

NATIONAL MAPPING OF SERVICES TO OLDER PEOPLE PROVIDED BY THE CATHOLIC COMMUNITY

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FOREWORD

Our society is getting older and how to respond to old age, how to live a full life in old age, how to counter the difficulties and fears of old age are proper questions for the Church to address at this time. With this in mind, Caritas Social Action Network (CSAN) commissioned the Social Policy Research Centre, Middlesex University, to undertake research into the services provided to older people by the Catholic Community in England and Wales.

This report is an initial look at the current Catholic engagement in services for old people and it is hoped that it will lead you, who read it, to begin to see how you and others with you can engage in the mission of the Church to enable older people to continue their journey in the things of God: and for us also to provide the opportunities and space for older people to teach us from their journey in the things of God. CSAN, as an agency of the Catholic Bishops' Conference of England and Wales, has the task of gathering together people within the local Church who have the charism and talents to proclaim the message of the Gospel through the corporal works of mercy. The call in *Matthew 25* has always been an imperative for the Church – to bring forth the love of Christ in those who are in need through welfare work that is itself inspired by the same love of Christ. Christian charity is much more than resolving a human need. Charity grows out of a relationship with Christ, person to person.

Community care is one of the mantras in modern societies but it is not usually understood as being founded in Christ. CSAN understands community care in the light of the Gospel, so this report on Older People's Services is offered as starting point to reflect on how, in a welfare state where there are professional bodies offering community care for every need, Catholic men and women today can bring Christ the Healer, the Teacher, the Master, the Redeemer, into our communities of care. There is a risk that we leave the response to human needs to those who are professional: there is a risk in our modern structured world that initiatives are not taken up and the Church is open to this risk. This is why the Report speaks of how "the full potential of the laity can be realised": that "people in parishes generally need to become more involved and proactive...": that there is the risk of an "absence of community".

At a time in the Western world when we are living longer lives and also at the same time the Church is experiencing a change in the patterns of vocations to religious life and priesthood, many of the services that the Church has traditionally provided are reaching a point at which they may have to cease or to be re-thought and re-imagined because the Sisters and Brothers who provided the inspiration and human resources are no longer available, and the economic and regulatory pressures are making it harder and harder to maintain the services. It is essential that the Church asks the questions that the Report raises and goes on to find the most appropriate responses to the needs of older people, so that they and we are truly the People of God.

I would like to thank the Middlesex University team for their work on this report and to endorse the recommendations arising from the research. What is imperative now is that through the coordination provided by CSAN those with an interest and care for the future of the Churches' work in this all come together to learn from the findings and to plan how best to promote the social and pastoral needs of older people.

Right Rev Terence J Brain, Bishop of Salford and Chair of CSAN

ACKNOWLEDGEMENTS

We would like to thank all those people who participated in this research. We are especially grateful to those who took the time to complete the questionnaires, take part in focus groups and interviews.

As a research team we are particularly appreciative of all the support we received from CSAN, especially Philippa Gitlin and Lesley Versprille. We would also like to thank the CSAN trustees and members of the Older People's Forum for all their helpful feedback and suggestions.

We also wish to acknowledge the help we received from Terry Philpot at the start of the research process when he proved such a mine of information.

Introduction

This research conducted by the Social Policy Research Centre at Middlesex University was commissioned by Caritas Social Action Network (CSAN). The research commenced in February and was completed in July 2009.

The Catholic Church nationally is undertaking a huge amount of work to support older people (Community Care: The Challenge for the Catholic Church, 2000). However, much of this work goes on at local level, in parishes and deaneries across the country. It is difficult to quantify its true economic value. Nonetheless, there is evidence to suggest that this kind of support is of immense practical, emotional, social and spiritual value to many older people (Von Hugel Institute, 2009; Philpot, 2002; 2007). In addition, academic research indicates the importance of spiritual support for older people in residential care (Lowis, et al 2005). Official sources also indicate the high quality of care offered by many Catholic care providers (Commission for Social Care Inspection, 2008; 2009).

In an effort to uncover the range and diversity of provision for older people by the Catholic community in England and Wales, this research aimed to:

1. Use demographic projections to estimate the level and range of care required in the next 10 years.
2. Map the service provision of residential care and generate a data base which will be used by CSAN to produce a directory of Catholic Residential Care for older people.
3. Identify and highlight what is distinctive about Catholic care provision.
4. Highlight models of innovative and effective outreach and befriending projects to help shape the Church's care in the community.
5. Recommend ways in which Religious organisations could work more closely together to maximise the expertise and resources available for working with older people.
6. Recommend ways in which the laity can be enabled to work more effectively with older people at parish level

Structure of the Report:

In the next section we present an overview of the research methods used and the challenges faced in doing this piece of research. Chapter 2 analyses demographic data projecting future population trends. Chapter 3 presents a summary of the main issues and concerns discussed

in the relevant literature, including reports by academics, the voluntary sector and professional bodies. Chapter 4 summarises the responses from the questionnaires and analyses the results from the deans, residential homes and outreach projects. Chapter 5 is devoted to the qualitative data and presents the findings from the interviews and focus groups. Chapter 6 presents our conclusion and recommendations.

A data base of all the Catholic-run residential homes we have identified, including their contact details and summary of their service provision is published as a separate document.

Research Methods

In carrying out this research, the following methods were used:

1. Demographic Projections, in order to identify future population changes and needs we used the mid-year population estimates produced annually by the Office for National Statistics (ONS). Breaking these down by region also shows the differences across geographical location and thus helps to suggest where future provision may be most needed.

2. Literature Review, in order to analyse the current and future needs, gaps and debates in the service provision for older people we consulted a wide range of relevant sources.

3. Survey of provision at Deanery Level throughout England and Wales

Questionnaires were sent to all 262 Deaneries:

- a. to determine whether parishes and communities/lay groups in the deanery support older people through luncheon clubs, day centres or befriending.
- b. to identify Catholic run residential homes within each deanery
- c. identify examples of good practice
- d. investigate challenges and need for support

The intention was to expand the list of services and build a series of case studies as positive examples of what parishes and organisations across the country can achieve.

4. Questionnaires to Residential Homes run by Catholic communities, to map the level of provision, number of users, religion and ethnicity of users, costs of care, numbers of lay and religious staff, identify challenges and support needs.

5. Questionnaires to Religious Congregations, to assess the extent to which they provide care for older, retired religious, as ‘family members’.

6. Questionnaires to outreach and befriending projects identified by the Deans, to build up a fuller picture of the nature and extent of provision at local level.

7. Interviews and Focus groups with a selection of care providers including (see appendix):

- a. CSAN member agencies
- b. Catholic charities and religious institutions not yet affiliated
- c. Outreach and befriending projects
- d. Providers of residential care
- e. Domiciliary care providers
- f. Deans, priests and sisters working in different regions across England and Wales.

The Research Process

The Deans

A questionnaire, accompanied by a letter from CSAN explaining the aims of this study was sent to all Deans in England and Wales. However, the rate of response was low and so a reminder letter and additional copy of the questionnaire were sent to all those who had not replied. In an attempt to further increase the response rate, several Deans were telephoned. In the end only 76 Deans completed the questionnaire – a response rate of less than one third. The feedback from the phone calls and also from some of the Deans who returned the questionnaire was that they simply did not know about all the projects going on in their deaneries and it would be more useful to contact each parish individually. A survey of all parishes in England and Wales was beyond the scope of this research study. Instead it was decided to identify a range of outreach and befriending projects as a way of indicating the diversity of such provision

Residential Homes

There is no comprehensive list of Catholic residential homes. Some residential and nursing homes were listed in the Catholic Directory 2009. Further research was necessary to identify residential provision through the websites of each Deanery in England and Wales. This proved an extremely time consuming process. This information was complemented with an internet search in the following websites: www.carehome.co.uk, www.ucarewecare.com,

www.carehomesguide.com, www.housingcare.org, www.guide2care.com, www.careuk.net.

This produced information about the main service providers of care homes for older people. However, there was no indication of religion affiliation. Hence, additional research was required to identify which homes were run by Catholic organisations. This was achieved by searching websites or by telephoning each home individually.

In order to cover all the possible sources of information, the websites of all members of the Conference of Religious of England and Wales were searched. The Long Term Care Directory of Major Providers 2009 produced by Laing and Buisson was also a source of information as well as the Care Quality Commission (CQC). Catholic publications such as the Universe newspaper, were consulted in an effort to identify additional residential services which may have overlooked.

This data was then used to compile the data base of Catholic-run residential homes which is provided as a separate document. A key obstacle to identifying Catholic run homes is that many providers do not advertise themselves as 'Catholic homes', rather they tend to describe themselves as being run by a Catholic order or organization but open to, and respecting, all faith denominations. We return to this in more detail later in the report. Nonetheless, we are reasonably confident that by using the diverse searches outlined above we have managed to identify the vast majority of Catholic-run homes for older people in England and Wales.

We also aimed to identify care homes run exclusively for nuns and priest. A questionnaire was sent to the Conference of Religious which they agreed to distribute to all their members. However, only 12 responses were received. It was not possible to do any follow up on the non-responders because the Conference of Religious was not able to divulge the contact details of the various congregations.

The main obstacle in identifying homes for nuns and priests is the fact that most of them are not registered as care/nursing homes and thus are invisible to bodies such as CQC. Thus we were largely reliant upon the returned questionnaires to help us identify homes providing care to older religious men and women.

In general, the response rate to the questionnaires sent to residential care providers was disappointing. The first questionnaire was followed by a reminder letter and telephone calls.

The difficulty in getting the homes to return the questionnaire or complete it over the phone was discussed with CSAN. On CSAN advice a final letter from the Right Rev Terence J. Brain, Bishop of Salford, chair of CSAN, explaining the importance of this project was sent to non-responders. However, following this letter only 5 additional homes returned the questionnaire.

It is important also to note that several of the returned questionnaires were incomplete and failed to answer all the questions. For example, information on cost or the type of services provided was often not provided. In addition, several respondents did not answer the open ended questions on spiritual provision, the importance of Catholic identity in the quality of care and the role of CSAN.

When follow up telephone calls were made, the most common response was that the manager was the only person authorised to complete the questionnaire and 'was too busy' to deal with it at the moment. The few homes that agreed to be interviewed over the phone withheld information such as the weekly cost or the staff qualifications.

Outreach and Befriending

Identifying the big providers of outreach and befriending schemes was not a difficult task, their names are well known among the Catholic community. However, identifying small, local groups proved to be more difficult. As mentioned above, our research relied on the scarce information provided by the Deans, supplemented by internet searches and the Charity Commission. In total 50 of these organizations were identified with 28 completing the questionnaire.

