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Preventative Social Care and Community Development in Wales: "New" Legislation, "Old" Tensions?

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Abstract

Prevention is becoming ever more central in UK care policy for older people, though precisely what this entails, and how it works most effectively in social care and support, remains ambiguous. Set against the "newness" of recent social care legislation in Wales, this article explores the perspectives of professionals on prevention and community development, particularly for older people. This draws on qualitative data collected from 11 Welsh local authorities, four NHS Wales health boards, and eight regional third-sector organisations, incorporating 64 interviews with directors, executives, and senior managers. Recent research has highlighted concerns over the slipperiness of prevention as a concept, resulting in multiple interpretations and activities operating under its banner. Consistent with this, our data suggested a kaleidoscopic picture of variously named community-based initiatives working to support the intricate web of connections that sustain older people, as well as provide practical or material help. Similarly, professionals highlighted varied agendas of community resilience, individual independence, and reducing the need for state-funded health and social care, as well as a range of viewpoints on the roles of the state, private sector, and the third sector. Analysis revealed fragments of familiar themes in community development; positive hopes for community initiatives, tensions between the mixed agendas of state-instigated activities, and the practical challenges arising from systems imbued with neo-liberal ideas. Realising the promise of prevention will require deft steering through these challenges.

Keywords

ageing; community development; independence; older people; social care and support; social policy

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1. Introduction

One of the four nations of the UK, Wales is a country of 3.1 million people (Office for National Statistics, 2022). As with other UK nations, and consistent with broader global trends, the proportion of this population aged over 60 years is increasing, being estimated to soon reach 30 percent (Older People's Commissioner for Wales, 2023). These demographic shifts have provoked urgent imperatives on how to meet current and future social needs for older people, particularly in a context where health and social care workforces and systems are under significant strain (Clifton, 2021; Welsh Government, 2023a). For Wales, these issues are further complicated by high levels of relative poverty and inequality, rooted in deindustrialisation and the decline of traditional heavy industries like mining and steelmaking (Best & Myers, 2019). The current UK cost of living crisis is also exacerbating the extent of these inequalities (Bevan Foundation, 2022), and the perceived strategic necessity of addressing the challenge, alongside Welsh labour government's policy values (Tarrant, 2022), have contributed to a renewed focus on prevention in social care policy and practice (Read et al., 2023; Welsh Assembly Government, 2011).

However, while recent UK-wide policy has emphasised prevention as one of its core tenets, research evidence from across the UK nations highlights significant variability in how this has been interpreted and enacted (Llewellyn et al., 2023; Marczak et al., 2019; Read et al., 2023; Tew et al., 2023). In England, for instance, Tew et al. (2023, p. 1) argue that inconsistencies in strategic implementation have been at least partially attributable to "the lack of any generally accepted conceptualisation as to what prevention might mean" in the context of social care. In Wales, Read et al. (2023) have established a slipperiness around the concept of prevention in social care policy, arguably contributing to the presence of "fused principles" around it. These principles encompass discourse over financial imperatives, cost-saving and budget reductions, together with values-based ideas such as encouraging independence, social justice, and a more general sense that prevention is "doing the right thing." The tensions emergent from the co-existence of different principles have implications for actors within local government seeking to further a prevention agenda in a context of devolved financial challenges (Ifan & Sion, 2019).

Devolution of powers from the central UK government has shaped public policy in Wales. The National Assembly for Wales was created in 1999 and renamed the Senedd in May 2020, after a series of interim legislative steps extended its taxation and borrowing powers. Devolved policy powers include health, education, housing, transport, and social services (Law Wales, 2021). Key to the approach adopted in devolved government has been avoiding considering any policy area in isolation from the others, for example, perceiving health, housing, and transport as interdependent domains of activity (Welsh Government, 2017, p. 13). Wales also has a strong history of community-led community development outside the state (Clarke et al., 2002). Working class solidarity and rural communities, together with the nonconformist religious movement, were major influences on community life and community development (Clarke et al., 2002) with mutualism and co-operatives having deep roots (Working Class Movement Library, 2023).

