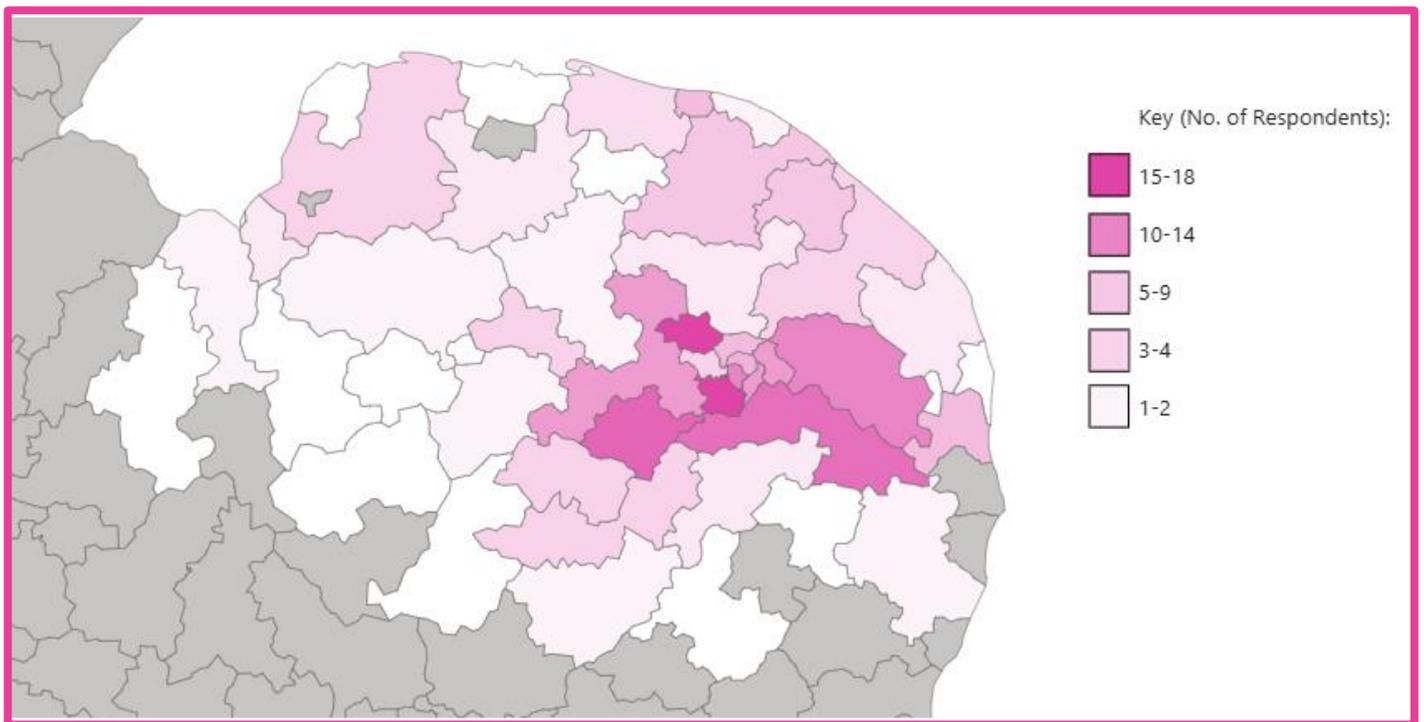


Figure 6 - A heatmap displaying the location of respondents. Total responses for this question numbered 243.

Limitations

There are a number of constraints on how representative our data is. The number of responses is too low to be statistically significant, and respondents were self-selecting, rather than randomly sampled. As discussed in the previous section, the sample of respondents over-represents women, and under-represents men. To try to mitigate this, we split the sample into responses from males and from females to look for any significant differences in responses by gender, and have reported on any we found.

Some geographical areas of the county are also probably under-represented, but we did receive responses from a wide set of different areas, which should go some way to representing the diversity of views across the county.

For all these reasons, the findings of the survey cannot be guaranteed to be representative of Norfolk's population of over 55s as a whole. However, they are likely to give us an indicative picture of what wider trends may be.

What we found out

Expectations of later life

As mentioned above, we opened each focus group by asking people to talk about what they thought later life would be like, since the measures people take to prepare for the future are likely to be shaped their expectations of this life stage.

While ageing is most often thought of as a biological process, it is also a social and cultural process involving a change in how we see ourselves and the roles we take on in different areas of our lives. This means that people's expectations are an integral part of ageing, rather than something separate (Rothermund, 2024). Several studies have found that people's beliefs about older age are likely to shape their health outcomes as they age. This can partly be due to how expectations shape people's behaviours. For example, people might place less importance on seeking healthcare as they age, if they expect older age to be a time of decline and suffering (e.g. Sarkisian et al., 2002).

An important set of studies has also shown that more positive views of ageing can extend people's life expectancy and directly affect how people age physically (P. B. Levy, 2022). When people hold negative ideas about ageing, and institutions such as medicine, the workplace and the media reinforce these views, it can lower people's life expectancy.

In all the focus groups except one, almost all comments about ageing were negative. The main expectation people discussed was of declining health and physical ability as they aged. Many people told us that they expected to lose their independence and to experience suffering because of ill health. For example, one person said they expected later life to be "not very nice, in the sense that you lose your independence". Another tried to be positive, but commented, "I'm finding that I can't become any more positive at 67 than I was at 27. In fact, probably you go the other way".

Another person summarised their expectations as follows:

I expect to have to give up more and more of the things that I enjoy. I have an allotment, but I would expect, if I live long enough, that my physical world will narrow down more and more. I mean, hopefully I wouldn't lose mobility and be confined to a house ... So, I don't look forward to it with any positivity and I rather hope I die sooner rather than later.

The feeling that people were living longer nowadays, but often did so in ill health, was widespread among the focus group participants, and several people said that they would prefer to die sooner if it meant avoiding suffering in later life. Several people also expressed fear at the prospect of declining health, and this was partly related to what they saw as the unpredictability of health, and how suddenly your life might change because of it. As one person reflected,

I would say the biggest thing that can change your life in a heartbeat is your health. I've had a personal issue in my family where one day everything's hunky dory and the next thing, everything's turned upside down ... I think as you get older, you are going to get health problems. Majority of the people I would say. And there's a curve ball that is coming in one shape or form.

It was also related to the fact that most people in the focus groups were pessimistic about the capacity of health and social care services to look after them well in the future. People were aware that services were under pressure, facing increasing demand without sufficient resources. A typical comment was,

I think it could be quite difficult, actually, with the way the social services have problems, don't they? The health service has problems, and as we get older, they're the services that we will need. So, we can't see that getting any better. Really scary.

These comments were often informed by people's personal experiences of NHS services, as they had begun to rely more on them:

I also think that the services, all our services like GP hospitals and everything like that could help towards a bit more than they do at the moment. Well, I think the National [Health Service], it seems like it's breaking down anyway ... You think about the doctor, it's just a waste of time. They say, 'Ring up at eight o'clock'. Eight o'clock, two minutes past eight, there's no appointments left. What do you do? You're left floundering, aren't you?

Most of the comments like this referred to primary care, but people were also worried about hospital appointments:

I was referred to the hospital to a consultant to the hospital in July last year. I got to see him in April, and he said he would also refer me to another department, and I've not heard anything yet. Whenever I phone up and try and chase it up, the message I get is, 'Oh, you've just got to wait. There's plenty of people on the waiting list. Once we reach you then we'll be in touch'. So, it seems as though it's not going to be a quick fix. It's going to be [a long wait], which in turn then could lead to worse health as well.

For the participants in the Polish focus group, their dissatisfaction with health services came partly from their experiences in Poland, particularly as regards physiotherapy. They spoke of the sanatorium system in Poland, under which you can refer yourself to go and stay in a care facility, where you would have intensive treatment until you recovered from your problem. Their experience in Norfolk was that they would, after a physiotherapy consultation, be given a sheet with exercises to carry out, and little follow-up support.

In most of the groups, people also said that they thought that they were treated differently by health services because they were older. One person said that when they told their GP about a health problem, rather than investigating the cause, the doctor would say, "That's because you're getting older". Another person said that they were told, "Well, what do you expect at your age?" Two people spoke about asking for a particular kind of check-up at their GP, only to be told that they were no longer eligible for it, because they were over 75.

Another person, relating her experience of what she saw as negligent aftercare after she had had two heart attacks, said that “after 60 years old, it’s a closed door”.

This perception seems to have led to a pronounced cynicism for some about the intentions of health services when they interact with older people. One person commented, “We weren’t never expected to live this long. I don’t think they want you to ... Years ago we weren’t expected to live this long. People died young”.

Another person was alarmed when her husband was in hospital, and a doctor spoke to her about a Do Not Resuscitate order (DNR):

My greatest fear now, I think I told you about my husband going into hospital with them wanting me to sign the DNR and they were not going to do anything for him until I fought for it. And then they gave him the proper oxygen and stuff like that. He had Covid. It wasn't nothing bad. So, they were going to let him die, basically ... So, I am a bit nervous now about going to James Paget Hospital because I do not want to sign this DNR business because they just leave you and it worries me how many other people have just lost their lives because had they signed the DNR.