Some small groups declined to complete the questionnaires because they perceived their activities were too informal and difficult to quantify and label. Some of the returned questionnaires were only partially completed which made it difficult to present an accurate panorama of the scope of this type of service provision for older people.

Qualitative Research: Interviews and focus groups

The original intention had been to undertake interviews and focus groups with a range of care providers. However, because of the paucity of information emerging from the questionnaires, the rich qualitative data derived from the interviews and focus group became even more important. Telephone interviews were carried out with care providers in the North-East, South-West and East of the country. In addition, face to face interviews were carried out with a diverse range of services in the London area. These included large organisations such as Saint Vincent de Paul, smaller projects such as Vincentian Care Plus, a residential home in West London run by the Poor Servants of the Mother of God, and a Dean in an ethnically diverse, inner city district.

The focus groups included large care providers such as the Fr Hudson Society, St John of God, The Sons of Divine Providence, the Little Sisters of the Poor, Caritas Care, Preston, as well as local and regional projects such Hallam Pastoral Centre, Huddersfield Deanery Project, St Joseph's Welfare Centre, Manchester, and Growing Old Grace-fully (Dioceses of Leeds and Hallam).

Although several groups said they were too busy to attend, we were very pleased that such important and innovative projects participated in the research,. Repeated attempts were made to contact several other care providers, congregations and local projects. Both the Middlesex research team and the office staff at CSAN made countless phone calls to no avail. Nonetheless, as the following chapters show, the data emerging from those who did participate is not only rich, but insightful, raising important issues for the further discussion and research.

Conclusion

It is important to consider the reasons for such a poor response rate despite all the various efforts taken to contact organisations and encourage their participation. Clearly, everyone was busy and smaller projects, in particular, were under-resourced, short staffed and lacked the time to complete the questionnaire. Others, such as the Deans, also lacked the information necessary to answer the questions.

However, the poor response rate may also reflect the fragmented nature of Catholic care providers and the absence of any overall coordination. Many providers are working in isolation and indeed, some do not regard themselves as part of a wider network of Catholic organisations. Despite the efforts of CSAN and the research team, they may not have fully appreciated the importance of participating in the research.

CHAPTER 2

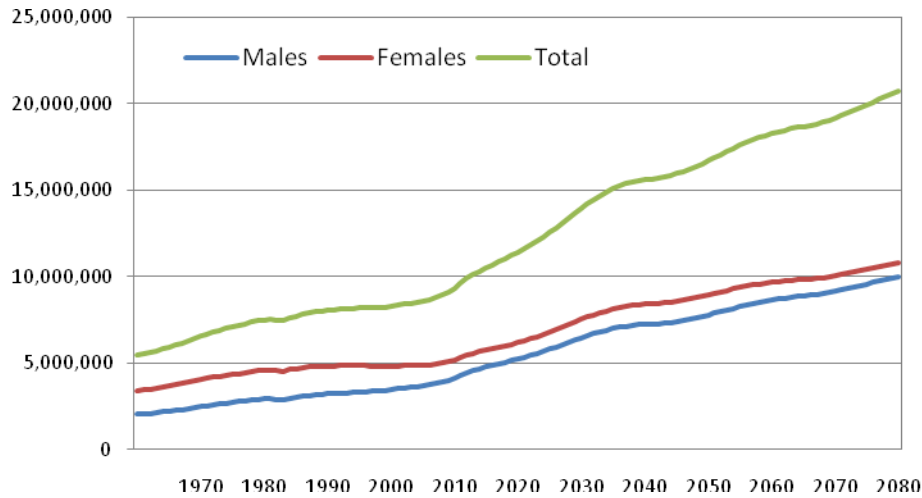
Older people in England and Wales: demographic trends and statistical profile

Population estimates and projections

The UK population is becoming older: over the last few decades, the proportion of people aged 65 and over has grown dramatically and is expected to further increase in the next 50 years. As the number of older people grows, information on the characteristics of this population become more important for policy makers and service providers. The main data source on the population's age structure are the mid-year population estimates produced annually by the Office for National Statistics (ONS). According to the estimates for England and Wales, in 1999 there were 8.3 million people aged 65 and over: 16% of the overall population. In 2009 they had grown to 8.9 million (16.4% of the population), more than a 7% increase. In 2007, for the first time, there were more people over pension age than under 16 (ONS 2008c). This dramatic change in the numerical relationship between age groups is the result of a combination of factors: the post-War 'baby boomers' now reaching pension age, low fertility rates from the mid 1970s, and an increasing life expectancy for both men and women (Blake 2009).

In terms of future trends, the ONS produces national projections every two years, the latest available being based on the 2006 mid-year population estimates. The main focus of these projections is on the period up to 2031. Longer-term data – up to 2081 – are also available, but are highly uncertain, in particular for sub-national areas. Over the next 10 years the population over 65 is projected to grow by a further 25%, reaching 11.1 million in 2019. The 'elderly support ratio' – the proportion between people in working age and pensionable age in the UK – is projected to fall from 3.35 in 2002 to 3.10 in 2011 and 2.53 in 2031. This trend is also affected by the rise in the state pension age for women in the 2010s (Wittenberg et al., 2004).

England and Wales – Estimated and projected population aged 65+

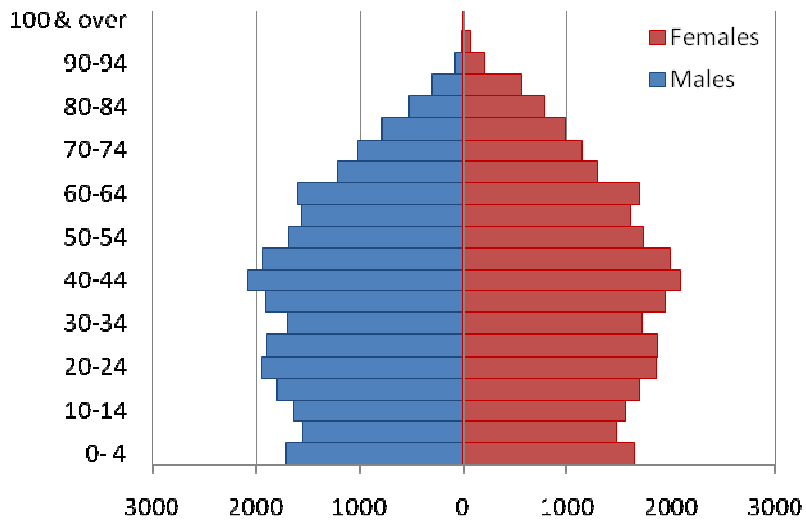


Data source: ONS population estimates and projections (2006-based)

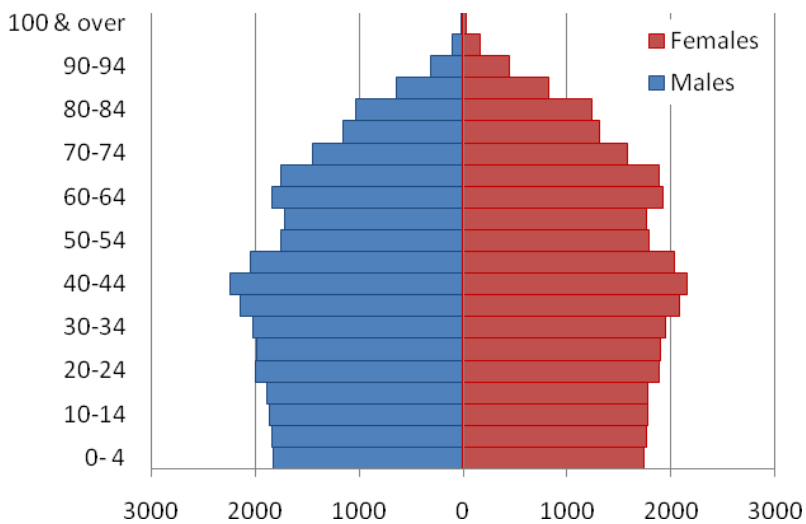
Until recently, broad age groups – such as the ‘65 years old and over’ used above – have traditionally been adopted to describe the characteristics of the population of older age. This is because historically they represented a small proportion of the population and so estimates by finer age groups would have been unreliable (Dini and Goldring 2008). However, with the aging of the population, official statistics have started looking at age in a more analytical way. In particular, recent ONS studies have used the ‘85 years old and over’ category to look at the characteristics of the ‘oldest old’, which represent the fastest growing age group in the country (Blake 2009). In 1969 only 0.8% of the population of England and Wales were aged 85 or more, 40 years later they were about 1.2 million (2.2%). The official projections show this trend is likely to continue and by 2031 there will be around 2.5 million ‘oldest old’, 4% of the population. This rapid growth is mainly due to increased survival rates at older ages: the average life expectancy at birth in 2005/7 had reached 77.2 years for males and 81.5 for women (ONS 2008a).

The gap between male and female life expectancy has been narrowing significantly in the last few decades and it is expected to further decrease in the future, with a clear effect on the gender balance at older ages. In 1982 there were 155 women aged 65 and over for every 100 men of the same age. The projection for 2032 is 120 women for every 100 men aged over 65 and 140 women for every 100 men aged over 85 (Dunnell 2008).

England and Wales – Population pyramid 2009 (estimate, in thousands)



England and Wales - Population pyramid 2030 (projection, in thousands)



Data Source: ONS 2006-mid year based population projections

England and Wales - Estimated and projected population aged 65+ by gender (in thousands)

	2006		2009		2020		2031	
	Male	Female	Male	Female	Male	Female	Male	Female
65-69	1,146	1,231	1,213	1,295	1,387	1,489	1,751	1,884
70-74	965	1,102	1,020	1,144	1,396	1,541	1,451	1,587
75-79	760	983	785	978	1,004	1,151	1,153	1,318
80-84	507	796	533	780	720	896	1,029	1,244
85-89	248	492	295	551	427	599	644	831
90-94	80	219	84	205	181	306	317	450
95-99	14	59	18	63	45	97	107	169
100+	1	8	2	9	5	14	19	34
All 65+	3,722	4,889	3,950	5,027	5,166	6,094	6,470	7,516
% 65+	14.1%	17.9%	14.6%	18.0%	17.5%	20.3%	20.4%	23.4%

Data source: ONS population estimates and projections (2006-based)

Regional variations

The age composition of the UK population is characterised by large variations at subnational level. According to the ONS estimates, the Local Authorities with the highest percentage of population aged 65 and over in 2007 were Christchurch (29.6%), West Somerset (28.2%), Rother (28.0%), North Norfolk (26.9%) and East Devon (26.6%). In most cases the proportion over 65 is expected to reach or go beyond 32% by 2017. These areas are located on the south and east coast of England, reflecting retirement migration to coastal areas (Uren and Goldring, 2007). Many local authorities with the highest projected change in population aged 65 and over are located in Middle England (e.g. East Northamptonshire +52.6%, South Northamptonshire +50%). In several of these areas the population ageing would be a reflection of past times of rapid development, with large inflows of families, followed by a significant number of children leaving the family household to migrate to city areas with the presence of higher education institutions (Blake 2009). This is one of the reasons why London represents a major national exception, with 11 local authorities which are projected to experience decline in the number of older people in the next few years.