Since 1999 there have been various iterations of Welsh social policy to support community development, for example, initiatives such as Communities First (2001–2008) with its focus on poverty reduction (National Assembly for Wales, 2007). Successive Acts in Wales have prioritised well-being, co-production, and prevention as focal points of the reform of existing practice; two recent examples are the Social Services and Well-Being (Wales) Act 2014 (SSWBA; Welsh Government, 2014) and the Well-Being of Future Generations

(Wales) Act 2015 (Welsh Government, 2015). The SSWBA has an explicit focus on preventative social care, inclusive of community development, for example, support for place-based community programmes and community-owned initiatives and enterprises (Welsh Government, 2014). This emphasis is evident in other government strategies such as Age Friendly Wales: Our Strategy for an Ageing Wales, marked by language of empowerment and responsibility, with a focus on "independence, participation, care, self-fulfilment and dignity of older people," self-responsibility, and support "if needed" (Welsh Government, 2021, p. 2). Many of these concepts and terms originate from the 1991 UN Principles for Older People, now over 30 years old, demonstrating the longevity of this discourse around ageing in global and local policy (Office of the High Commissioner for Human Rights, 1991).

Much like the idea of "fused principles" and contested narratives around prevention outlined by Read et al. (2023) in relation to Welsh local authority practice, themes of contestation and obfuscation mark out community development more broadly, with tensions in values, agendas of state-instigated activities and local community actors, and "whose interests are served" (Mayo, 2008; Mowbray & Bryson, 1981; Pearce & Lohman, 2022; Shaw & Martin, 2000). Austin et al. write (2005, p. 404) that there is a need to "distinguish between community-based service delivery and community development"; they are different in genesis, processes, participant agency, and freedom to collectively imagine and act for change outside of prescribed boundaries. Moreover, there is a solid critique that policy language of "responsibility" and "community solutions" can move attention from structural level change as a priority preventative agenda (Austin et al., 2005; Ward, 2023).

Against this backdrop, this article explores professional perspectives on implementing the current Welsh government policy agenda on prevention and community development, as it relates to older people. In doing so, the complexity of these local arrangements, particularly in a context of financial challenge for state agencies, demonstrates a preference towards community-based care provision for this group. As outlined by the likes of Cockburn (1977), community working in the "local state" context has the potential to facilitate the growth of neo-liberal approaches in care and support, driven by notions of corporate management and alleviation of state responsibility (e.g., Mayo, 2008; Shaw & Martin, 2000; Ward, 2023). The extent that this is demonstrable in the Welsh context will be considered, amidst ongoing discussions of where preventative services are perceived best to sit, and how this is facilitated and evaluated at a local level.

2. Methods

Determining Best Preventative Social Care Practice (DBPSCP), the research study from which this article is drawn, is a Health and Care Research Wales-funded project exploring how preventative social care is understood and enacted across Wales. The SSWBA legislated for Wales to establish seven regional partnership boards (RPB), with these being the mechanisms by which health and social care integration would be managed across the country. As such the seven distinct regions incorporated statutory bodies from both health and social care: the 22 Welsh local authorities, the seven Welsh health boards, and the 22 community voluntary councils, with other third-sector agencies being involved with the RPBs in different regions. Each regional footprint generally consists of between one and six local authorities, one and six community voluntary councils, and one health board. In terms of policy implementation, these also sit in complex relation to other agencies, such as the RPBs in terms of health and social care, and public service boards (PSB) across other public policy areas, with statutory responsibilities shared and split between them.

For instance, each PSB is required to publish an annual local well-being plan specific to its locality (Welsh Government, 2023b).

The phases of research reported here incorporate four of the seven Welsh regions, with these, in turn, incorporating 11 Welsh local authorities, four NHS health boards, and eight community voluntary councils. The broader DBPSCP study has deployed additional phases of research establishing how service users and carers experience preventative services within their regions and local communities. Data reported here, however, are restricted to professional perspectives, stemming from an inductive, grounded theory exploration of how prevention was considered across the different regions, noting any variability or overlaps in definition and application, and how community development factored into this.