These concerning findings suggest that people’s negative views of older age are not only related to wider cultural ideas about later life, or about pressure on services. They also seem to be linked to the attitudes that some people perceive from health service personnel when they have sought treatment. Research in other settings has called this “structural ageism”, which means “the discrimination directed against older persons by the policies of institutions and the actions of those affiliated with them” (B. R. Levy, 2022, p. 1). One study in the US found that one fifth of people over 50 had experienced such discrimination from health services, and that it seemed to result in worse health outcomes for those experiencing discrimination frequently (Rogers et al., 2015). A review of research on ageism from across the world found that in 85 per cent of the 149 studies, clinicians were less likely to offer interventions to older people than to younger people, even when the benefits were just as likely for both groups (Chang et al 2020, cited in B. R. Levy, 2022).

Findings from other research also suggest that when people encounter ageist attitudes, it makes them less likely to seek treatment for worrying symptoms (Sun & Smith, 2017), and less likely to take part in physical activity (Hooker et al., 2019). The ageism people reported encountering in our focus groups could therefore in itself undermine their preparations for later life.

Another cause of worry for some of the participants was money. Even for people with good private pensions this was a concern:

Yes, obviously finance is going to come into it a lot because if you've had a good job, you've suddenly cut down, haven't you, to your pension. And even though you do try and save and put a little buy, it just seems to dwindle a little bit because of how things are at the minute.

At the time of the focus groups, the cost of living was rising quickly, and people worried that this would reduce how far their pensions would stretch. People were also worried about changes in benefits, particularly with the winter fuel allowance due to be withdrawn. Other kinds of changes were also a worry for some, such as changes in building regulations and EPCs (Energy Performance Certificates) potentially affecting their housing situation.

Another prominent theme was also about how older age can “creep up on you”, and that there is no clear dividing line between being young and being old.

I think what I find difficult is when you're saying prepared for “older age”, when does that start? And actually, when I think about when I was a lot younger, anybody over 60 seemed very ancient and now you're there. You're thinking, “Surely I'm not that person yet?”

People talked about ageing as more of a continuum, and of ‘old age’ as we conventionally think of it, as arriving at different times according to different people. By this they meant that increasing frailty and dependence can arrive at quite different times, depending on one’s circumstances and luck. Also, given that there is quite a wide range of different problems that can arrive with ageing, it can be hard to know what precise challenges you will personally face with ageing until they arrive:

“I guess the thing is, if you're looking to want to provide support, I think people are going to need something individual because all of us have a different experience going into that. And if you have something which is just very blanket, it will either be too early for some of us or be too late because actually, we only know what we need when we encounter the problem”.

Some people suggested that retirement was a life transition that was not marked the way that the transition to adulthood and working life was. Little education is given about how to prepare for older age, and how to thrive in older age. Some people suggested that there should be more information about how to prepare, and more reminders given to people when they reach different ages (e.g. 40, 50, retirement age) about what the best activities are to prepare for later life at their age.

Finally, a minority of people did talk about more positive topics. The most commonly mentioned was spending more time with their family. As one participant said,

“There are positives. There are, definitely. Yeah, absolutely. Especially for the family, isn't it? Yes. If you've got family, yeah, a hundred percent. Yeah, I mean I'm a nanny and a great nanny and I have much joy with the children”.

Participants in the King's Lynn focus group, who had Ukrainian, Latvian and Lithuanian backgrounds, were more aspirational when they spoke of later life, compared to the other groups. People spoke about wanting to stay independent, active, and socially engaged for as long as possible. Others saw older age as an opportunity to focus on personal growth, such as learning new languages, reading more books, or developing hobbies.

“In older age, I want to remain active and socially engaged. I hope to travel, continue learning English, and read more books. Spending quality time with my children and grandchildren is also very important to me.

Additionally, I would like to join clubs or social groups to communicate with others, make new friends, and share experiences. My goal is to stay mentally and physically active for as long as possible”.

However, they also spoke about the unpredictability of later life, something which was complicated for the people from Ukraine, due to the uncertainty about the future in their country of origin.

What people were doing to prepare for later life

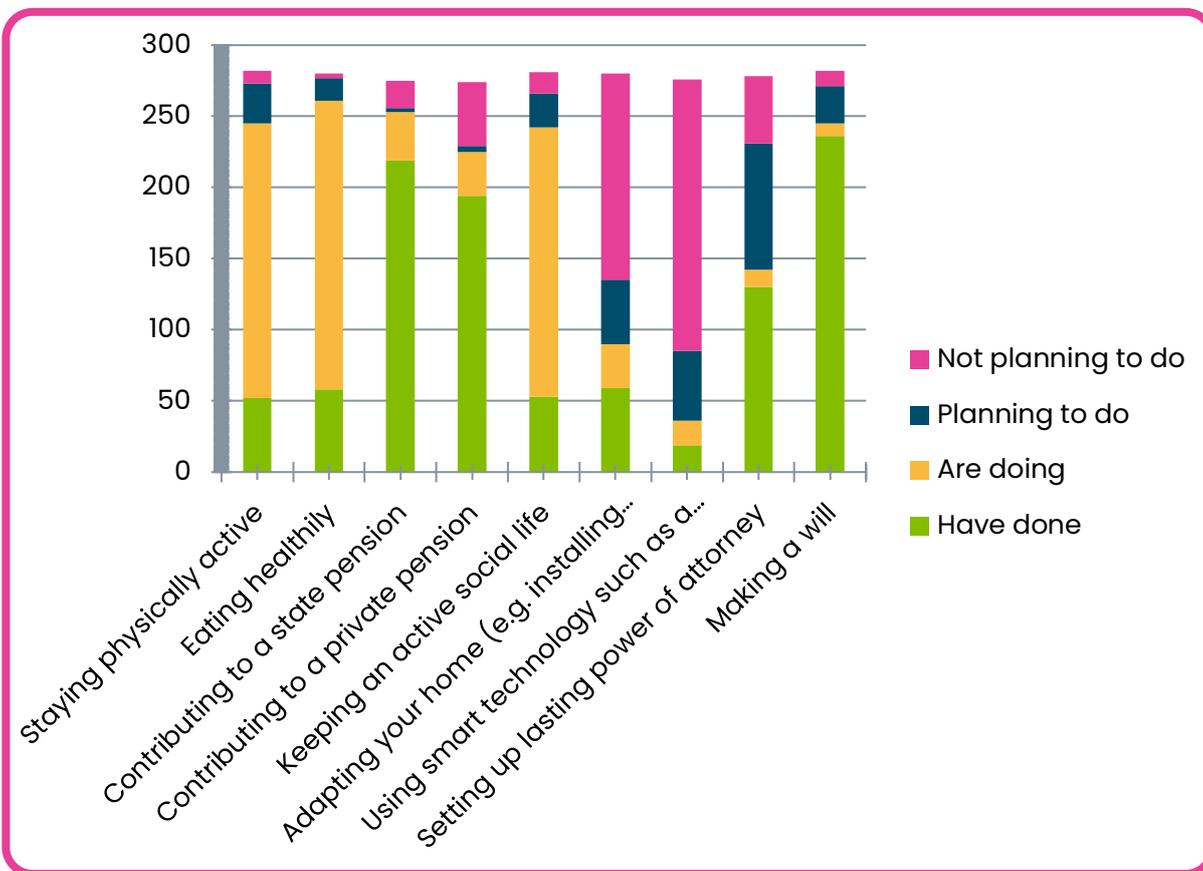


Figure 7 - A bar chart depicting the preparations that respondents were making for later life. Total responses for this question numbered 283.

We asked people in the survey what they had already done to prepare for later life, and what they thought the most important things were to do to prepare. People’s responses to the first of these questions are summarised in figure 11, above. Most people told us that they were doing, or have done, most of the things that we asked about. The four most popular measures were, eating healthily (93 per cent, or 261 people), contributing to a state pension (90 per cent, or 253 people), staying physically active (87 per cent, or

245 people) and making a will (87 per cent, or 245 people). Keeping an active social life (86 per cent, or 242 people) and contributing to a private pension (80 per cent, or 225 people) were also popular measures.

The data from the focus groups suggests that when people say that they are physically active, they can mean quite a wide range of different things. For a minority of people in the groups, exercise meant more formal exercise, such as going to a Tai Chi class or doing walking cricket. For others it meant simply walking around town several days a week, doing grocery shopping and visiting friends. So, the finding from the survey that most people self-reported as physically active should be treated with caution. That said, there was some variation between different groups answering the question about physical activity. More male than female respondents reported being physically active (91 per cent of men, or 61 people, compared to 84 per cent of women, or 144 people). Fewer people in the youngest group of respondents (55 to 64 year olds) reported being physically active than other age groups, with 76 per cent (55 people) reporting being physically active, compared to 95 per cent of 65–74 year olds (90 people), and 81 per cent of 75–84 year olds (48 people).

Also, a lower proportion of the youngest age group reported keeping an active social life, with 75 per cent (54 people) saying that they did so, compared to 88 per cent of 65–74 year olds (87 people) and 90 per cent of 74–85 year olds (53 people).

Three measures were less popular. Setting up a lasting power of attorney had been done by 47 per cent of respondents (or 130 people), with a further 4 per cent (or 12 people) saying that they were currently doing so. 32 per cent (89 people) said that they were planning to do so, and 17 per cent (47 people) said that they were not planning to do so.

Measures to adapt one's home (such as by installing grab rails or ramps) had been undertaken by just 21 per cent (or 59 people), with 11 per cent (or 31 people) in the process of doing so. 16 per cent (or 45 people) were planning to do so in the future, but 52 per cent were not planning to do so.