UK - Percentage population aged 65 and over, by region

	1997	2007	2017	1997- 2007 % change
England	15.9	16.0	18.2	14.5
North East	16.1	16.9	19.6	21.7
North West	15.9	16.2	18.6	17.0
Yorkshire and the Humber	16.0	16.0	18.0	12.5
East Midlands	16.0	16.3	19.2	20.0
West Midlands	15.7	16.4	19.0	21.0
East of England	16.2	16.8	19.6	21.0
London	13.1	11.7	11.8	-9.9
South East	16.4	16.6	19.3	17.7
South West	18.7	18.8	21.8	16.6
Wales	17.4	17.8	21.2	21.8
Scotland	15.5	16.4	19.5	25.8
Northern Ireland	13.0	13.8	16.5	26.9
United Kingdom	15.9	16.0	18.4	15.7

Data source: Blake 2009 (ONS mid year population estimates and 2006-based projections)

Ethnicity and Religion: an increasing diversity

The older population of England and Wales is also becoming increasingly diverse in terms of ethnic composition. However, data on age and ethnicity are still very limited and existing figures are still at ‘experimental’ level (ONS 2008e). In 2005, White Irish and Black Caribbean were the ethnic minority groups in England with the highest proportion of people aged 65 and over. This reflected the large number of young migrants who arrived in the country in the 1950s. In the near future, the number of elderly people from most ethnic minority groups, including Pakistani, Bangladeshi and Chinese, is expected to grow significantly, reflecting migration waves in the 1970s and 1980s (Dunnell 2008). This will have an effect on community life and issues of service provision. Research has shown that there are major differences in access to material resources at older ages, both between and within ethnic groups (Evandrou, 2000).

England - Population by ethnic group and age, 2005 (percentages)

	Under 16	16–64	65 and over	All people (thousands)
White				
White British	19	64	17	42,753
White Irish	6	65	29	592
Other White	13	78	9	1,623
Mixed	46	51	3	791
Asian or Asian British				
Indian	19	74	7	1,215
Pakistani	32	64	5	826
Bangladeshi	34	62	4	324
Other Asian	21	74	5	310
Black or Black British				
Black Caribbean	18	69	13	590
Black African	26	72	3	659
Other Black	35	62	4	110
Chinese	13	82	4	347
Other ethnic group	15	82	3	325
All ethnic groups	19	65	16	50,466

Source: Office for National Statistics, Social Trends 38 (Experimental Statistics)

Data on age and religious affiliation are even scarcer. The only reliable source – the Census 2001 – provides some information about the religion of pensioners-only households. In Britain, among the household identified as Christian, 17% are pensioners living alone, the proportion is 19% among Jewish and only 2% among Muslims (ONS 2006). These data is also likely to change significantly in parallel to the aging of ethnic minority groups.

Great Britain - Pensioners Households by Religion, 2001

Religion	One pensioner household	All pensioners families
Christian	17	10
Buddhist	5	2
Hindu	3	3
Jewish	19	12
Muslim	2	1
Sikh	4	3
Other religions	8	4
No religion	4	3
Religion non stated	17	8
All households	14	30

Source: ONS 2006 (Census 2001)

Health and Social Conditions

Although the UK population is living longer, not all the time gained is made up of happy years lived in good health. The most recent statistics show that ‘Healthy Life Expectancy’ – i.e. years of life spent in ‘good health’ – is usually much lower than life expectancy overall. Boys born in 2006 could expect to live healthily and without any disability until the age of 62, but on average would spend 8.7 years of their life in poor health and 14.5 years with a disability. For girls the periods spent in poor health and with disability are even longer: 10.9 and 17.4 years respectively. In other words the gap in healthy life expectancy between man and women is smaller than for the total life expectancy: women live longer, but are not healthy for much longer.

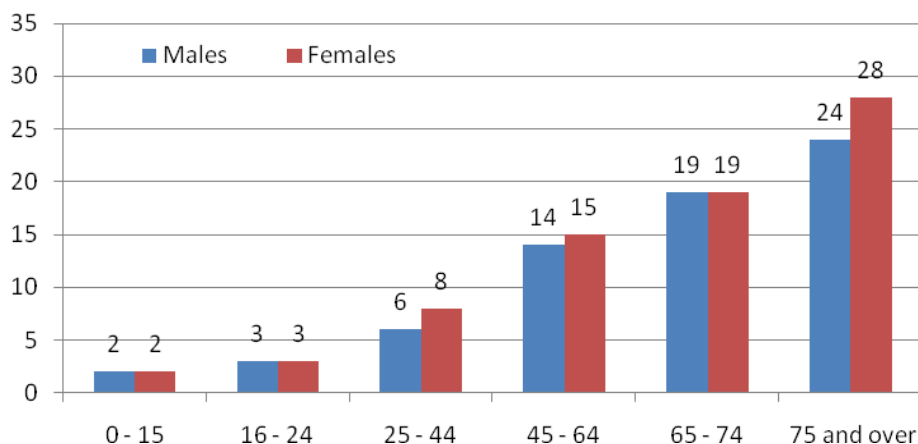
UK - Healthy life and disability-free life expectancy, by sex, 2004–06

	Males		Females	
	At birth	At age 65	At birth	At age 65
Life expectancy	76.9	16.9	81.3	19.7
Healthy life expectancy	68.2	12.8	70.4	14.5
Years spent in poor health	8.7	4.1	10.9	5.2
Disability-free life expectancy	62.4	10.1	63.9	10.6
Years spent with disability	14.5	6.8	17.4	9.1

Source: Office for National Statistics 2009 (Social Trends 39)

Recent results of the General Household Survey confirm this scenario: 24% of men and 28% of women aged 75 and over consider their health to be poor – the figure is the same (19%) for men and women aged 65 to 74. This is particularly so among minority ethnic groups.

Great Britain - Percentage of people with self reported non-good health, 2006



Source: *General Household Survey (Longitudinal)*, Office for National Statistics

One of the most common health issues affecting the old and very old is dementia. The Alzheimer's Society (quoted in ONS 2009) reported that one in 14 people aged 65 and over and one in 6 people aged 80 and over has a form of dementia. The estimated overall cost of care provided to support people aged 65 and over with late onset dementia in 2005/2006 was around £ 17 billion. Of this, 41% was accounted for by supported accommodation (including residential homes) and 36% by informal care.

Poor health conditions, together with a number of other factors, are strongly associated with social isolation, exclusion and depression. A recent IPPR study (Allen 2008) highlighted that life in the over 80 age group is often marked by increased depression. This seems to disprove a well established idea that life satisfaction reaches its lowest point in the mid 40s, after which it starts improving for the rest of one's life. In reality, breaking down the 65+ group into finer categories suggests increasing life dissatisfaction after the 80th year of age (ibid.).

Even amongst the increasing number of older people who are relatively healthy and wealthy, a significant proportion struggles with loneliness and isolation. A 2006 report based on the English Longitudinal Study of Ageing (Barnes et al. 2006) highlighted that around a half of older people suffer from at least one of the dimensions of Social Exclusion (these include social relationships, leisure activities, civic activities, access to services, neighbourhood, finance, material goods) and 20% of them were affected by a combination of two or more dimensions. Being among the 'oldest old' and living alone are among the main key characteristics strongly related to an older person experiencing multiple exclusions.

Living arrangements and care

The ageing of population in England and Wales poses major challenges in terms of caring and financing care for older people. The latest Census showed that most of people live 'in the community' well into later life. In fact, around three quarters of those aged 90 and over were still living in private households. This is made possible by unpaid (informal) care by the family supported at least in theory by investment at local authority level. The volume of home help hours provided or purchased by local authorities in England has increased significantly over the past two decades, with an estimated 3.4 million contact hours provided in 2004 against the 2.2 million hours of 1994 (ONS 2005a). However, the actual number of households receiving council funded home care services has fallen consistently since 1994. This suggests that local authorities are providing more intensive services for a smaller number of people.

Care provided at community level is predominantly supplied by family members. In 2001, almost 80% of all older people with mobility problems were helped by their spouse or other relatives. As well as receiving care, older people are also major providers of care. In 2001, 1.2 million men and 1.6 million women aged 50 and over were providing unpaid care to family members or neighbours in England and Wales. In other words, about one older person out of every 6 is a care provider; of these, around a quarter provide 50 or more hours of unpaid care a week. However, the proportion of older carers declines with age: 25% of women aged 50-54 provided care compared with 20% of those aged 60-64 and 3% of those aged 85 and over.

The number of people living in residential care or medical establishments is lower but nonetheless highly significant, in particular among the oldest old, and with major differences between men and women. According to the Census, less than 1% of men aged below 75 were living in medical and care establishment, but the proportion grows to 2.5% among those aged 75-84, to 8% for those aged 85-89, and reaches 17% for the over 90. Among women, the proportion of those living in care establishments is 4.3% for the 75-84 age group, 14.3% for the 85-89 and almost 30% for those aged 90 and over. Among the oldest old living in care establishments, the majority live in private or voluntary nursing or residential care homes.