3. Qualitative Interviews

Data collection was conducted between May 2022 and January 2023 and consisted of semi-structured interviews performed and recorded over Microsoft Teams by the lead author. Interviews were carried out across all four Welsh regions (Localities A–D) and engaged with professionals working within that regional footprint. Regions were purposively sampled to reflect a range of sizes and organisations involved, as well as to incorporate both rural and urban settings. Participants within each region were also purposively sampled based on how prevention was interpreted at a regional and local level, with the key criteria being their involvement with strategizing or enacting preventative services. Participants were approached using previous contacts in RPBs as gatekeepers to establish contact over email, with information sheets outlining the DBPSCP study provided once this was brokered. Interviewees were split into two broad cohorts: those involved with RPBs and strategizing towards prevention at a regional level (cohort i) and those working at a local, managerial level within a health board, local authority, or third-sector organisation (cohort ii). Practically, the delineation of participants into these two categories means that there are considerable overlaps and variations between them in the types of roles performed. This is largely due to local variations in how systems and roles were organised. Generally, participants involved with RPBs (cohort i) were directors of social services, NHS executives, and senior representatives of community voluntary councils or other third-sector organisations. Those working at a local level (cohort ii) largely incorporated senior managers in health or social care, as well as senior professionals within community voluntary councils and other third-sector organisations. In total, 64 interviews were carried out across the four localities, as outlined in Table 1.

Table 1. Sample Size Split by Four Welsh Localities.

	Cohort i	Cohort ii	Total
Locality A	3	10	13
Locality B	6	12	18
Locality C	3	9	12
Locality D	3	18	21
Total	15	49	64

Interview schedules for both cohorts were developed to enquire about how prevention is understood and organised within each region, the types of initiatives associated with prevention for older people, how well these were felt to be working, and any barriers to implementing the preventative agenda. These were intended to take a semi-structured approach, with broad questions and follow-up prompts in place, conducted in a

conversational style. The length of the interviews ranged from between 35 to 80 minutes, though the majority (56/64) were between 45 and 60 minutes.

3.1. Data Analysis

Once completed, video recordings of interviews were converted to audio and transcribed. Transcripts were uploaded to QSR NVivo to assist with analysis. Analysis was performed in line with the inductive thematic approach of Braun and Clarke (2006) with a coding framework being developed over several iterations, and through ongoing group discussions within the research team. Though coding was predominantly undertaken by the lead author, dialogue between team members helped to validate coding interpretations, as well as highlight interdependencies between themes, and identify further amendments to the initial framework. Within this process, particular themes associated with the varying approaches to community development in each of the Welsh regions became more transparent, with this interlinking to how prevention was perceived locally, and how such approaches are funded and evaluated.

Additional validation activity was performed with the study steering group, designed to offer locally informed advice and guidance to the research team throughout the study's duration. The steering group was comprised of lived experience representatives in each of the researched Welsh regions recruited from local 50+ forums and was convened roughly once a quarter, though this fluctuated based on the demands of the study at particular times. The 50+ forums in Wales were established following recommendations from the Welsh Government in 2004. The intention behind them was to enable older people to have a representative voice in consultations with local authorities and other organisations (Caerphilly Over 50, 2023). The reported data was validated by a process of being presented to the steering group, feedback being gathered, and this ultimately re-informing the development of the framework. This process also offered the opportunity to open debate on alternative perspectives on how data were being interpreted.

4. Ethics

The research study was granted ethical approval by Camberwell—St Giles NHS Research Ethics Committee in February 2022 (REC ref no. 22/LO/0004). To ensure anonymity, participants have been identified by the part of Wales they work in (Locality A, Locality B, etc.).

5. Findings

In line with previous research (e.g., Read et al., 2023; Tew et al., 2023) an overarching dimension within many interviews was the multi-faceted way in which prevention as a concept was interpreted locally. There was a focus on supporting older people to remain independent and socially connected, hospital admission avoidance, and health and care integration with a focus on partnerships and multi-disciplinary teams, all set amidst the need to alleviate pressure on overburdened health and care systems. For older people particularly, one of the more consistently returned themes was the role local communities were felt to play within this. This included strategies for community development and local mechanisms and resources to support people to connect to statutory and other private or voluntary services. Relatedly, how interlocking services were organised and increasingly perceived as interrelated parts of a "whole system" was an identifiable theme. "Community" in this context most typically was viewed as "place-based community."