The least popular measure was using smart technology (such as a falls alarm or voice assistant). Most respondents (69 per cent, or 191 people) were not planning to do this, 17 per cent (49 people) planning to do so, and only 7 per cent (or 19 people) having done so and 6 per cent (or 17 people) planning to do so.

People with disabilities and/or long-term conditions also gave significantly different answers to these questions, compared to those without. These differences are summarised in the table below.

Preparation	With disability/long-term condition (102 people)	Without disability/long-term condition (113 people)
Physically active	78%	84%
Eating well	89%	77%
State pension	88%	77%
Private pension	77%	99%
Active social life	71%	92%
Home adaptations	44%	22%
Smart technology	21%	8%

Table 2: Preparations undertaken by people with and without disabilities and/or long-term conditions

As the table shows, there are significant differences across all the preparations, with more people with disabilities and/or long-term conditions reporting eating well, having a state pension, having made home adaptations, and using smart technology. More people without disabilities or long-term conditions had private pensions (by a 22 per cent margin) and an active social life (by a 21 per cent margin). We might speculate that the differences in private pension take up could be due to people with long-term conditions and disabilities being, on average, more likely to be poorer and out of work (Croft et al., 2025). The difference in active social life between the two groups seems to tally with wider research on these populations that suggests that the proportion of people with disabilities in the UK who report feeling lonely “often or always” was four times higher than that of non-disabled people (Office of National Statistics, 2021). This finding suggests that people in these groups will require more help to build and maintain a good social life as they age.

In the two focus groups with people from ethnic minority backgrounds, most of their preferences were similar to the other groups, only differing significantly in two respects. In the focus group with Polish people who had settled in Norwich, none of the participants had amassed a private pension, and all said that the reason that they had not was because they had only been in the UK for around 15 years, and so had not had the chance to build up much of a pension pot compared to people who have lived in the UK all of their lives.

Most of the Ukrainian people that we spoke to had not made wills, saying that they did not see the point, as they did not have many possessions to leave behind. This could be because they left their possessions in the Ukraine when they fled the war. However, there are still several reasons that people should make a will, even if they do not have many assets to leave behind, including that it can prevent family disputes and stress, protect non-married partners, provide for the guardianship of children, and ensure wishes for one’s funeral are carried out.

Answer Choice		1st	2nd	3rd	Response Total
1	Staying physically active	131	55	20	206
2	Eating healthily	35	87	43	165
3	Keeping an active social life	16	46	61	123
4	Making a will	41	17	25	83
5	Contributing to a private pension	19	14	35	68
6	Contributing to a state pension	14	12	25	51
7	Setting up lasting power of attorney	9	17	23	49
8	Adapting your home (e.g. installing hand rails, walk-in showers, ramps, etc)	9	8	12	29
9	Using smart technology such as a voice assistant or a falls alarm, or similar	0	8	13	21
10	None of the above	6	0	6	12
Other					20

Table 3

Most important measures people should take in preparing for older age, ranked in order of the total number of rankings. Total responses: 282.

We also asked people about what they thought the most important preparations were for later life. We asked people to pick only three priorities, to try to understand which areas people would like to prioritise – rather than ticking all of the options that they thought were important. People’s priorities overlapped with the preparations that most people had done, but there were some important differences.

Whereas most people had state pensions (89 per cent or 253 people), and most people had made wills (87 per cent or 245 people), only 18 per cent of respondents (or 51 people) ranked having a state pension as a top-three preparation, and only 29 per cent of respondents (or 83 people) ranked making a will as a top-three preparation. Rather, when asked to prioritise, the most popular responses were staying physically active, eating well and keeping an active social life.

This could be because most people already had wills and pensions, and so no longer thought of these measures as a priority. However, our focus group data also suggests that many people think that “health is wealth”, and also see it as something that they can exercise some control over, and have a good knowledge of what the consequences of not doing so are. Almost all the people we spoke to in focus groups said that they had reduced alcohol consumption as they aged, and only two participants still smoked.

Some focus group participants said that the cost of staying healthy, and particularly of eating well, made it difficult. In the Kings Lynn focus group, and one of the Great Yarmouth focus groups, participants talked about how the rising cost of living was making it harder for them to buy nutritious food. The survey results could suggest that this problem is more widespread. More respondents who have private pensions (who tend, on average, to be wealthier than those who do not), reported eating healthily (94 per cent, or 211 people), compared to those without private pensions (85 per cent or 41 people). Focus group participants in three groups also mentioned the cost of gym memberships and exercise classes as a barrier to staying physically active. 88 percent of survey respondents (or 199 people) with private pensions reported staying physically active, compared with 76 per cent of respondents (or 37 people) without private pensions.

Lasting power of attorney

In the survey, we asked in more detail about lasting power of attorney, because in the focus groups an important theme emerged of people’s reluctance to make one. This was common across most of the focus groups, and people gave several different reasons for why they had not established one.

Some people had simply not got around to it yet, but were planning to do so in the future. Other people mentioned that they did not have anyone in their family who could act as an attorney, and either were not aware that they could, or did not want to, nominate someone outside their family, such as a solicitor, as their attorney. This was also related to the idea that it was expensive to set up a power of attorney. This is not necessarily true if you know someone you can nominate as your attorney, as you can

set up a power of attorney yourself without going to a solicitor. It currently costs £82 to apply to register an LPA yourself (and this will rise to £92 on 17th November 2025).

For other people, it was a trust issue. In one focus group, people talked about companies which they had heard were setting up lasting power of attorneys for people, and using them to take advantage of people. For others, it was because they did not trust anyone enough to give them that power, even close relatives. As one person said, “sometimes you don’t even believe in your own dog”.

This lack of trust was, for some participants, linked to some apparent confusion over what lasting power of attorney was, and an intention to “hope for the best” rather than give someone else control over their affairs. The following exchange illustrates this:

Participant 1: “Yes, it’s for when you lose your independent thinking”.

Participant 2: “Yes, well, then I can authorise someone then [at that point]”.

Participant 1: “No, no, no, because it needs to be authorized beforehand, earlier”.

Another person said they would not take one out, “because in my family there was not such a large amount of dementia. It wasn’t like an issue in the family”, and another simply said, “I’m hoping I will die, still with my mind intact”.

One participant suggested that people do not want to set a power of attorney up, because they do not want to think about their own death:

“I mean a lot of older people, they seem to think that if they’ve done a will or done power of attorney, it’s somehow put a death knell on them”.

What people told us in the focus groups suggested that people tended to be swayed one way or the other by the experiences of people that they know. One person was adamant that they would not establish a power of attorney, due to an earlier experience:

“In Poland I was a court guardian for such a person. [Power of attorney] was assigned, and someone just incapacitated a family member and did great harm to that person ... They locked him up in a psychiatric hospital. And that man is no longer... He is no longer incapacitated, but they did terrible harm”.

Equally, people could be convinced to change their mind in the other direction by their peers. In one focus group, two participants had said that they were unwilling to establish a power of attorney. However, after another participant had talked about their own positive experience of setting one up, and why they thought it was important, the other two participants resolved to set one up after the focus group.

To understand whether these attitudes were more widespread, we asked people who had not set up a power of attorney, about why they had not yet set one up.

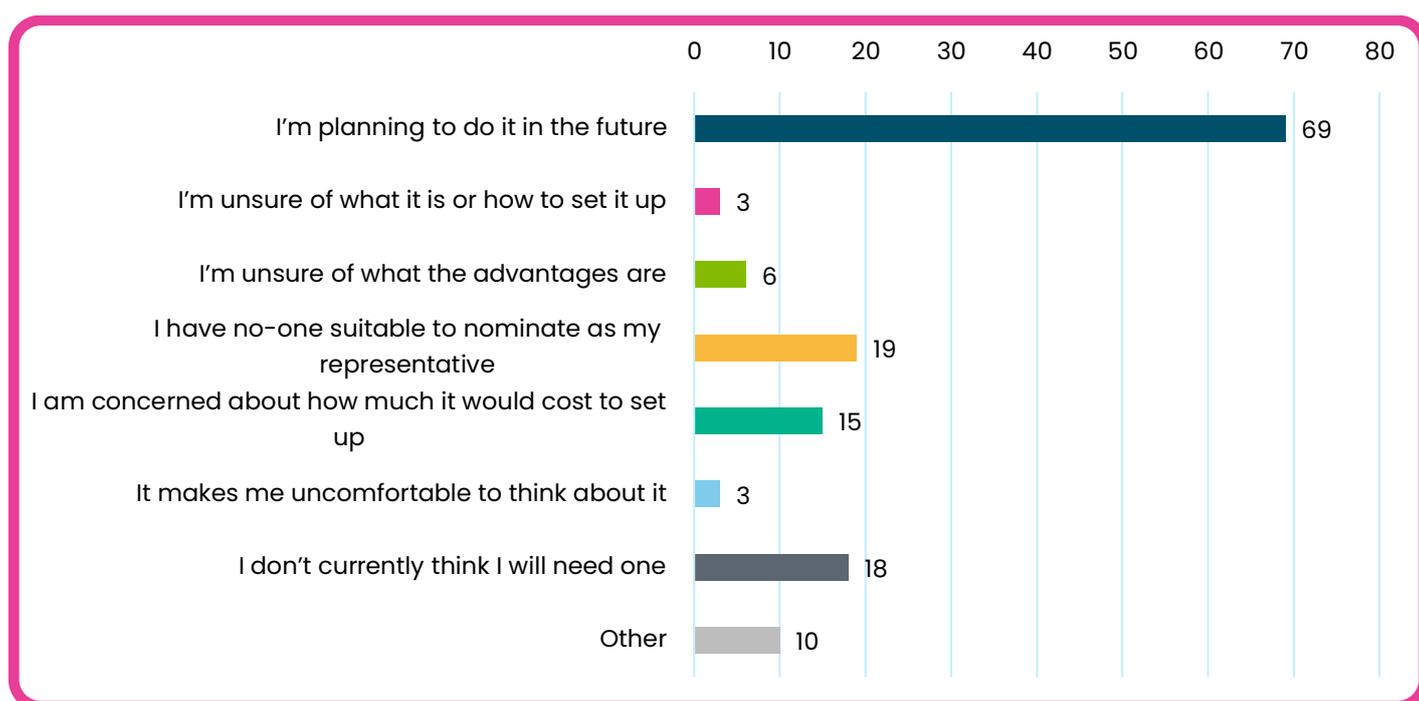


Figure 8 - A bar chart depicting the reasons why respondents had not set up a power of attorney. Respondents could select more than one option. 154 responses were received.