England and Wales – Percentage of people aged 50 and over living in medical and care establishments, by age and sex, 2001

	50–59	60–64	65–74	75–84	85–89	90 and over
Men						
All medical & care establishments	0.3	0.4	0.7	2.5	8.0	16.9
NHS ¹	0.1	0.1	0.1	0.1	0.2	0.3
Local authority	-	-	0.1	0.3	0.9	1.7
Nursing home	0.0	0.0	0.0	-	-	0.1
Residential care home	-	-	0.1	0.3	0.8	1.6
Other ²	-	0.0	-	-	-	0.0
Housing association ³	-	-	-	0.1	0.1	0.3
Private & voluntary	0.3	0.3	0.7	2.4	7.8	16.6
Nursing home	0.1	0.1	0.3	1.1	3.2	6.2
Residential care home	0.1	0.2	0.3	0.9	3.4	8.1
Other ⁴	0.1	0.1	0.1	0.4	1.2	2.3
Women						
All medical & care establishments	0.2	0.3	0.8	4.3	14.3	29.4
NHS ¹	-	-	0.1	0.1	0.3	0.4
Local authority	-	-	0.1	0.5	1.5	3.1
Nursing home	0.0	0.0	0.0	-	0.1	0.1
Residential care home	-	0.0	0.1	0.4	1.4	2.9
Other ²	0.0	-	-	-	-	-
Housing association ³	-	-	-	0.1	0.2	0.5
Private & voluntary	0.2	0.3	0.7	3.6	12.3	25.4
Nursing home	0.1	0.1	0.3	1.6	5.1	10.3
Residential care home	0.1	0.1	0.3	1.9	6.9	14.6
Other ⁴	-	-	-	0.1	0.3	0.5

1 Psychiatric hospital/home, other hospital home.

2 Other local authority home.

3 Housing association home or hostel.

4 Private/voluntary psychiatric hospital/home, medical and care home, hospital.

Source: ONS 2005b (Census 2001)

Latest NHS data (NHS 2008) on residential and nursing care placements funded by local authorities in England indicate that among the 236,100 supported residents in registered accommodation, 77% were aged 65 and over (182,200) and 42% were aged 85 and over (99,400). More than half (58%) of the supported residents in registered accommodation aged 65 and over were in independent residential care homes and 14% were placed outside their original local authority. However, the number of elderly people residents in registered accommodation has fallen by 14% between 2004 and 2008. Councils report that this relates to the national policy to support more people to live independently in their own homes.

CHAPTER 3

Older People and care: policy and future challenges

Recurrent themes in policy

From the 1970s there has been a major shift to deinstitutionalise care for different groups of people including those who are elderly. One of the main reforms of care for older people from the 1980s onwards was the widespread relocation of older people from hospitals to nursing homes in an expanding private sector (Glasby 2007). The Community Care Act (1990) introduced a contract culture around arrangements for continuing care and was arguably the greatest drive towards care “by” and “in” the community with residential and home care provided predominantly through the independent sector. Concern for the cost and ostensibly the quality of care and dignity of older people led to the *Royal Commission on Long Term Care* (Sutherland 1999), *the National Care Standards Commission, the Care Standards Act (2000)* and subsequently *National Minimum Standards* for provision of care and the Commission for Social Care Inspection.

Within the series of reforms that started in the early 1990s perhaps two had a major impact on the scope of the provision of residential and care services for older people: the shift of the social security budget for residential care to local authorities (NHS and Community Care Act, 1990) and the introduction of the National Minimum Standards (National Care Standard Commission, 2000)

According to Philpot, the aim behind giving local authorities the power to control the budget for residential care was to ‘create packages of care to suit the individual needs of older people and also to create a level playing field between the private and the public sectors’ (Philpot, 2002a). However, the ultimate result was the creation of an assessment system whereby local authorities determine whether the old person was in real need of residential care and how much the local authority would pay for this person’s place in a home. Therefore, financial assistance by the local authority was now based not only on the person’s care needs but also a means tested assessment of his/her financial situation (for instance, home owners having to pay the full cost of accommodation)¹. The criteria to qualify for assistance with the cost of

¹ The White Paper published in 2006 (Department of Health) emphasised the idea that residential care is a social service and that as such is not free and that ‘where needs are greater than friends and family can cope public

residential care is so high that many elderly home-owners are faced with selling their homes, spending life savings or staying at home facing isolation or the risk of accidents. According to Counsel and Care, 'only those older people with the highest dependency needs, without any available support and on low incomes, will get council services...eligibility criteria remains rigid and dehumanising, penalising rather than encouraging good health and well-being and maintaining independence' (Counsel and Care, 2008)

Besides, the fees that local authorities agreed to pay were in most cases far below the actual cost of residential and care provision meaning that top-ups had to be paid by relatives or by the older people themselves. On the one hand, this has led some care providers to target self-funded residents (in 2005 almost 30% of places were occupied by self-funded resident) and, on the other hand, in some cases being unable to profit from service provided (Philpot, 2002a).

Thus, the reforms have also opened up a 'market' of residential services provision which may well come to be dominated by a small number of very large providers. As Wanless states, 'homes providing care for older people are becoming larger...with the market changing and becoming more concentrated with fewer, larger homes' (2006:23). Small home-owners and non-for-profit organizations are being badly affected by these reforms, putting at risk the future of small care providers or those operating in the voluntary sector.

In addition, the most vulnerable part of the residential sector has been hit by the introduction of the New Minimum Standards². However appropriate, this required providers to allocate a big portion of their budget to bring the homes up to the new standards; for already struggling small and not-for-profit home owners this proved too much to bear and home closures increased considerably. Wanless established that by 2007 the number of places in residential homes had decreased by two thousand (2006: 22). In 2002, the Department of Health announced that minimum standards will be replaced by guidance on good practice. Local

resources get to those who need the most help and who cannot afford to pay for extra support themselves' (In Wanless, 2006:20)

² 'The National Minimum Standards are the product of the 1998 Modernising Social Services White Paper. The NMS are not legally enforceable but are guidelines for providers, commissioners and users to judge the quality of a service. Inspectors must take them into account when judging whether providers are compliant with regulations.' (Community Care, 2008:2)

authorities may now choose the lower standard for reasons of cost, causing empty places in the homes that went ahead with the improvements required by the standards commission.

New Direction: Domiciliary and Community Care

Derek Wanless was commissioned by the Treasury to review the health care system. The brief was to examine technological, demographic and medical change over the two subsequent decades and to identify factors which would determine the financial resources required to inform fiscal and economic decisions. The report, *Securing our future health : taking a long term view (2002)* demonstrated clear evidence that the future would bring greater pressure on social rather than health care. It identified the need for investment in neglected areas as well as establishing a balance between health and social care and using resources more effectively. The introduction of National Minimum Care Standards, National Service Frameworks (NSF), National Institute of Clinical Health and Excellence (NICE) guidelines were all part of the drive towards efficiency.

Securing good care for older people: taking a long term view (Wanless 2006) was undertaken with similar objectives to the earlier review, but with a focus on older people and the funding of care for this group. The review identified shortcomings in the social care system, poorly delivered services and limited funding. It identified greater expectations among older people and more focus on staying at home and being cared for at home or close to home, with respite, day care and social work to improve outcomes. There was evidence that early care in the community could reduce and delay the need for intensive services. However this contrasted with local authority practice of increasingly shifting towards more intensive provision for fewer clients.

As a consequence, since the beginning of this decade policies on services for older people have seen a new direction focusing now on the belief that people prefer to remain at home for as long as they can. This position developed into a new form of support system that 'is fit for the 21st Century: a system that is personalised to individual needs and gives real control to those needing care and their carers...that gives people who would benefit from it access to care in the home' (HM Government, 2008:4). The emphasis was therefore to increase the 'proportion of older people receiving help to maintain a high quality of life independently at home rather than in a residential care' (Department of Health, 2006). This shift in the policy

has required developing innovative forms of support that can eventually replace or delay entering a care home; schemes such as day centres, respite care, meals-on-wheels, intermediate care or extra care housing (also known as very sheltered housing or assisted living) are considered the best way of preventing the causes that lead older people to residential homes and also to deliver the best outcome within already constrained resources (Wanless, 2006).

However, many older people are not getting personal care services or benefits which enable them to stay in their own homes (CSCI 2008). The number of hours of intensive support has risen although the number of people receiving this care has remained stable despite a growing volume of older people and rising levels of dependency (CSCI 2008). Those who are lost to the system because they are not eligible and cannot afford to pay for personal care struggle with fragile informal care and experience a poor quality of life.

While the thrust of care policy for older people for the last two decades was about keeping them in their own homes as long as possible, the need for nursing home or residential care for frail and vulnerable people especially those without family support is acknowledged (Help the Aged, 2004). As mentioned earlier, the number of residential beds has fallen following the introduction of various legislations, national minimum standards and especially the restriction on funding at local authority level. Although institutional care is often a last resort, there is evidence that the criteria for funded care have become higher and higher to fit in with local authority budgets (CSCI 2009). There is still considerable debate between health and social care professionals about the boundary between healthcare which is free at point of delivery and means-tested social care (Glasby, 2007). Therefore budget conscious professionals argue about who should pay for older peoples' care, which results in some vulnerable elders falling through the policy net. Moreover, the array of means testing and support entitlements are unwieldy and bureaucratic. Contrary to assumptions that the more affluent have fewer problems, CSCI (2009) argue that those who have to fund their own care are particularly disadvantaged by a lack of advice and information about care options and are often invisible to local councils.

The Catholic Church and the provision of services for older people.

Information regarding services provided by the Catholic community to older people is very limited. The only studies known were commissioned by Catholic bodies themselves

interested in highlighting not only its contribution to the sector but also the way in which the provision of services, especially residential care, has been affected by government policies and legislation and future challenges.

Documents such as 'Community Care: the Challenge for the Catholic Church' (2000), 'On the Homes Front: the Catholic Church and Residential Care for Older People' (2002), 'Length of Days: How can the Church meet the challenges of an ageing society?' (2007) and 'A Case for Change: The Response' (2008), recount the history of Catholic Church provision for older people in England and Wales. They all agree that the 1990s "market" reforms left the not-for-profit and voluntary sector unable to handle the increasing costs of implementing regulations and the New Minimum Standards.

In fact, Philpot (2002) argues that following the introduction of this regulation 'residential care provided by religious congregations started closing at an increased rate during the 1990s. However, this was not just to do with the cost of renovating homes to meet the new standards, but having to recruit lay people to meet the requirement for qualified staff which demanded a minimum of 50% trained to NVQ level 2³. Some Catholic homes charging an average of £150 below market rate per week per person and were therefore unable to generate sufficient profit (CSAN, 2008). Having to invest in improving homes and hiring qualified staff has left the Catholic sector in a difficult situation and in competition with 'corporate and larger owners that have become the dominant segment in the market' (Philpot, 2007).

However, behind this panorama lies the important financial and human contribution of the Catholic community. Not only does it offer the capital resources, such as property, but also the unseen contribution made through unpaid hours of voluntary service by members of the religious congregations in residential homes as well as in domiciliary care (CASC, 2000), a point to which we will return in more detail later in this report. In this regard, there has been inadequate recognition that the strength of local churches lies in their buildings and land and their access to volunteers. Local congregations might explore the use of buildings for

³ Laing (2008) states that care staffing is the single most important determinant of care home costs due to the increase in the level of dependency that residents have when entering a care home. The decline in the number of vocations has contributed to the increase of the cost of services provided having to be forced to hire also non-qualified staff to meet increased the hours needed to look after each resident. From 2004 to 2008 the in-pur of hours has increased from 19.5 to 20.5 hours per person.

luncheon clubs, day centres for drop-ins, or simply the provision of a day programme of activities for lonely older people or those with mental health problems (CASC, 2000).