Our findings will first cover how community development for older people was conceived and understood by participants. This will explore the link between community development and prevention, as well as the range of ways this was discussed. Secondly, we will outline the different forms of community working perceived as being preventative by participants, with these including micro-enterprises, community connection, community asset-mapping, place shaping, and interpersonal interviewing. Finally, we will highlight how the role of the state was described alongside community development approaches, and how issues such as partnership working, and the economic context of local government influenced the approaches undertaken.

5.1. Community Development and Preventative Working: Concepts and Articulations

Interviews enquired around how prevention was considered by participants across their various settings, and in what ways this was being enacted. A consistent thread within responses was the need for strengthened local communities, as well as debates on how this might be best nurtured, and the level of state involvement in this. Data collected were rich with descriptions of how community development formed part of the preventative agenda. Numerous interviewees specified that such approaches to community working were a core part of their strategies for social care and support:

> If a village is vibrant and has events on, we know notionally that produces more resilience in older people...so there's that tier of prevention as well, which is less about social services and more about healthy vibrant communities. (Locality D, P1002, local authority director)

> I suppose the strength of the voluntary sector is very much in the preventative fields and I suppose at one end of the spectrum it's about community development. (Locality B, P2007, third-sector manager)

> Because the aspiration from a preventative point of view is that we're trying to make sure that we're exploiting all opportunities within the community before we start looking at some of the more traditional means of meeting statutory needs. (Locality C, P2007, local authority manager)

These quotes confirm that part of the recent strategic focus on community development as a form of prevention aims to slow or reduce the flow of individuals into state-provided services. Participants expressed that, for older people specifically, the logic underlying this was often expressed through the connection between social isolation and poor health and well-being outcomes, with "vibrant communities" perceived to mitigate this.

How these communities were described by professionals was noted to incorporate a range of terms, demonstrating expectations of what communities could be, both as an end in themselves, and if they were to serve a preventative purpose. Ideas of health and vibrancy established above were complemented by notions of resilience, resourcefulness, connection, and cohesion:

> As we will tap into those resources and connect those resources to the people or those services' preventative agenda, people might actually be more aware of where they sit with regards to their health. (Locality A, P1002, health board senior manager)

We don't seem to be that willing to engage in the conversation about managing demand and prevention is an inherent part of that. Prevention, self-care and prudent health care, and resilient communities. (Locality B, P1001, third-sector director)

Discourse around resilience and resourcefulness was particularly commonplace, as was the idea of connecting individuals to focal points of these resources and resilience within local communities. There was considerable variation between localities in how these characteristics of a community were felt to be most effectively coordinated with this often driven by the types of activities emphasised by health and social care planning bodies in each region.

5.2. Forms of Community-Based Prevention

When discussing the role of community-based prevention, a range of diverse, though sometimes interrelated, initiatives were brought forward as examples. These incorporated a range of agencies, funding sources, and approaches. Though present across all regions, the role of voluntary, third, and private sector organisations was notably varied. A commonly reported initiative was the development of micro-enterprises, sometimes for care provision and often also for low-level support based within local communities. These were in place across three of the four localities, as well as referenced as aspirational plans in the other:

We've been really successful around the development of micro-enterprises. I think the latest figures were…we've got over 100 individuals now who are providing over 300 hours of community support through micro-enterprises. (Locality B, P2013, local authority manager)

We've got sort of micro-enterprises that are cropping up in the county now and that we're supporting to get developed. These are individuals…running their own little businesses, providing care. (Locality C, P2002, local authority manager)

The development of micro-enterprises as care providers was generally seen to offer citizens greater choice over which services they engage with. These initiatives were predominantly sole-trader small businesses offering care and support services, albeit networked into other similar sole-traders within their local communities. The work associated with this was largely performed by third-sector organisations. However, it was noted that in some areas the approaches associated with micro-enterprises differed:

We used the Community Catalyst[s] model whereas some local authorities…have tweaked it a bit and in doing so I don't think they've done themselves any favours. (Locality B, P2013, local authority manager)

The precise nature of the "tweaks" to the Community Catalysts (2023) model inferred by this participant was unclear, though it was noticeable that localities had different forms of partnership working. For some, this work was commissioned, whereas in others it was taken in-house to local authorities via mainstreaming of the work into statutory budgets. This form of community-based prevention, regardless of its placement within the wider system, incorporated identification and assistance of potential micro-providers and then encouraged formal and informal support networks to share advice, knowledge, and best practices.