As the chart shows, the most popular response (19 people) was that they were planning to set up a power of attorney in the future. This suggests that they were not unwilling to establish one, but also did not see it as a strong priority. For the remainder of

respondents, one of the most popular responses was that they had no-one to nominate as a representative (19 people). These respondents may not be aware that it is possible to nominate a professional attorney, such as a solicitor, or may worry that they cannot afford to pay a professional attorney. 15 respondents said that they were worried about the cost of setting up a power of attorney. 18 people said that they do not currently think that they will need an attorney, which suggests either wishful or optimistic thinking, or a misunderstanding of what a power of attorney is for. Nine people admitted to not knowing enough about what a power of attorney is and how to set it up, or what the advantages are. These results seem to suggest that the concerns people expressed in the focus groups are shared more broadly by a minority of people.

We then asked people who had set up a power of attorney, what the main factor was in motivating them to do so.

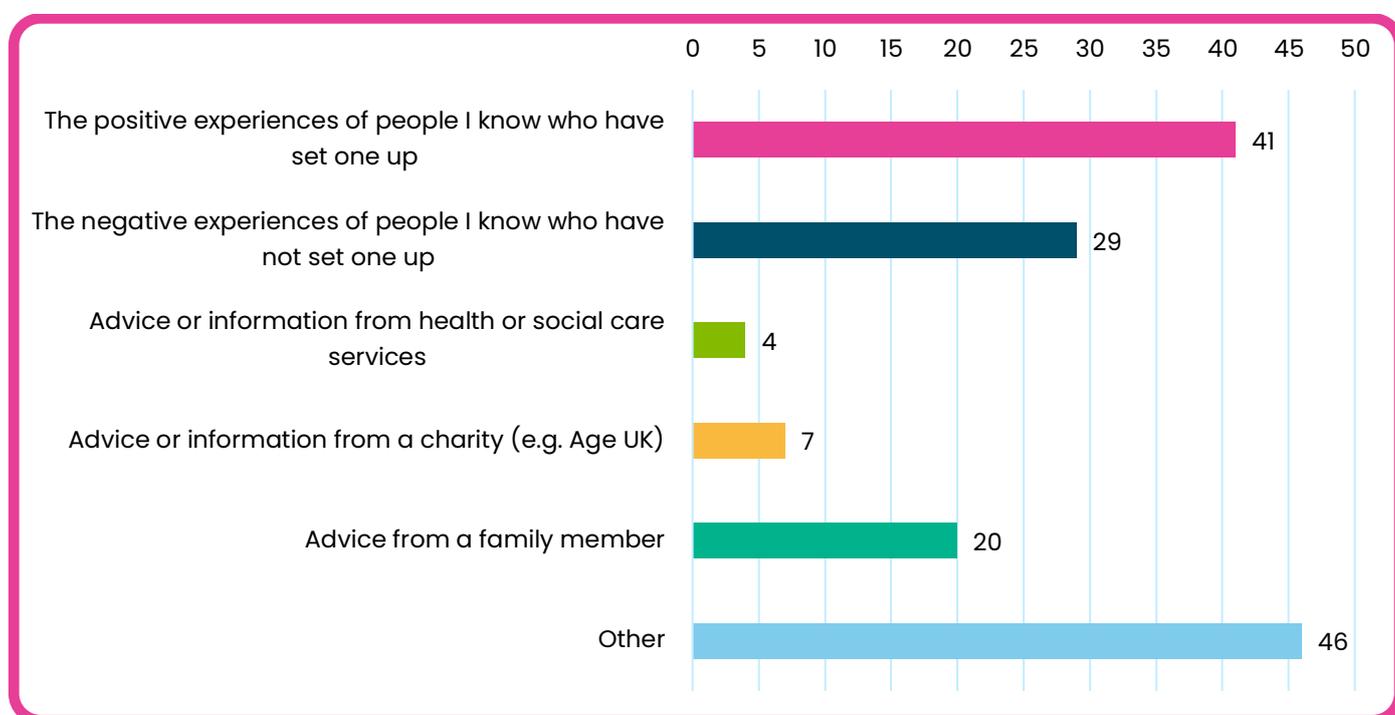


Figure 9 - A bar chart depicting the reasons why respondents had set up a power of attorney. Respondents could select more than one option.

As the chart shows, the two most popular motivators for setting up a power of attorney were the positive experiences of people the respondent knew (41 people) and negative experiences of people the respondent knew who had not set up a power of attorney (29 people). The third most popular motivator was 'advice from a family member' (20 people). This suggests that, as in the focus groups, the advice and experience of peers and family members is much more important in influencing people's choices, compared to other factors.

Fewer people mentioned advice or information from professionals here, with only four people saying that advice or information from health or social care services had influenced them, and seven saying that advice or information from a charity had influenced them. As part of the 'other' responses, 11 people mentioned advice from a financial adviser or a solicitor.

The rate of adoption of powers of attorney went up with age. Of 55–64 year olds, 31 per cent had a power of attorney, of 65–74 year olds 50 per cent had one, and of 75–84 year olds, 74 per cent had one. It may therefore be worth understanding what had influenced the early adopters to take out a power of attorney, compared to the older groups. For the younger group, the positive experiences of people they knew were more important, with 43 per cent of this group citing this as a motivator, compared to only 27 per cent of the older age groups. These findings could suggest how people can be most effectively encouraged to adopt a power of attorney earlier in their lives.

Attitudes to the 'promoting independence' approach to later life

An important question for the move to a greater emphasis on promoting independence is how comfortable people in the relevant age groups feel about being called upon to take more responsibility for preparing for later life. In the focus groups we discussed with people what they thought of this move, including any advantages and potential concerns they had with the approach. These themes then fed into the construction of the survey questionnaire to try to understand attitudes across the county more broadly.

Perceived advantages of the approach

In all focus groups, people broadly welcomed the proposed approach, and there were two main sets of reasons why.

The first was often based on the idea that 'other people' were using services that they did not need, or would not have needed had they looked after themselves better. As one participant said:

I don't think all people try hard enough. They can do, but they don't make an effort. You could do a lot more, probably, for yourself.

Another person said,

I mean, I'll say it as it is, [people] need to be shown, told and pushed because if they're then going to the doctor's surgery to make an appointment for something that could have been done by dealing with their weight problems, and we probably all have weight problems and dealt with them. They become diabetic, as you say. They get straight to the front of the queue.

These concerns were expressed by some participants more than others. Political outlook seemed to shape these attitudes, as people describing themselves as more right-wing in outlook expressing these opinions more forcefully. An alternative point of view was given by people expressing more liberal or left-wing political outlooks, as described in the section on concerns below.

The other set of reasons people were in favour of the proposed approach, was related to the idea that being more self-sufficient would, in itself, improve people's quality of life. As one person told us,

I believe that focusing more on self-help is the right approach. People should be encouraged to stay as active and independent as possible. It's important to maintain one's health, both physically and mentally, and self-help strategies can play a significant role in keeping people engaged and empowered.

People in the focus groups were often keen to talk about the measures that they had taken to prepare for later life and to maintain their independence, and had clearly enjoyed doing so.

The chart below summarises the survey responses about the advantages of an approach to promote independence. The most selected option was that this approach will help people to stay independent for longer, and so have a better quality of life for longer (87 per cent or 234 people). The next most popular response was related to the idea that doing things for yourself improved quality of life in itself: 67 per cent of respondents (or 180 people) answered "Yes" to the option "Life is more fulfilling when you do things for yourself". The third and fourth most selected options were related to pressure on services, with 65 per cent of respondents (175 people) saying that it will save money through reducing pressure on services, and 63 per cent (170 people) saying that it will reduce the number of people claiming services who could have avoided it.

Overall, very few people thought that there were no advantages to the approach, with only three percent (or seven people) selecting this option.