New Challenges and the Future of Service Provision by the Catholic Community

In 2004 a study from the Joseph Rowntree Foundation (Wittenberg et al. 2004) calculated that, in order to keep pace with the ageing of the UK population, the number of places in residential care homes, nursing homes and hospitals would need to rise from around 450,000 in 2000 to around 1,130,000 in 2051: a 150% increase. The number of home care hours would also need to increase, from around 2 million to almost 5 million a week: an increase of around 137%. These projections are based on the assumption of existing life expectancy, dependency rates, patterns of care and funding arrangements and are extremely sensitive to any 'systemic' change in this respect. In terms of overall long-term spending, this would need to increase from about 1.4% of GDP in 2000 to around 1.8% of GDP in 2051. This calculation is based on a forecast real GDP increase of 2.25% a year, i.e. on the assumption of an expanding economy. The effects of a sustained economic crisis would be extremely difficult to forecast.

The challenges faced by the Catholic community in the provision of care for older people not only relate to the increasing costs of keeping care homes open or the decreasing number of vocations that will eventually offer their services at low cost but also to the ability to keep up with a market orientated culture that requires profits to be reinvested in services and the ability explore new options and diversify the scope of the services provided.

As mentioned earlier, government policies are orientated towards keeping older people at home as long as possible. Initiatives such as domiciliary care, intermediate, day and respite care as well as outreach and befriending schemes are needed to make this feasible in the long term. The Catholic community has already begun to address this transformation and has seen an increase in the number of older people being reached and cared for at home. It is important to mention the invaluable work that Catholic organizations such as Saint Vincent de Paul, The Union of Catholic Mothers and The Catholic Women League, among others provide for elderly people who live at home. Such provision will be considered in more detail elsewhere in this report.

Given the demographic shift and the projections that, residential and nursing home places in the UK would need to expand by around 150% over the next 50 years, there is considerable scope for residential care by Catholic communities. However, according to Philpot (2007) 're-inventing themselves as places of specialist provision like, for example, for dementia care and end-of-life-care' or entering the growing market of sheltered (extra-care) housing" is required if they are to succeed. Besides, the Catholic community has to seek the help of charitable organizations that 'are set up to retain the founding ethos of charitable hospitals and nursing homes while ensuring that they can also develop the services needed to keep up pace with modern practice' (CASC, 2000).

Needs of Black and Minority Ethnic elders and carers

As noted in the previous chapter, there are increasing numbers of older people from a variety of minority ethnic groups in Britain today (ONS 2001) and as they become frail require support and care in home and residential settings. There is still a tendency to assume that the family can and will care for them when they are frail or ill, but there is a growing body of evidence of the difficulties experienced across all groups. There is limited evidence of the benefits of separate services for specific ethnic groups, but it is clear they have specific preferences and wishes (Mold et al 2005). While there may be reluctance to access mainstream services, there is some evidence that when services are cultural and religiously sensitive people are more willing to access them (Jewson, et al 2003).

Cultural sensitivity training tends to focus on caring for people from other cultures but rarely addresses the fact that care providers in Britain rely on minority ethnic staff and migrant workers (Ciangiano et al, 2009). This raises questions about language, cultural and religious sensitivity as well as the reality that such staff are unaware of the traditions, customs and expectations of older people from indigenous backgrounds. It is important that work is done to overcome the cultural and linguistic barriers, stereotypes and assumptions that may divide care workers and older people. This is not simply a matter of ensuring that migrant care workers receive adequate language training but also that local dialects, colloquialisms and the euphemisms used by older people, especially to describe bodily functions, are clearly understood. The exploitation of migrant care workers, particularly those working in the private care sector, (Cangiano, et al, 2009) and racism against them are major causes of concern (Doyle M, and Timonen V 2009).

Rising numbers with dementia

It is estimated that around 700,000 people experience dementia and that the numbers are forecast to increase by almost a million over the next 15 years (PSSRU 2007). Historically there has been a lack of attention by policy makers and service providers but dementia must now become a priority for health and social care commissioners and providers (PSSRU 2007). The extent of support for patients and family in their own homes and communities must be expanded. More energy needs to be invested in statutory, voluntary and private partnerships to develop a range of integrated, comprehensive quality models for the future (PSSRU 2007). The National Dementia Strategy (DH 2009) highlights the need for innovative models of care which include sheltered housing, extra care, and respite for carers. Healthcare literature suggests that spiritual care is as important as physical and psychological interventions. According to Bephage (2009), by identifying a person's spiritual needs healthcare staff are able to positively contribute to a person's wellbeing while in care.

Spirituality and Catholic Services

Within the very practical approach to care for older people the topic of spiritual provision is often overlooked. As CASC (2000) argues, there is a growing awareness of the need for 'culturally specific care; that is, care in a setting which is familiar to the older person and he or she can be confident that their wishes will be respected'. The role that the Catholic community can play in this aspect is to ensure that, as well as continuing to provide practical support, the emotional and spiritual needs of older people are also taken into account. The Catholic care ethos based on dignity and the respect for life give confidence to older people that they will be treated appropriately.

Moreover, it has been recognised that 'spiritual beliefs and, in particular, religious association in care homes give elderly people a balance between their internal selves and their environment' (Lowis et al, 2005). It is also known that having the opportunity to express their beliefs and being immersed in a setting that offers the opportunity to practice religious activities can have a positive control over health matters; according to Lowis, 'practicing religious activities might even be associated with a longer survival of up to 7 years'.

Catholic homes and befriending schemes also contribute greatly to tackling one of the major problems that older people face, i.e. social exclusion and isolation. Care homes run by Catholic congregations are in close contact with parishes and the local community providing the opportunity to older people to maintain the relationships and activities that they had before entering the homes. Some of the homes that have a chapel often welcome the local community to mass and services. Spiritual care can also be important in enabling people to prepare for the end of life.

End of life issues

The end of life is increasingly more complex as people are living longer, albeit with greater frailty and multiple health conditions. Concerns about the end of life and debates about euthanasia and assisted dying have resulted in a growing body of literature, strategic policy and good practice guides in the last three years (DH 2008, BGS 2009, NAO 2008, GSF 2009). There is research evidence that the wishes of older people are not well catered for and although most would wish to die at home, there is a lack of skilled services to enable this (NAO 2008). Although some 70% of deaths of older people take place in care homes and 27% in hospital, there is a lack of formal or compulsory training in end of life care especially in care homes (NAO 2008). The majority of care homes have a policy about death but few have policies around anticipated prescribing, advanced care planning, how to talk to patients or relatives about death and dying issues. Although there are a growing number of specific training programmes, good practice guides available to enhance the quality of end of life provision for older people, there is as yet little evidence that they are used as widely as is needed (BGS 2009, DH 2008, GSF 2009).

Facing Future Challenges

The aim of this research is to map the care provided for older people by Catholic organisations. Through document analyses, questionnaires, interviews and focus groups we have endeavoured to capture the range of that provision. Although our findings cannot claim to be exhaustive and all encompassing, they do provide a snapshot of the diversity of projects, agencies, organisations and services offering care along a spectrum from residential to semi-independent living, to respite, outreach and befriending. The people we spoke to in the course of this research address in depth many of the issues we have briefly raised in this

short review of the literature. In the following chapters we explore the difficulties facing Catholic care providers and the various strategies they are adopting to meet and overcome these challenges.

CHAPTER 4

SERVICE PROVISION: RESULTS FROM THE SURVEY

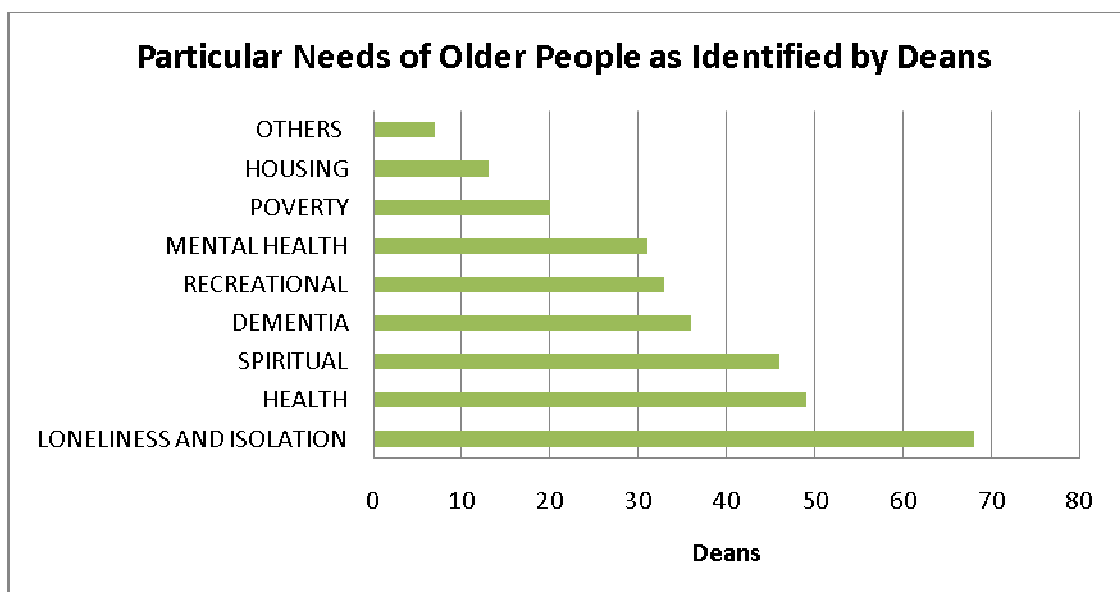
Information Obtained from Deans in England and Wales

Questionnaires were sent by post or email to 262 Deans across England and Wales. The aim of this questionnaire was to identify the proportion of older people in each deanery, the main needs faced by this sector of the population and the how those needs were being served by different groups and organisations in each area. As mentioned in the research methods section, the response rate was disappointing despite our various efforts to remind the Deans to reply. The results presented in this section are drawn from the information provided by the 76 Deans that completed the questionnaire.