Though elements of prevention are undoubtedly evident in the work of micro-enterprises in and of themselves, they differed from many of the other initiatives discussed by virtue of their status as private sector sole traders based within local communities. Many other forms of "community working" outlined were incorporated into activities of third-sector organisations, or the state itself in some cases. One such example shared across each of the regions was the role of a community connector—individuals based in local communities with a broad knowledge of the events, activities, organisations, and initiatives operating within them. In spite of variations in origin, this term was often used interchangeably with titles such as social prescribers, local asset coordinators, or community navigators:

> The one exception that I would highlight is that…community connector, community navigator, social prescribing stuff. Now that has been a game changer. (Locality C, P1001, third-sector director)

> It very much includes social prescribing, it's about how you connect people into their communities. (Locality A, P1001, health board senior manager)

> In fact, in [omitted] we're often the first port of call and not a gap filler, so the community connector is a key element. (Locality D, P2006, third-sector manager)

For some participants, there was a distinction between social prescribing and community connection, with this hinged upon where the role was situated:

> We do have in [omitted] the social prescribers….I don't think they're placed in the right place at all because…in [omitted] they're placed within GP [general practitioners] surgeries. (Locality D, P2003, third-sector manager)

> When we talk about social prescribing, it's very much the medical model…it doesn't recognise that sometimes…access to good social engagement and involvement…is worthy in and of itself. (Locality B, P1003, local authority manager)

While the role of community connection or social prescribing was often seen as synonymous, there was a perception from some that the latter was more associated with medical systems. In these cases, the role was generally set within GP surgeries or hospital-based memory clinics. Though reported as a difference by some, the broad overlaps were demonstrable through community connectors also being placed in GP settings in certain localities:

> GPs were telling us that they…get a lot of people come through the door, that there may not be an actual medical issue or there may be a social issue…and how we can help support them do that. (Locality C, P2006, third-sector manager)

Other participants suggested that, rather than where the role was situated, another distinction was the activities being performed in and of themselves. This could include connecting individuals to pre-existing community events or activities, as well as other elements like understanding specific localities, developing the presence and capacity of community resources, and working co-productively to identify community-based activities that might benefit individuals:

> I lead on the asset-based social prescribing project...and that employs what we call local asset coordinators to link the most vulnerable people in communities back to community activity. I also lead on a place shaping asset-based programme which is around identifying those assets in the communities that can be used to link those people to. (Locality B, P2008, third-sector manager)

Here, the participant outlined two distinct asset-based projects with these incorporating the community connection or linking work, alongside aspects of "place shaping" and local community development. This distinction is further outlined in the two quotes below:

> She's set up a load of groups, there's like dementia friendly cinemas, there's dementia friendly choirs, you know, cafes, you know, and she basically...sort of helps to develop those groups but then puts people in touch with them. (Locality D, P2002, local authority manager)

> When we look at things like local area coordination....I can't see it's worked much more effectively than where you've got, like you have here in [omitted]...community connectors who are almost like third-sector brokers. They were doing far less of the community development stuff and doing far more of the working with people to find out how they could access what's already there. (Locality B, P1006, local authority director)

In the extract from Locality D, the work of a dementia community connector is described both in terms of "putting people in touch" with local groups and activities, as well as "helping to develop" community assets. Similarly, while not perceived as favourably, the participant from Locality B also highlights the difference between "community development" and helping to link people to "what's already there." The other dimension of this form of working is related to the mapping of local communities:

> With our community coordinator, we've mapped each locality to see who and how each third sector, private sector, anyone that's within that locality, could support people that are requiring our services. (Locality A, P2006, local authority manager)

> They just went out and basically recruited about eight dementia advisors in their area without doing a mapping exercise...and then once they had them in place they found out that there was a duplication of work. (Locality B, P2006, third-sector manager)