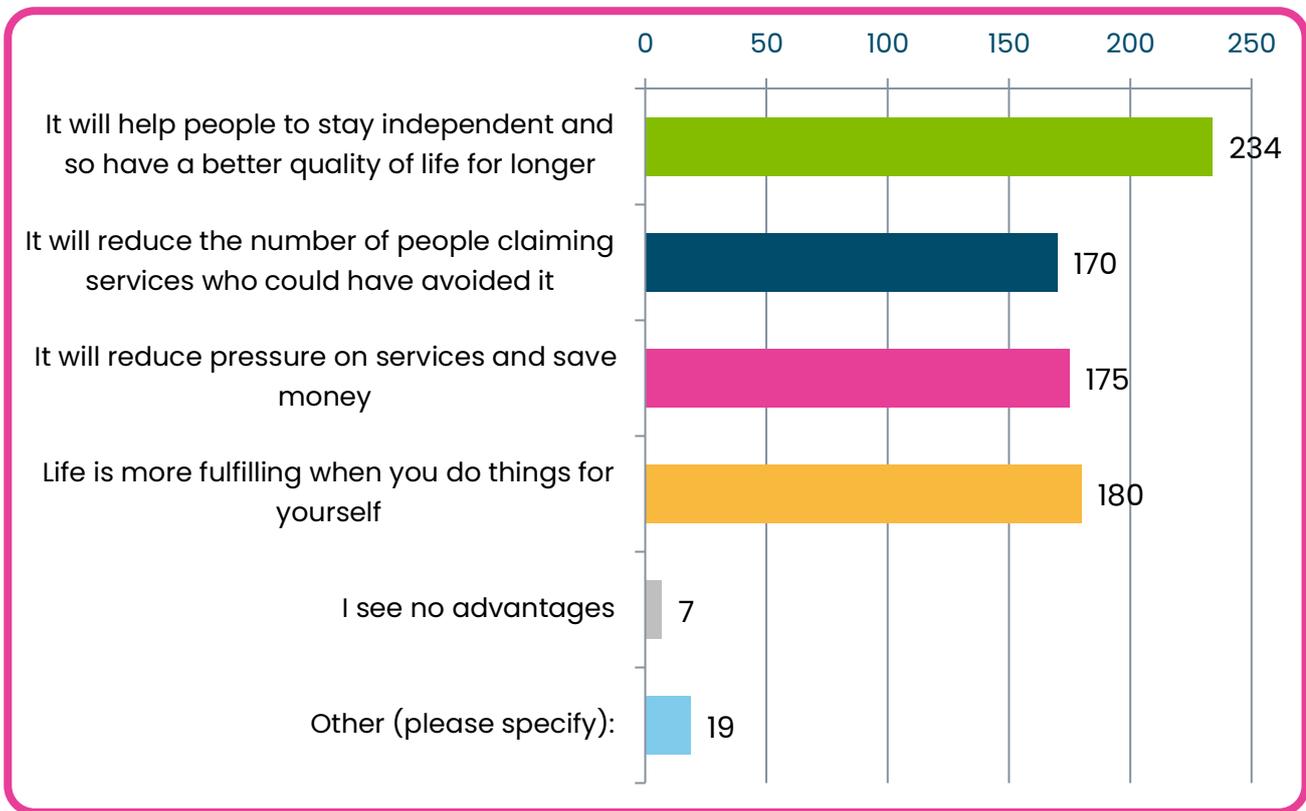


Figure 10 - Bar chart depicting perceived potential advantages of staying independent for longer. Participants could select three options. Total responses for this question numbered 269.

Concerns about the approach

Participants in the focus groups did express potential concerns with the proposed approach. People in most focus groups were keen to say that not all people would be able to help themselves, and that a balanced approach was needed, encouraging people to help themselves, but providing help for those who were not able to prepare for later life themselves. When people made this argument here, they were either talking about people they knew, or people that they imagined would not be able to do prepare for later life by themselves. As one person said:

Well, we would speak from a position of being financially comfortable and, unfortunately, we sort of know people who are really desperate ... I think the question is: Am I fit enough to do it? Am I financially placed to do it? If I were just living on a state pension, then I would struggle to do self-help.

Someone commented in the survey, similarly:

As long as this initiative is backed up with properly funded social care/health services for older people who, through no fault of their own, cannot remain independent, and are also, through no fault of their own, under resourced, then it could be a useful addition to services. Without proper funding people will fall through the net.

In the survey, 55 per cent of respondents (or 145 people) said that they thought that some people may not be able to help themselves, and 53 per cent (or 141 people) said that they thought that some people may not be able to afford to help themselves.

Some people, both in the focus groups and the survey, raised the question of the knowledge and skills that people would need to be able to prepare for later life and maintain their independence. 48 per cent of respondents (or 127 people) were concerned that some people don't know how to prepare for older age. One respondent to the survey commented, "I don't know what to do, no advice on anything". Another said that the approach, "needs to be carefully planned, and widely disseminated".

Some participants in the focus groups suggested that some people might require some face-to-face contact with services, before they would be able to prepare themselves to stay independent for longer. As one person, who works in a GP surgery, said:

The people who most need it are probably least able to access it. It is in many cases a cop out by organisations into, "We'll put everything on a website or we'll put it in a leaflet. People can pick those leaflets up, they can get online most of them. And so, we've done everything we need to. That's it. That's our job out of the way". And it absolutely isn't. Is it people, like you said, perhaps if people are supported initially then they can go on and help themselves, can't they? So, in health it's called supported self-management rather than self-help.

One person suggested that information on self-help would be best provided by peers, rather than by professionals:

I think the other thing is it sometimes helps to hear people who've been in the same position themselves when they started on that. So, you are not

just listening to a professional saying, “Oh you'd be all right”, kind of thing. Actually, you want to hear from other people saying, “Well, initially, I was a bit worried, and it didn't quite work, and this is why I had to go back”. So, some advocacy or peer to peer stuff ... I think it is important to have access to people in a similar situation.

Another issue that came up, was how this approach might affect people's opportunities to see professionals face-to-face. Some concern was raised about this in four of the focus groups. One person commented:

So, my comment on this is that yeah, okay, people who can be empowered to do it and want to do it that way, they're fine, but don't take the human bit out of it. It's dehumanising. Dehumanising, isn't it? Because, you actually, if you minimise the contact, people will go off in the dark, or won't get the help that they need.

32 per cent of respondents (or 86 people) said that a potential concern with the approach was that it would result in less face-to-face contact with professionals. In a similar vein, people making free-text comments about the promoting independence approach, said that a hands-off approach would not work for everybody, and that some people would need services to proactively seek them out. Some typical comments were:

“Older people are often proud and don't like to ask for help. Those living alone without a support group around them will fall through the net. You have to take this approach to them rather than expect them to come to you for help”.

“I seem to be invisible to Social Services, how will anyone help me if I need it? Human contact is still important”.

“Some people just will not ask for help. It is the old adage that it is shameful if you ask for any assistance or payment”.

Almost one fifth of people said that they had no concerns about this approach (17 per cent or 46 people). This is considerably more than those who said that they saw no advantages to the approach. However, people with disabilities and/or long-term conditions were less optimistic about this approach. Specifically, 59 per cent (or 61 people) worried that some people might not be able to help themselves (compared to 50 per cent of those without disabilities or long-term conditions, or 56 people). 42 per cent (or 43 people) were concerned that it would lead to less face-to-face contact with professionals (compared to 27 per cent of those without disabilities or long-term conditions, or 30 people), and 61 per cent were concerned that some people may not be able to afford to prepare (compared to 45 per cent of those without disabilities or long term conditions, or 15 people). One person in the survey expressed the concern that advice about preparing for later life was generic, and did not include advice specifically for those with disabilities, saying "I've not read anything that takes account of disabled people and people living longer with more complex health needs".

These findings suggest that the approach should be tailored to take account of the specific concerns and needs of these groups. More broadly, the findings suggest that people want this approach to be accompanied with good education and information tailored for those who need it, a balance between promoting independence and helping those who cannot prepare for older age without help, and the continuation of opportunities to see professionals face-to-face.