Dean's estimates of older people their Deaneries

Deans were asked to estimate the proportion of older people in their area. Out of the 76 responses, almost half estimated that older people made up more than 50% of their parishioners. Five Deans estimated that older people represented more than three quarters of parishioners. The consequences of an ageing population, and indeed an ageing Church will be discussed in more detail in the next chapter. As noted in Chapter 2, the age profile varies across geographical locations, some parishes and deaneries particularly in urban areas contain large numbers of young families.

Table 1: Particular Needs of Older People as Identified by Deans



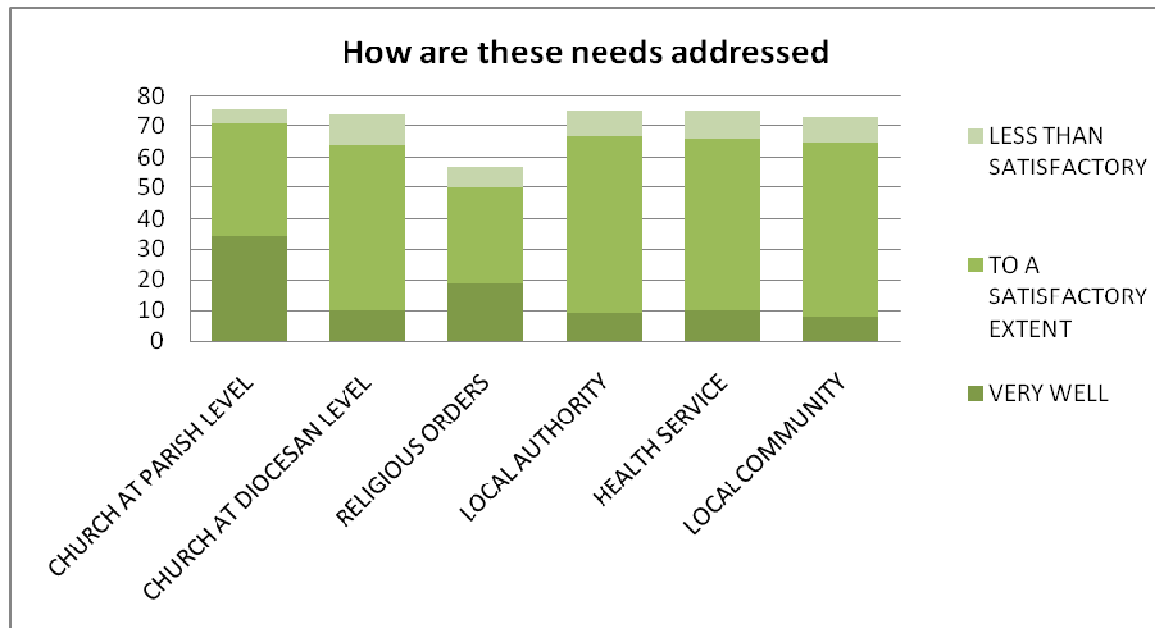
Note: Respondents could tick more than one box.

Deans were asked to identify the particular needs affecting older people in their area. As the graph above illustrates, the majority of Deans identified loneliness and isolation as the main problem facing older people. There is substantive evidence that older people experience multiple forms of exclusion, for instance, fear of crime, poor transport and changing communities contribute to social isolation for older people and their carers even when they have spent a lifetime in a locality (SEU 2005).

Physical health was the next problem identified by the Deans. Concerns about the poor health of older people in the community could be explained by the increasing number of older people with moderate health issues that do not fit the strict criteria set by the authorities for support (CASC, 2000). Spiritual needs were also highlighted by the Deans and these will be discussed in more detail in the next chapter.

Issues such as dementia and mental health are also cause for growing concern. In addition to research which suggests that dementia is increasingly affecting the older population, depression and poor emotional wellbeing are also increasing among older people: 'The National Services Framework for Older People suggests that under-detection of mental illness in older people is widespread, due to the nature of the symptoms and the fact that many older people live alone' (Allen, 2008).

Relative to other issues, poverty and housing appear not to be major causes of concern. As Philpot (2002) notes, the Catholic population in England and Wales has seen its living standards increasing over the years and becoming more 'middle class' 'benefiting from the greater post-war prosperity and from the spread of home ownership'. While it may well be true that some sections of the Catholic population have become more middle class, it has also been noted by some of our participants that financial worries are an increasing problem among the older population. As we discuss in the next chapter, the older generation may be reluctant to talk about their financial problems.

Table 2: How are these needs addressed?

The majority of the Deans indicated that the needs of older people are being addressed by the Catholic community and the public sector ‘to a satisfactory extent’. However, Deans also recognised that more could be done but, as it will be further explained in the next chapter, issues such as lack of funding and falling religious vocations could constrain the provision of services for older people reaching an optimum level.

Services for Older People by the Catholic Community

The questionnaire also asked Deans to estimate the number of services for older people offered in each deanery. As mentioned in the earlier Research Methods section, it proved impossible to map the range of services provided by Catholic organisations throughout England and Wales. It was hoped that Deans could help by identifying various projects within their deaneries. However, the low response rate meant that we could only locate a fraction of the community and outreach services on offer. Most Deans reported a number of befriending and outreach schemes (53 responses), luncheon (39 responses) and social clubs (43 responses) in their areas. There were fewer responses on residential homes (20), respite care (7), drop-in centres (8) and day care centres (8). These responses, however, are not an accurate reflection of provision as several Deans noted that they were not aware of the full extent of projects, services and organisations operating within their areas.

Many Catholic-run services that were identified clearly aim to address problems such as loneliness and isolation through befriending, domiciliary care and organising social events. The lower number of residential homes identified by the Deans could be explained by the closure of many Catholic-run homes since the New Standards Regulations were introduced. Philpot (2002) suggests that over 40 homes have closed and, in addition, that several congregations have withdrawn from running residential homes (some of which have been taken over by organizations such as the Hospital Management Trust).

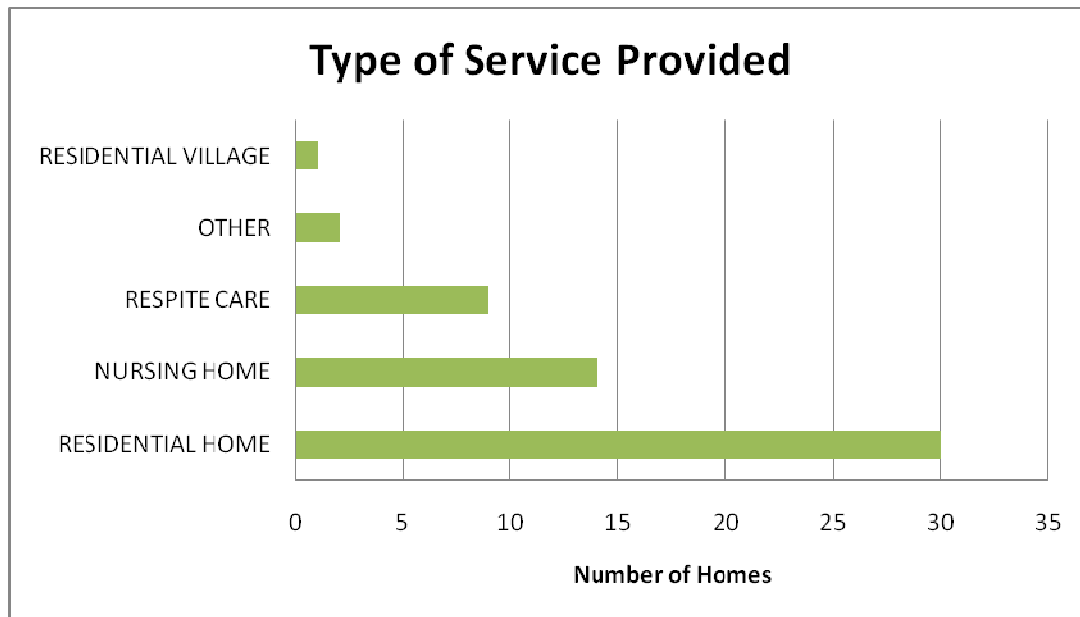
Drop-in centres, respite care and day care centres are growing as a response to the great number of older people living at home but in need of moderate levels of care and wishing to access the social activities offered. Some of these new alternatives are attached to residential homes, convents or parishes. In many cases these are run by lay volunteers from organizations such as Saint Vincent de Paul, The Union of Catholic Mothers or the Catholic Womens' League. This kind of outreach support will be discussed in more detail later.

Residential Homes

As has already been noted, it took considerable time and effort to identify Catholic-run residential homes. There is no comprehensive list of such provision. In the end, a total of 80 homes were identified and questionnaires sent to all of them. Despite a reminder letter, telephone calls requesting to complete the questionnaire over the phone, and a letter from the Right Rev Terence J. Brain, Bishop of Salford, asking those in charge to participate in this study, it was only possible to obtain information from 30 homes. The results presented here are based on those responses.

Description of Services Provided

Out of the 30 residential homes 14 also provide nursing care. 9 homes also provide respite care and a further 2 provide day care. As showed in Table 3, only 1 home reported having opened a residential village, a form of sheltered accommodation, which does not require dedicated and qualified staff but provides accommodation for independent living to older people with moderate needs in fully furnished flats or bungalows.