> So it [community connectors] encompasses it all, it's not just a standalone project, it pulls in other third-sector organisation, it tries to coordinate some of that support. (Locality C, P2006, third-sector manager)

Evident in the data are debates around the various types of community working required to pro-actively and effectively develop resilience and resourcefulness, with these varying in terms of who was best to perform such roles, and where responsibilities for the work lie. At a more interpersonal level, another core dimension of community-based prevention was felt to be embedded in the interactions between practitioners, people who use services, and local community members. Several of the professionals interviewed suggested that strengths-based and asset-based approaches were key to effective linking within communities. Generally, as

outlined in the following extracts, such approaches were perceived as a prerequisite to successfully connecting individuals to community-based activities that would most benefit them:

> We are much more focused on what the individual outcome is....You know, what that person really wants to happen, what matters most to them, and in so doing improving the well-being of that individual. (Locality C, P1002, health board director)

> They identify what matters to that individual, what their goals are, any barriers...that are present to prevent them from reaching their goals, and then what strengths they have and how we can...co-produce some solutions for them. (Locality A, P2006, local authority manager)

Rooted in the language of the SSWBA, the importance of "what matters" conversations was returned to frequently. Each of the localities provided instances of such conversations being performed by social prescribers, community resource teams, or community connectors:

> The community connectors, for example, they do training in making every contact count and motivational interviewing and being able to have conversations with people who want to make a change but don't necessarily know where to start. (Locality D, P2006, third-sector manager)

There was a uniformity of response around adopting asset-based or strengths-based approaches, regardless of the organisation conducting the work. Within this, the aim is to identify individual assets and strengths that may enable people to better engage with the communities around them, as well as seek to co-produce potential forms that this engagement might take. The extent to which differences in how the various systems were organised to enact these approaches play out, and how these are experienced by service users, is outside the scope of this article, though it is worthy of further investigation.

5.3. Statutory and Community Service Provision: Contextual Challenges and "Whole System" Solutions

There have been ongoing debates around how community development functions alongside local state agencies, as well as whose purposes are served, when linked to ideas of prevention. Within the collected data, discussions around how community development work was delineated between state provision and third-sector or alternative agencies were notable throughout the localities. In this section, we shall first highlight aspects of the local government context that have led to community-based work often being performed by non-state partners, before considering the extent to which this was perceived as a "whole system" approach by participants.

5.3.1. Contextual Challenges

Without a doubt, one of the clearest challenges associated with community development and prevention for local actors was the current and impending financial situation of the local government. For many participants, the fiscal environment surrounding statutory bodies was a key contributory factor in looking to establish other non-state agencies within the preventative agenda:

> We're working in a fiscally massively constrained environment and therefore who's got what budget for what becomes a big issue and a driving force. (Locality D, P2011, health board manager)

For some participants, the financial pressures within their organisations meant that core funding for preventative services was often de-prioritised:

> The problem with prevention is getting it funded because our finance colleagues…they're not very keen on investing in prevention because they can't see the result very clearly. (Locality A, P1003, local authority director)

> I've got to mention, at the moment, with budgets, it's really challenging. It's going to be increasingly challenging over the next two years. (Locality C, P1003, local authority director)

This, coupled with what was perceived as a historic disinvestment in community development work, has meant that many such services have been dependent on short-term government funding:

> We have disinvested, within Wales, in community development and…that is a problem. (Locality B, P1003, local authority manager)

> I think we haven't embedded where we should have done because of funding pressures, and therefore we've become reliant. (Locality D, P2013, local authority manager)

Financial issues were reported across all localities, and it was common to hear of community work being sustained through short-term funding mechanisms. In many of the localities, this funding was diverted to third-sector organisations. In others, though, third-sector partnerships were run on a commission-only basis. Regardless, an inherent dimension to much of the data was the belief that the financial issues of the local state could be mitigated by adopting a "whole system" approach to social care, with this extending beyond traditional state organisations in delivery.