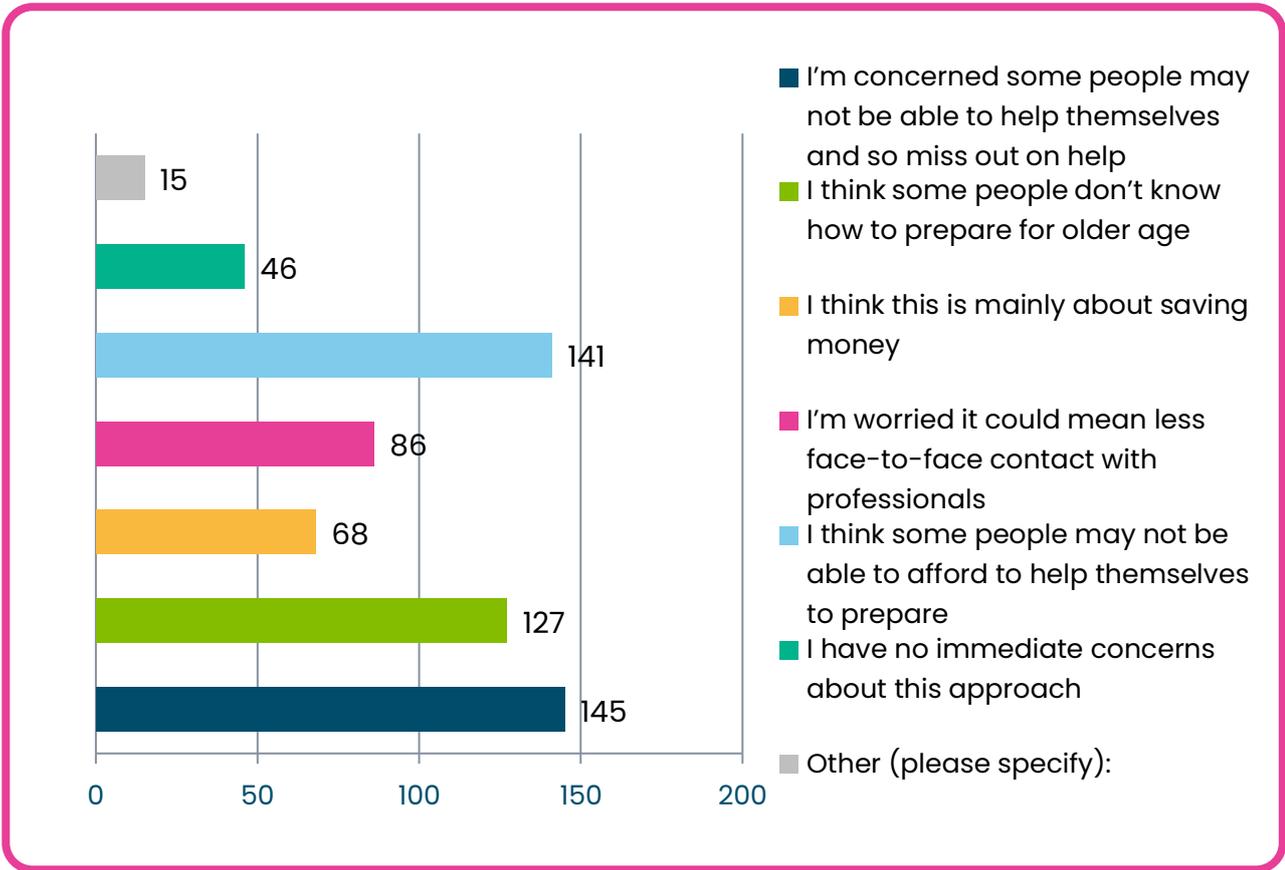


Figure 11 - Bar chart depicting perceived potential concerns of encouraging people to stay independent for longer. Participants could select three options. Total responses for this question numbered 265.

What assistance people would like from services in Norfolk

In both the focus groups and the survey, we asked people what kind of help they would like from services to help them to prepare better for older age, and asked them to prioritise the three kinds of help they wanted most. The answers from the survey are summarised in the table below. The most popular response, by some distance, was help to stay physically active, with 135 responses (54 per cent). The next four options all had similar numbers of responses: help to stay socially connected (36 per cent, or 91 responses), information on the practical aspects of ageing (36 per cent, or 90 responses, including 47 ranking this first), support with home adaptations (35 per cent, or 89 responses), and supporting families and carers to look after older people (34 per cent, or 86 responses). Information is discussed in more detail in the next section, but in this section we discuss help to stay physically active, help to stay socially connected, and support with home adaptations.

Table 4

Most important types of help that NCC should provide in helping people prepare for old age. (251 responses received)

Answer Choice		1st	2nd	3rd	Response Total
1	Helping people to stay physically active	67	42	26	135
2	Helping people to stay socially connected	19	35	37	91
3	Providing information and education on the practical aspects of ageing	47	20	23	90
4	Supporting people to adapt their home (e.g. with hand rails, walk-in showers, ramps, etc)	25	37	27	89
5	Supporting families and carers to look after older people	29	25	32	86
6	Developing age-friendly environments (e.g. through better accessibility of public spaces or improved public transport)	26	21	31	78
7	Helping people to eat better	16	33	19	68
8	Norfolk County Council signposting people to other sources of support (charities, etc)	12	11	16	39
9	Providing advice and support on assistive technology (e.g. voice assistants, motion sensors, pendant buttons)	5	14	18	37

10	None of the above	3	1	2	6
Other (please specify):					30

When people in the focus groups discussed the help that they wanted with staying physically active, they spoke both of practical help, and of information. Some spoke of needing encouragement, motivation and regular discipline to stay physically active, and mentioned subsidised exercise classes or personal trainers. Four focus group participants were currently participating in subsidised classes, two doing Tai Chi classes which had been prescribed by social prescribers at their GP surgery, and two doing walking cricket sessions which were initially subsidised by Norfolk County Cricket Club, with a view to becoming self-funding afterwards. The request for subsidised exercise was related to the rising cost of living, and the limited spending power that many people had, as discussed above. It was also related to the perception that they did not know how best to keep in shape as they aged, and people mentioned wanting information and guidance on what sorts of exercises to do at different ages and when you have particular physical conditions, and on strength and flexibility.

In five of the seven focus groups, help with staying socially connected was one of the top three desired forms of help that participants agreed upon. Maintaining a fulfilling social life after retirement was a challenge that people raised in all of the focus groups. One person reflected on their experience of their Tai Chi class:

Participant 1: Yes, it is. I think the socialising is a big thing. I know we make new friends.

Participant 2: I think that's one of the big things I've missed since I retired is the camaraderie.

Participant 3: Yeah, that's exactly what my husband said when he retired. Yeah, it is when you've worked with a lot of people.

Participant 1: We sit down after we've done our exercise, we go sit in the coffee shop and we have a coffee. We sit there for a good hour and a half chattering and it's, it is just lovely.

In three groups, they thought that there were already opportunities to join social groups in their local area, but that people did not know that these existed. In these cases, they

recommended that information on local opportunities could be improved. In one group, people said that they did not want to have opportunities only to socialise with other older people, but would also like to join more diverse groups, that would not “pigeonhole” them according to their age. Participants reflected:

Participant 1: It's actually really stimulating to be with younger people and they often laugh. I mean I must sound so old fashioned to them.

Participant 2: I'd rather have some young people. I really miss it. You need the challenge. I don't mean challenge in a bad way ... But to be reminded that what the world is becoming can seem very scary and alien unless you're actually part of it and associated with people who are younger. Otherwise, you look at people with tattoos or people who are gender fluid or whatever and it just seems very alien. Whereas if you are actually in amongst people, you realise that every they're just ordinary people aren't they?

In two of the groups, participants were keen to make the point that community centres are, in their view, an underused and underfunded resource in Norfolk. They spoke of the many benefits that they got from their own local community centres:

Socialising, talking, providing meals, providing exercise, knitting club. They do this music club today. Bingo ... I think this is an actual lifeline for a lot, a lot of people. One of the best that I know. There must be an awful lot of elderly people that are very, very, very lonely. So, the social connection is really important.

In both groups, participants argued that these centres were cheap to run, because of the number of volunteers who work in them, and also that, being locally based, they were easy for people to access, and the staff had a deep knowledge of the local community.

There were some significant differences in what help people wanted to prioritise between different population groups. 67 per cent of male respondents (or 51 people) wanted help with staying physically active, whereas only 48 per cent of female respondents (or 65 people) did. This is despite more male respondents reporting being

physically active than female respondents (91 per cent of men, or 61 people, compared to 84 per cent of women, or 144 people). 42 per cent of men (or 28 people) wanted support for carers and family members to look after older people, whereas only 33 per cent of women (or 57 people) did.

42 per cent of women (or 71 people) wanted help with home adaptations, compared to 20 per cent of men (or 13 people), despite the proportions of people with disabilities and long-term conditions being similar for men and women. In the focus groups, a common issue during discussion of home adaptations was the difficulty for people in rented accommodation to undertake home adaptations, because their landlords would not allow them to. However, most people were also unaware that they may be able to get help with adaptations through district or city councils, or through the county council, and did not know how to access this help.

38 per cent of respondents with disabilities or long-term conditions also wanted help with home adaptations (compared to 31.5 per cent of those without these conditions), and 37.5 per cent of those with these conditions wanted age-friendly environments, including better accessibility of public spaces or improved public transport, compared to 28 per cent of people without these conditions.