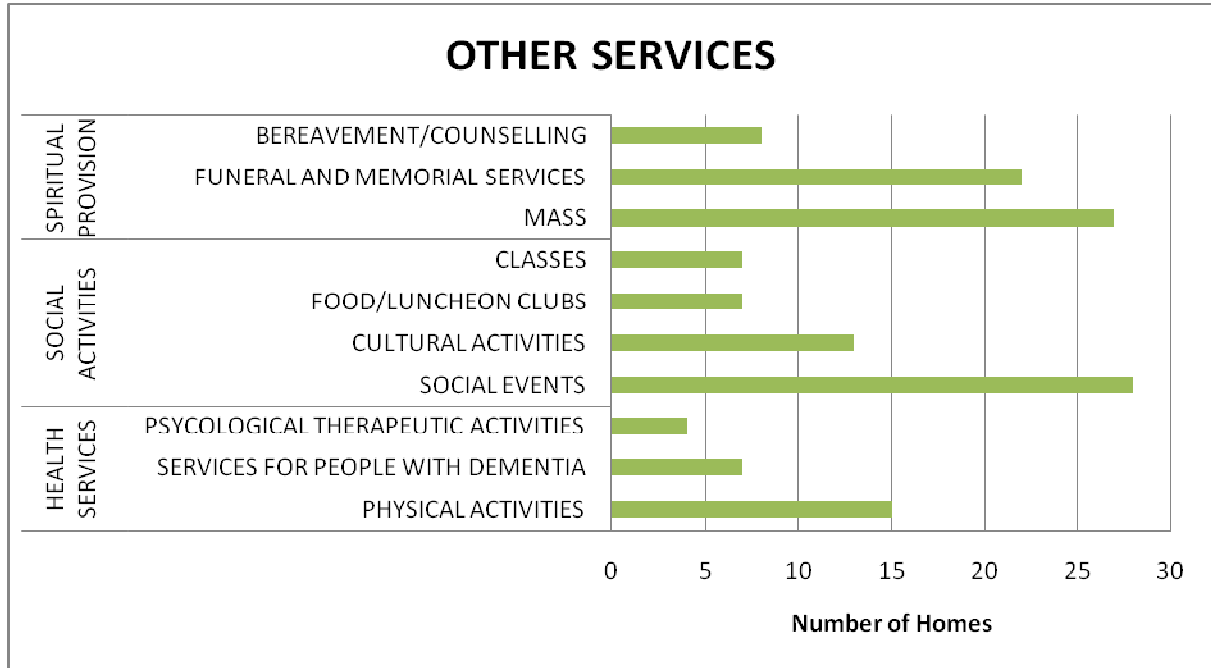
Table 3: Type of Service

Note: Respondents could tick more than 1 box

Other Services Provided

As can be expected, those homes that provide nursing care and specialised in treating residents with dementia or physical disabilities included a range of other health services. However, the high level of spiritual provision is perhaps the most distinctive characteristic of homes owned or run by the Catholic organisations. 27 homes reported having a chapel on site open not only to residents but also to visitors and members of the local community. As shown in Table 4, 22 homes offer funeral and memorial services to residents and 8 counselling or family support to carers. Likewise, social activities play an important role within this holistic approach of caring offered by Catholic homes, 28 homes hold social activities open to non-residents and 13 reported holding cultural activities aim to integrate residents from other cultures.

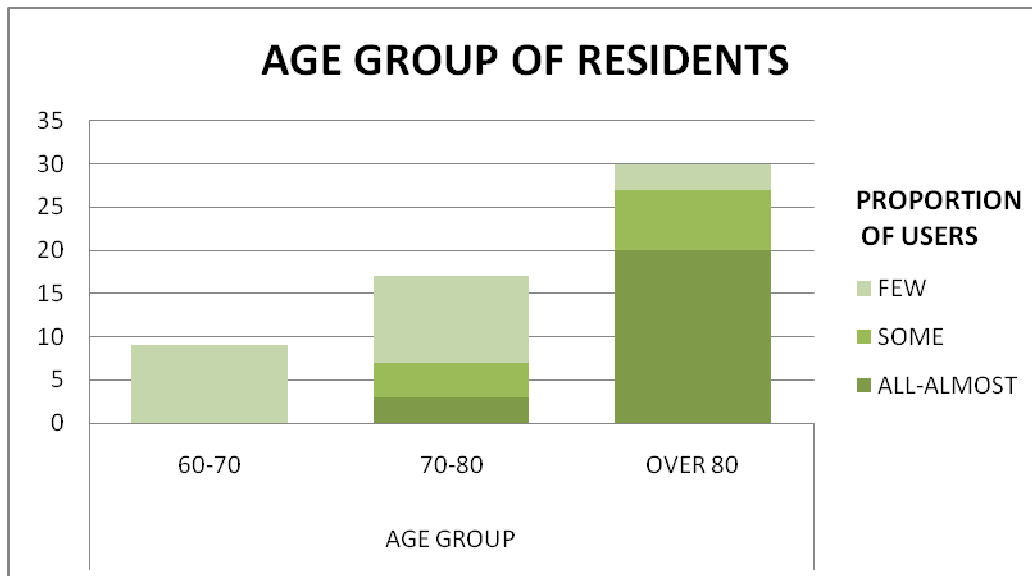
Table 4: Other Services Provided



Note: Respondents could tick more than 1 box

Description of Users

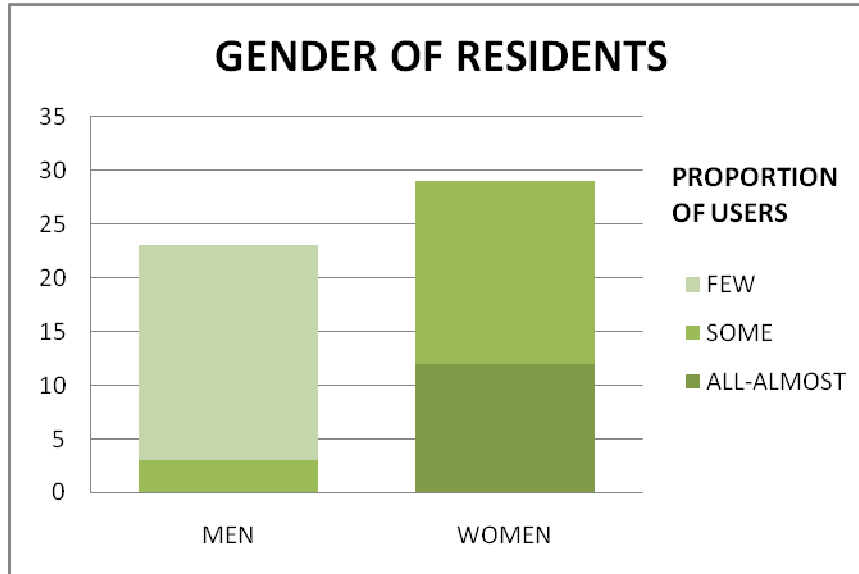
Table 5: Age Group of Residents



As shown in table 5, in 20 homes all or almost all the residents are in the age group 80 and above. The age group 70-80 years constitutes the majority of residents in 4 homes. Only in 9 homes are there residents aged between 60 and 70 and in all of these cases they account for

25% or less of the total number of residents. This pattern is strongly linked to current regulations seeking to keep older people at home for as long as possible delaying the age of entry to residential care, as well as a lower level of need among the younger age bands.

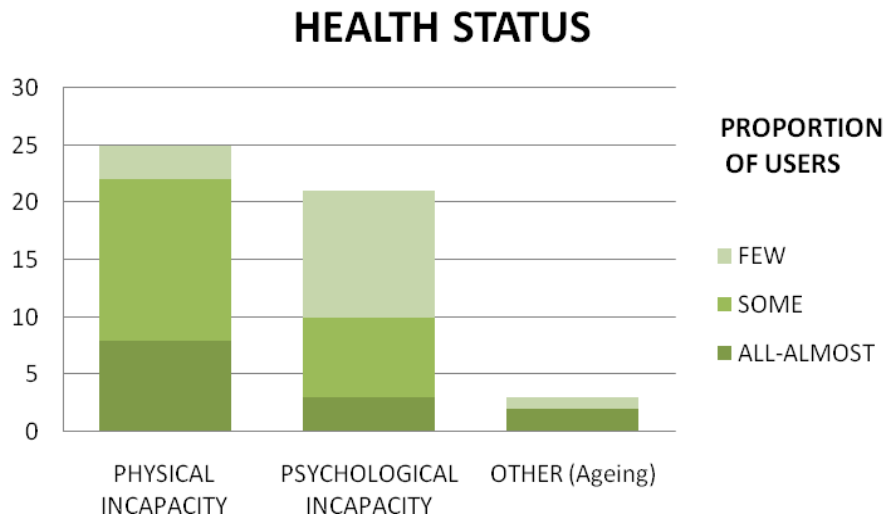
Table 6: Gender of the Residents



The high concentration of women living longer and therefore in care/residential homes has is consistent with previous studies. In 2002 the Health Survey for Older People found that ‘women over 65 make up 57% of residents in private households, but 75% of those in residential care homes’. Philpot (2007) describes the characteristic residents of a care/residential homes as female, unmarried and living alone. When enquiring about the entry criteria, one home was female only with the rest open to both male and female. Results from the questionnaires showed that women constitute all or almost the residents in 12 homes. By contrast, as shown in table 6, the concentration of men in 20 homes is not larger than 25% and in only 3 homes do they equal the number of women residents.

Health Status

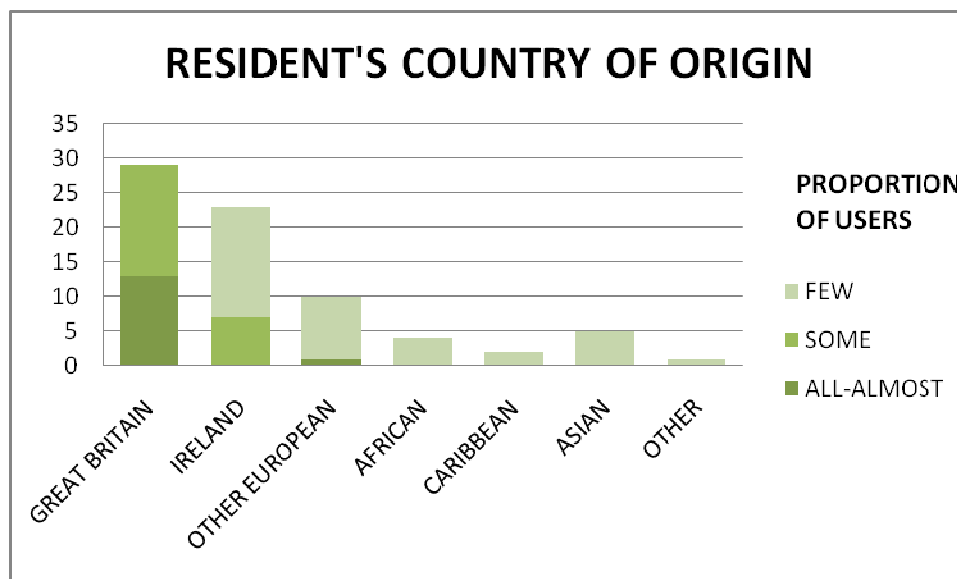
As mentioned before, the entry to a care/residential homes is usually considered as the last option and it is done when the person has physical or mental needs that do not allow him or her to continue living at home. Hence, as can be seen in table 7, it is not surprising that most of the residents have some sort of incapacity with 25 homes having residents with physical incapacities and/or 21 with psychological incapacity. Interestingly, 3 homes mentioned ‘ageing’ as a form of incapacity.