5.3.2. "Whole System" Solutions

Perspectives on how the delineation of the social and health care system between multiple agencies was working were varied, with this seemingly informed by the nature and quality of collaboration between state and other partners:

> We couldn't do it on our own, we do need the third sector. But what we found with the third sector is they're quite often subjected to yearly funding.…What we need to do is ensure we can provide a continuity of service. (Locality A, P2009, local authority manager)

> The way that local authority relationships with the third sector have been historically is that we were effectively the "cash cow" and we were being asked to provide them with money, for them to deliver a service, so that would be inherently cheaper…and actually it isn't necessarily cheaper. (Locality B, P1003, local authority manager)

While these participants allude to poor local authority outcomes, both financial and otherwise, when re-allocating funds to the third sector, others saw this form of working as an imperative given the economic context. When this collaboration between the sectors was felt to be working well, it was seen as a key part of the preventative strategy:

> The work we do with…the third sector around our community connection. We've now, we had moved statutory funding into their, their organisation, which was a direct replacement to build that up. (Locality D, P1003, local authority director)

Indeed, for some participants, ideas of partnership working were central to the "whole system" approach encouraged in recent Welsh legislation. Though this was sometimes restricted to statutory health and care systems, many participants saw the need for collaboration with alternative providers to develop communities:

> It's a whole system thing, isn't it? And I guess what I'm suggesting is we go even further, and we start with that community resilience and then we look at low-level services and early intervention. It's a whole system, but it starts much earlier. (Locality D, P2014, local authority manager)

> We can't deliver our, our services, without linking with third sector and the breadth of the third sector is phenomenal…so, when we're talking about delivery, we've got to…understand that really broad delivery. (Locality B, P1003, local authority manager)

Data highlighted ongoing debate around the role of the state in developing communities and how best to utilise scarce resources within a "whole system." Allusions to "top-down" or "bottom-up" approaches were implicit in descriptions of how care and support were organised within many local authorities. For instance, the development of micro-enterprises and "good neighbour" schemes were seen as hugely positive in many of the studied regions, though several participants mentioned concerns over local authority risks and liabilities:

> There are huge risks with it because they're unregulated, they're not monitored…so there are issues and I'm sure it's a complete pain in the neck for the Council to monitor all of these…micro-enterprises, but if I was going to design a domiciliary care sector today I think I would encourage that. (Locality A, P2005, local authority manager)

> We have tried, on a lower level, to get a good neighbours-type scheme up and running, which I think would be really good for prevention but the minute you start talking about DBS checks, you start talking about safeguarding…everybody runs away. (Locality C, P2006, third-sector manager)

Though the respondent from Locality A above highlights issues with regulation and local authority liabilities with respect to care provision, the use of micro-enterprises is still regarded positively. Interestingly, though, within that locality, there was greater evidence of a "top-down" approach to community working at play in one of the constituent local authorities. For instance, whereas other counties within each region would deploy third-sector organisations for community connection activities, participants from this local authority demonstrated a different approach:

> Hence why we decided to create...a community connector role for our well-being social service...loads of other organisations will use the third sector for that. And we've found that's worked better for us because our well-being service has the full catalogue of services available in the local authority...but also what we can do from our funding pool is we can commission third sector to work with us. (Locality A, P2009, local authority manager)

The logic associated with these variations in approach incorporated a range of themes. For some participants, the benefits of the third sector were in their capacity to deploy bottom-up, locality-based community work. This relied on their knowledge of communities, their ability to source alternative funding from private and other sectors, and the use of asset-based approaches to community and individual working. Another benefit mentioned by several participants was that third sector or voluntary organisations were sometimes perceived more favourably by a locality's citizens, particularly those that may be harder to reach:

> I suppose, for some, a distrust of statutory services, which creates that, almost, last-minute, "I'm not going to ask social services for help until I'm absolutely on my knees and completely desperate," at which point, there is very little we can do to re-able or support the individual. (Locality B, P1002, local authority director)

For some participants, the perceived desire of some citizens to remain distant from statutory services was justification for offering a range of initiatives rooted in community or other sectors. The interviewee below highlighted how micro-enterprises also served such groups:

> They're in the market of people who simply want to approach someone else to provide a service and don't want to come anywhere near social services. And those customers exist in every population across the country. (Locality D, P1003, local authority director)

Across all localities there were identifiable overlaps in the types of initiative discussed in terms of prevention and community development, as well as in the styles of approach adopted to enact them. That said, the extracts outlined above also demonstrate some variation in how the role of the state is perceived to operate most effectively.