Information people wanted to help them to prepare for older age

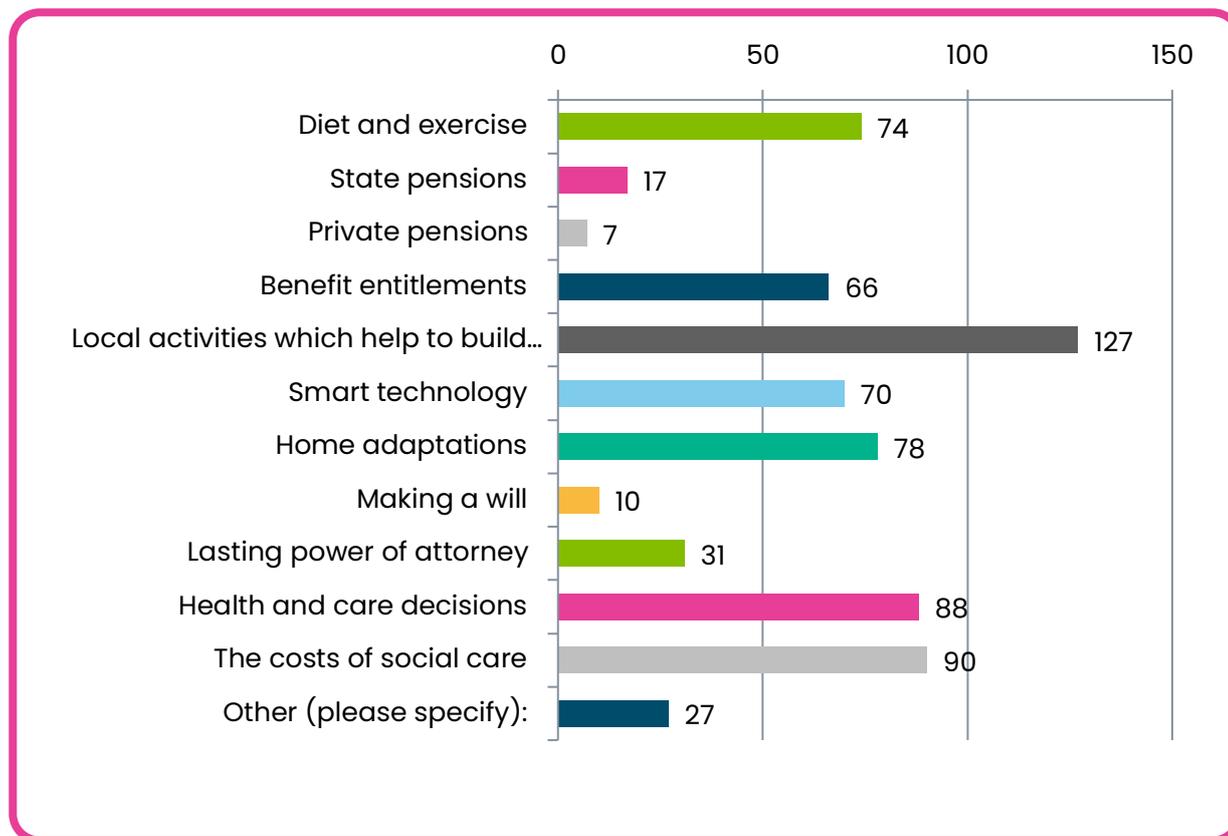


Figure 12 - Bar chart depicting which subjects participants would like more information on relating to preparing for older age. Respondents could select up to four options. Total responses numbered 235.

In all our focus groups but one, improved information was a top priority for participants. As discussed in the section on the “Promoting Independence” strategy, our feedback also suggests that people are keen that this strategy be accompanied by information that can help people to preserve their independence.

The figure above shows what people told us in the survey about their top four priority subjects for more information. The top result was for information on local activities which help build social connections, selected by 127 people (which is 54 per cent of the total). The next three options were for information on the costs of social care (selected by 38 per cent or 90 people), guidance on health and social care decisions (selected by 37 per cent or 88 people) and information on home adaptations (selected by 33 per cent or 78 people).

In all of the focus groups, the issue of the format of information came up, particularly with people commenting that many people were not comfortable using the internet, and worrying about the effects of more information moving online, with no easily accessible alternative. The following comment was typical:

[Services should] not just assume that everybody has computer and is able to use things like that. iPads, I know several who go nowhere near an iPad or a computer, they just don't know. They weren't brought up in that time and they just, well, they're lost.

While such comments were common, it is also worth noting that many of the focus group participants were over retirement age, and most of them were comfortable using computers. Some were keen not to generalise about older people not liking online information. One person commented, during a discussion about printed information:

Participant 1: It's got to be a combination of social media as well because lots of people, my mother, as I say, is 95, she will pick up her iPad.

Participant 2: Oh lovely.

Participant 1: Yeah, she will. Because she likes to see all the photographs we put on and stuff like that. So, it's got to be a combination of everything hasn't it?

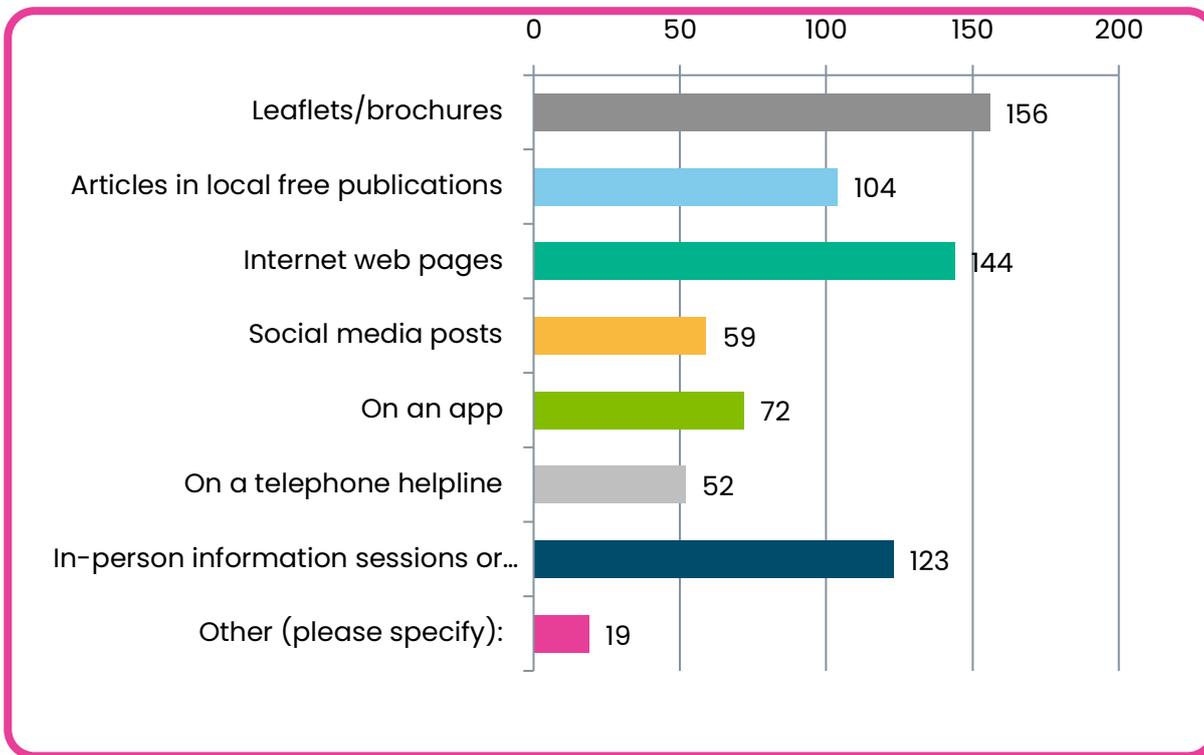


Figure 17- Bar chart depicting what preferred format information around preparing for later life should be presented in. Respondents could select any that applied. Total responses numbered 240.

The chart above shows responses to the question of what format people would like to see information provided in. The most popular three answers by some distance were: leaflets or brochures (65 per cent, or 156 people), webpages (60 per cent or 144 people), and in-person information sessions or workshops (51 per cent or 123 people).

In four of the focus groups, participants spoke about the timing of disseminating written information to people, particularly thinking about targeting people at specific ages to give them useful advice about preparing for the future. As one person put it:

A long time ago, I think in the final year [of school], you used to have this sex education ... And next when you become pregnant and have a daughter on the way kind of thing, you've got the antenatal classes ... So, it seems like when there's a major change in your life coming up, we kind of have a blanket approach to try and reach people and engage with people. We don't do that with old age.

Another person suggested:

A set of alerts for age brackets, so as people are gradually getting older, their needs differ. So, some sort of advertising or publications can be there that say, "Are you now 55 and you ought to be thinking about this". "Are you now 60? You should have this in our opinion". "You're approaching 70? You should be looking at various things", and it would just get people thinking ... They would help themselves, so it'd be less pressure on the council.

Another person said that they often found the tone of guidance on ageing patronising, and would prefer information written by older people themselves.

If I go online about old age, it will be written in a certain way that will be off-putting for me from the beginning ... Do you know if I went into almost any other subject, people would be having a very straightforward conversation with you about stuff, but it almost feels that the people who write about old age are not people who are older age, and therefore they suspect what it is that I might need access to, or perhaps talk about things that might be affecting a particular service or something like that, and it can be quite patronising.

People in six out of the seven focus groups expressed a preference also for face-to-face information sessions. In multiple groups they spoke about having periodic drop-in sessions in local areas, where people could go and get advice from someone in social care, about preparing for later life.

The local police force in Attleborough occasionally have a surgery that people can go to, and so why not have a sort of social support surgery in a coffee shop in Attleborough that people can turn up to?

The difficulty of filling in complicated forms for benefits or lasting power of attorney also came up in three focus groups, and participants spoke of wanting in-person assistance with these:

It would be better to see these people face to face and have an appointment, even get 'em in for an appointment and help them do these forms. Because that would be much better than struggling away. And then perhaps one [form] will come back because that's not quite right and you can't expect some people to be able to fill in these things.

Finally, we asked people what venues they thought printed information should be made available in. This was because in several of the focus groups, people told us that information about later life should be made available “where people actually go”, rather than only having them available in services such as GP surgeries.

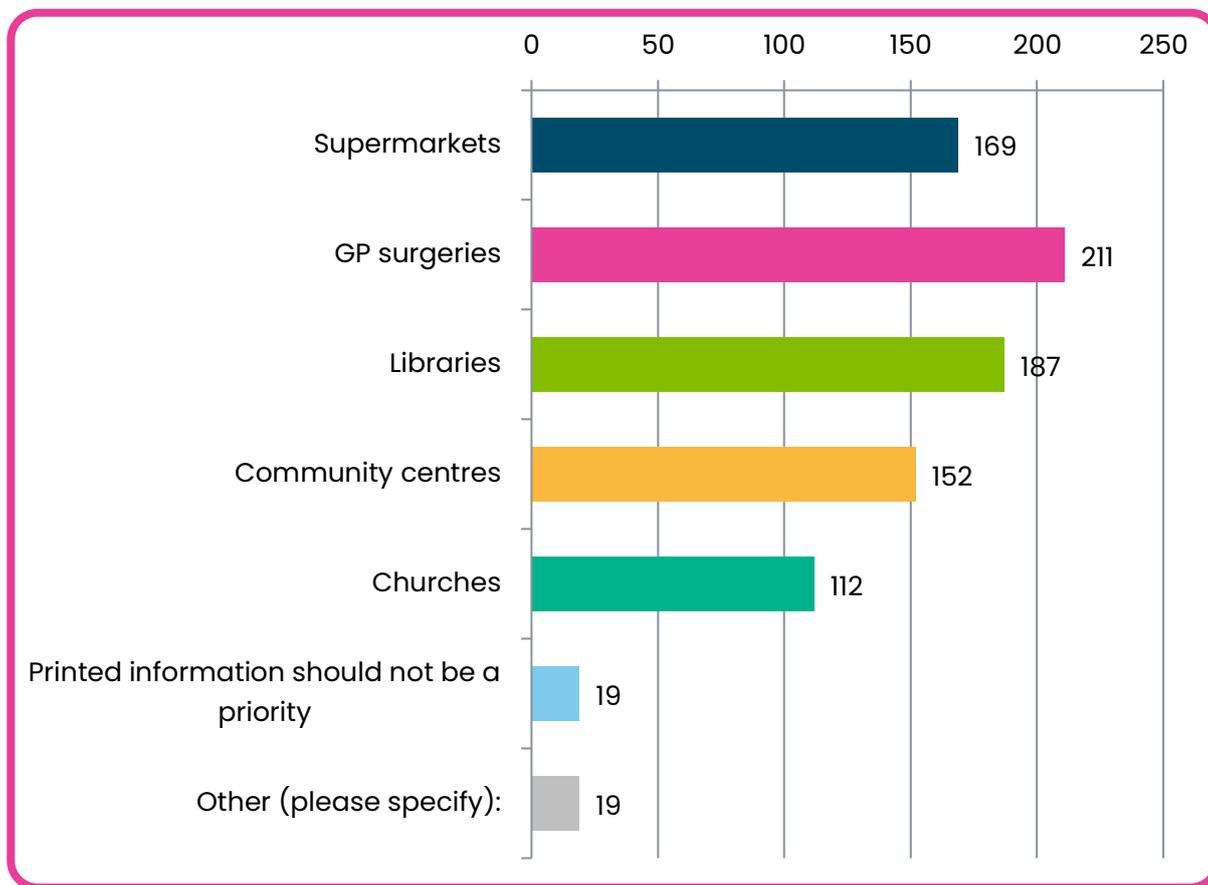


Figure 18- Bar chart depicting where printed information should be made available. Respondents could tick any options that applied. Total responses for this question numbered 240.

The most popular responses to the survey partly contradicted this finding from the focus groups. The most popular response was GP surgeries, with 88 per cent of respondents, or 211 people. The next most popular responses were libraries (with 78 per

cent or 187 people), supermarkets (with 70 per cent or 169 people) and community centres (152 people).

What this means

Our findings suggest that most people are receptive to the idea of being more proactive in preparing well for later life. They understand the benefits of being well-prepared, and understand that services are under financial and staffing pressure.

Many of people's priorities can be met with relatively inexpensive interventions. People are keen to have better information to help them to prepare well. Understanding people's information needs will be important, and people's feedback suggests that information that is timely, provided in both digital and printed formats, and available in the right places, will be important to reach the intended audience. They also need to be written in an appropriate tone, with input from people who have experience of later life.

The feedback we received also suggests that there are differing needs for different groups of older people. People with disabilities and long-term health conditions seem to need particular support with maintaining active social lives, physical activity and healthy eating. People from the ethnic minorities we spoke to may need advice and support on some of the financial and legal aspects of preparing for later life, particularly pension savings and making a will. Women may benefit from more support and encouragement to prioritise physical activity more.

Some of our findings also suggest that making better use of community assets, such as community centres, particularly those which make use of local volunteers, could be an important way to meet some of the needs that people expressed.

A particular cause for concern is people's pessimistic view of how health services will look after them in later life, and the perception that they will be discriminated against due to their age. This suggests that people may need to be better informed as to why they are not receiving a treatment that they expect to receive (for example due to co-morbidities). It may also suggest that people do face real ageism from services, and may be refused treatments based on their chronological age. As an article in the Royal College of Surgeons put it,

“Biological age, i.e. an index of functional ability or health, tells you more about a patient’s likely outcomes than their chronological age ... Chronological age should therefore not be used as a proxy for clinical factors” (Gottlieb, 2015, p. 1).

Finally, it is also important to note that people do have some concerns about the move to the promoting independence approach. We would echo their calls for a balanced approach, which builds people’s capacity for independence and self-help, whilst providing appropriate support for those who may be unable, at least initially, to prepare for later life by themselves.

Recommendations

1. Improve communication and information about later life planning

- Provide clear, accessible, and non-patronising information on: locally available groups that promote social connection, the costs of social care, guidance on future health and care decisions, and home adaptations.
- Provide more information on lasting power of attorney, and consider using real-life case studies presented using the words of people who have experience of them, and consider using peer educators.
- Use multiple formats for information, focusing on leaflets, trusted websites, and periodic, local drop-in advice sessions. Make printed information available in GP surgeries, libraries and supermarkets.
- Consider “life stage prompts” (e.g. at 55, 65, 75) to encourage timely preparation.
- Include information on preparing for later life that is tailored to people with long-term health conditions and/or disabilities.

2. Strengthen access to affordable physical activity for older people

- Expand subsidised exercise opportunities (e.g. Tai Chi, walking groups, chair-based exercise) through GPs, social prescribers, and community centres.
- Provide tailored information on safe, age-appropriate exercise, especially for those with long-term conditions and disabilities.

3. Support social connection and community hubs

- Support community centres, Men’s Sheds, and intergenerational projects as low-cost, volunteer-driven hubs for activity, friendship, and practical support.
- Opportunities should especially be targeted at people with long-term health conditions and disabilities, and the availability of accessible groups should be considered.
- Consider encouraging mixed-age participation, not only “older people’s groups”, to reduce age segregation.

4. Promote supported self-management, not just self-reliance

- For some groups of people, frame prevention around supported independence, recognising that not everyone can prepare alone (due to disability, finances, or social isolation).

5. Address ageism in health and care services

- Consider providing staff training on recognising and challenging ageist assumptions (e.g. dismissing symptoms as “just old age”).
- Promote equitable access to investigations and treatments regardless of age, in line with NICE guidance.

6. Improve access to information and advice on financial and legal planning for some ethnic minorities

- Partner with voluntary organisations, Citizens Advice, and trusted financial/legal professionals to provide free or low-cost advice on pensions and wills for people in ethnic minority communities who may have arrived in the UK in only the last 10-15 years.

Response from Norfolk County Council

We thank Healthwatch Norfolk for the report, which we commissioned to provide valuable insight into how people are preparing for later life and their views on what can help people to remain independent. With Norfolk's older population growing faster than the national average, proactive planning and intervention is increasingly important.

We recognise that many people are worried about this time in their lives and the report confirms that people have predominantly negative expectations of later life. It was positive that most people are taking some steps to prepare, particularly around eating healthily, staying active, maintaining social connections and making a will – but few people had taken measures such as setting up a lasting power of attorney, adapting their homes, or using supportive technology. Interestingly, people with disabilities or long-term conditions were more prepared but struggled more with staying socially connected. Also, people from minority ethnic communities faced additional barriers, particularly around pensions and wills.

The report highlights that most people want to remain independent, but not everyone is able to prepare alone—especially those with limited finances, health issues, or weaker support networks. Clear, timely, supportive information provided in community settings is crucial.

The areas of support that people have identified are rooted within communities – affordable physical activity; opportunities for social connection; home adaptation support; accessible information and help for carers. It included the value of community centres and local groups, with many people valuing intergenerational rather than age-segregated activities.

The recommendations are broad and will be of value to the work of many organisations across the county. We will share these findings through formal forums to enable wider consideration. Many helpful local approaches, services

and support do already exist, but not consistently, and not everyone knows about them. Addressing this and many of the recommendations from the report aligns closely with future plans for adult social care.

Looking ahead, our commitment is clear:

- Our mission is to empower residents and communities to live their best life by fostering independence, building strong partnerships and tailoring support.
- We are developing a place-based preventative offer rooted in asset-based community development, bringing organisations together at neighbourhood level through integrated neighbourhood teams.
- We will continue to strengthen community-led support and practice, with a strong focus on shared networks, local solutions, and meaningful engagement.
- Our transformation plans will evolve through ongoing engagement, feedback and learning, using this report to contribute to shaping services that support healthy, independent ageing across Norfolk.
- A continued focus on promoting Healthy Ageing amongst our Norfolk residents, signposting to support across three key strands including physical activity, social connection and health protection.

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healthwatch Norfolk

Healthwatch Norfolk
Suite 6 The Old Dairy Elm Farm
Norwich Common
Wymondham
Norfolk
NR18 0SW

www.healthwatchnorfolk.co.uk
t: 0808 168 9669
e: enquiries@healthwatchnorfolk.co.uk
✉ [@HWNorfolk](https://twitter.com/HWNorfolk)
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