6. Discussion and Conclusion

The findings outlined above explore how professionals working to support older people in four regions across Wales have embraced prevention, inclusive of community-based initiatives. Professionals interviewed demonstrated significant effort in this regard, with the development of initiatives that spanned new micro-enterprise models of care, community development initiatives, and supports for community networks each being referenced. The latter include community connection models, social prescribing, and community catalysts. Our study data suggested that many of these initiatives were actively seeking to place traditionally state-associated forms of work into local community organisations and create new markets and models of community care provision. The professionals working in this sphere also clearly saw these forms of community-based working as a potential force for good and community building, offering alternative modes of provision and thereby greater service and support access, choice, and control for older people. Consistent with previous instances of preventative policy, one core recent focus has been on developing resilient and

healthy communities. The backdrop is a significant crisis in the provision of social care, which is propelling the reach for new forms of care provision.

Proponents of the initiatives also suggested that their presence in local place-based communities, and the support provided by local government through rerouted funding to the third sector, could help to strengthen and empower localities and support "vibrant" communities and engagement with older people. Some participants felt this to be driven by long-standing relationships between statutory services and civil society more broadly, with certain pockets of the population perceived to distrust state-delivered services and preferring to engage with community-based individuals and organisations. Likewise, how community development and community-based initiatives were described more broadly by participants highlighted a strong association between prevention and the theme of a "reduced flow" of older people into state-based systems of health and social care. Prevention was cast in health and well-being terms and access to services, and from an institutional perspective, in respect to future demand management.

That there were mixed agendas for prevention is not inconsistent with ends evident in community development literature. Within this, arguments are made that a common nomenclature can potentially mask the political and ideological agendas of those using such language (Cockburn, 1977; Mayo, 2008; Thorpe, 1985; Ward, 2023). For example, there is a difference between a "community-based care service" and a "community development project" in terms of agency and empowerment, a point emphasised by Austin et al. (2005) in their work on community development with older people. Also, terminology such as social prescription gaining traction across Wales, and the placement of such workers within settings like GP surgeries or hospital-based clinics, meant that there were associations between this form of community linking work and medical rather than social models of care. As noted by Verity et al. (2021) and others, with preventative social care there is a need to understand and enact support, including community development work, beyond leaning on the definitions associated with clinical approaches to prevention, which can be at the expense of collective and structural considerations. These discourses may influence the actions of local actors where demand management of an immediate crisis has the potential to override social justice and inclusion principles and the longer-term perspective the latter entails (Read et al., 2023).

Despite the promise of the "new" prevention agenda in Wales, recent evaluations of the implementation of the SSWBA have demonstrated that the experiences of service users, carers, and individuals within local communities have not been wholly positive and have tended to vary significantly (Cooke et al., 2019; Llewellyn et al., 2023). System-wide issues of inadequate resourcing and staffing, as well as meaning many of the desired changes for health and social care are seen as extremely difficult by professionals (Wales Council for Voluntary Action, 2023), have also negatively impacted experiences of social care by those engaging with it. This theme was only residual in the data reported here, though may be expected to re-emerge in the findings from the broader DBPSCP study where service user and carer interviews are undertaken. Moreover, the active collective agency of older people in community development, where initiatives are driven by older people themselves, is muted in this data. History has reinforced the need for an alert critical awareness in community development. Notwithstanding the current optimism evident in this study, we suggest that bringing to the fore the voices, hopes, experiences, and actions of diverse older people themselves, together with deft handling of the tensions and challenges in preventative work will be needed to realise a progressive ambition in the development of community-based initiatives in tight financial times.

This study is not without its limitations. For instance, the data reported here only incorporates the views of professionals working in statutory and third-sector organisations in Wales. The broader DBPSCP study engages with older people and their carers, ascertaining their perspectives and role in prevention, so closely entwined with ideas of community development. Beyond this, the sample of Welsh regions does not fully encompass the breadth of approaches being deployed across the country. Nevertheless, our findings offer some insights into how community development is considered and enacted by professionals working with older people in a range of different Welsh localities.

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Conflict of Interests

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