Table 7: Health Status

Note: Respondents could tick more than 1 box

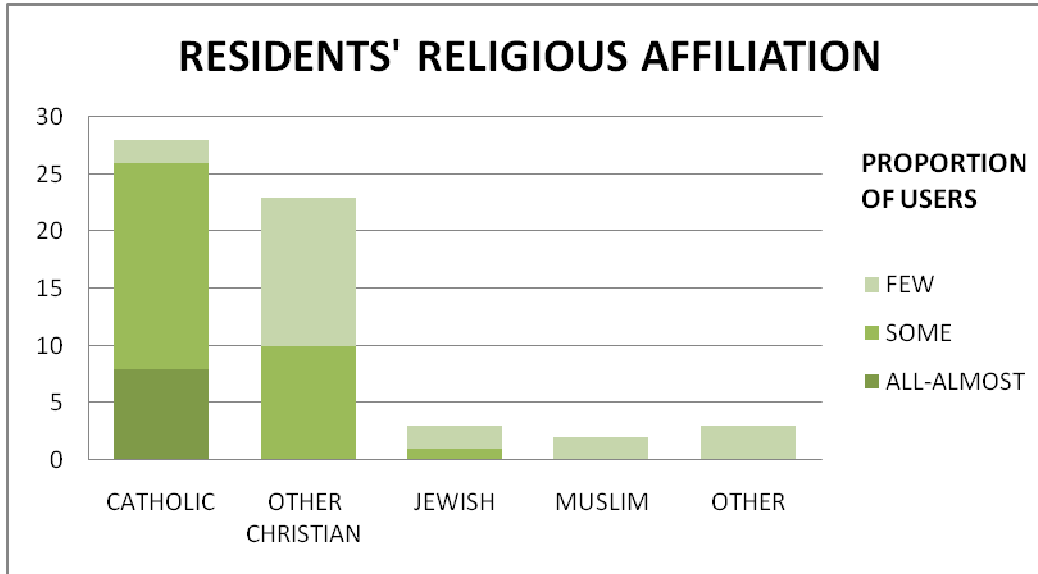
Country of Birth

Although most homes reported to have an overall majority of residents born in Great Britain and a significant number born in Ireland, the number of residents born in other countries is noteworthy. 21 homes have a 25% or less number of residents born outside Great Britain (of those one home specifically caters for elderly Polish migrants). This indicates that as the local population is ageing, members of migrant communities are also ageing, and that the Catholic community has indeed addressed these demographic changes opening the door to those communities in need of a ‘culturally specific’ care that respects individuality and difference. Cultural sensitivity will be discussed in more detail in the next chapter.

Table 9: Country of Birth

Religious Affiliation

As shown in table 10, Catholic residents and those of other Christian denominations constitute the majority of the population in 26 homes. However, what is noteworthy is the proportion of members of other faiths. 3 homes have Jewish residents, 2 Muslim and 3 from other religious beliefs. As mentioned in the literature review chapter, increasing numbers of ageing migrants and ethnic minority groups also need to be cared for and homes that offer spiritual provision and are open to all denominations represent an alternative to those who are seeking care based on shared beliefs of dignity and respect. When enquiring about the criteria of entry only three homes acknowledged that although open to all denomination they give priority to Catholics. The provision of care by Catholic organisations to non-Catholics will be discussed in greater detail in the following chapter.

Table 10: Religious Affiliation

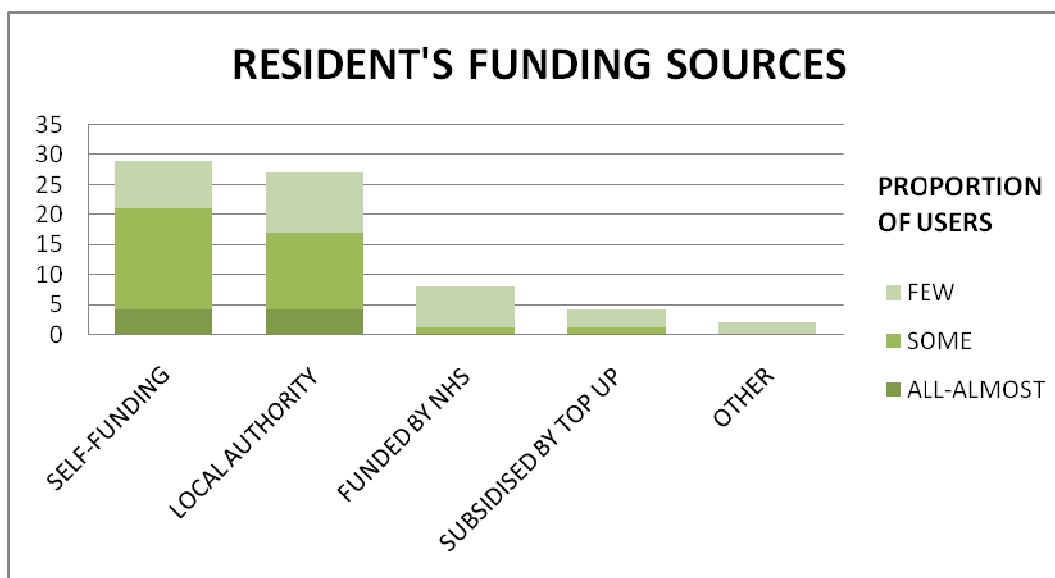
Residents Funding Sources

As can be seen in table 11, in 21 homes the majority of the residents are self-funded, which can reinforce the idea of a Catholic community better off and able to afford care in old age. However, there are also a significant number of residents supported by a combination of funding coming from the local authority, NHS, top up by relatives or the care home itself. Those residents unable to pay for a placement and relying in the funding available from local authorities may put a strain on the homes' finances. For example, CSAN (2008) found a home where 'the underfunding amounted to £150 per week per resident'. The assessment system determining the amount of local authority funding for home placement is unrealistic and in many cases does not meet the cost of quality service. This creates inequity and limiting the access to high quality homes to elderly people or families who can afford it.

The lack of correlation between what local authorities pay for placements and the actual cost quality care may lead some homes to attract privately funded residents. When enquiring about the homes' funding sources, we found 28 homes relying, at different levels, on residents' fees and being compelled to supplement these with a combination of charitable

trusts, fundraising events or donations as sources for further funding. Despite the high costs of placements, five homes mentioned low income as criteria of entry giving priority to those with limited resources.

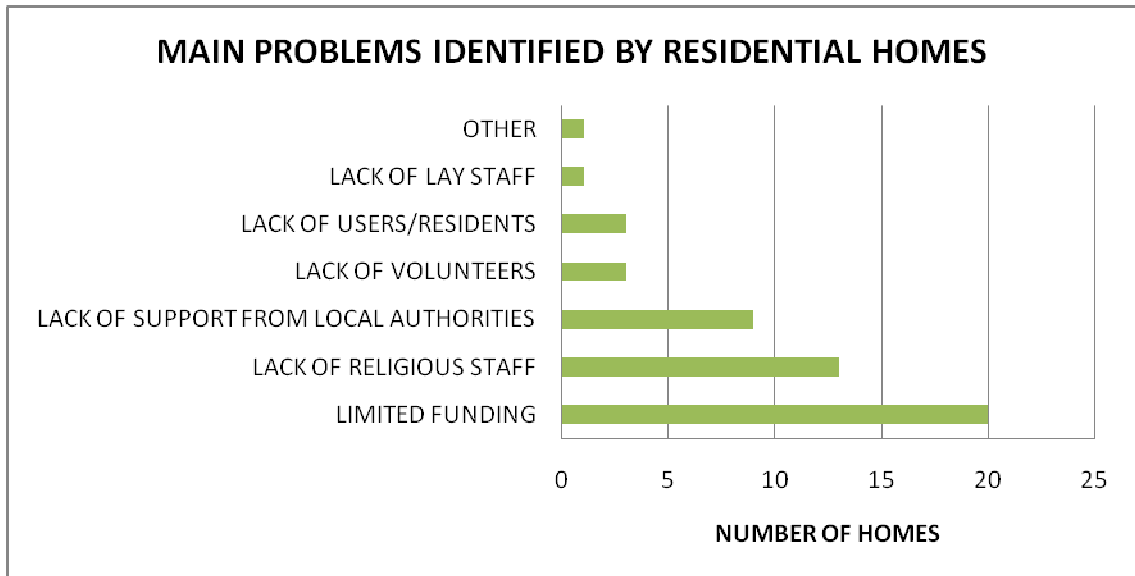
Table 11: Residents Funding Sources



Note: Respondents could tick more than 1 box

Main Problems and Challenges

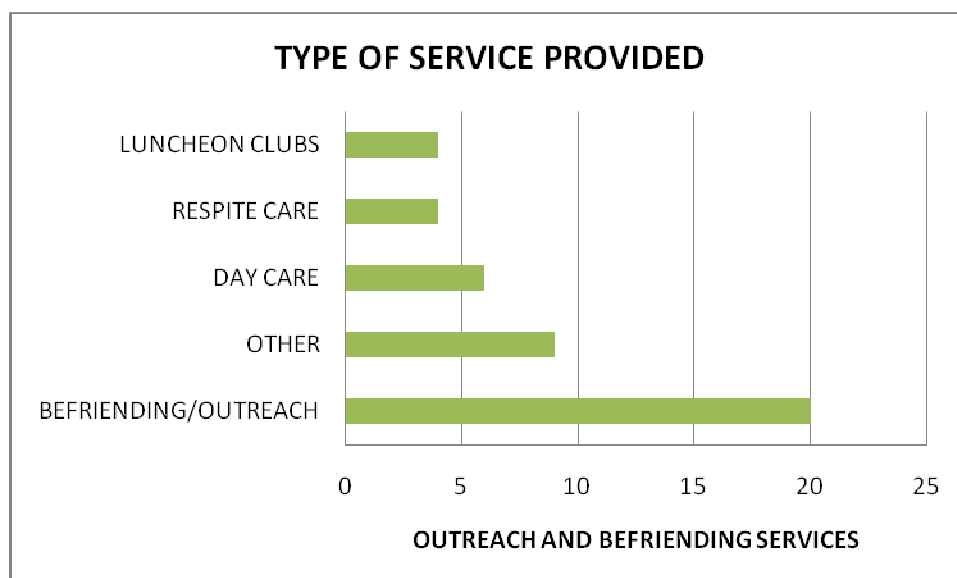
Predictably the main problem reported was the lack of funding with 20 homes being affected by increasing costs and few sources of funding. As Philpot (2007) argues, despite 'Catholic homes not seeking profit, they do require surpluses for reinvest'. This will be discussed in more depth in the following chapter. The second significant problem is the lack of religious staff; falling numbers of vocations has put a considerable strain on already limited resources; with fewer religious staff available to contribute the unpaid work that was previously taken for granted. Nine homes also mentioned being affected by the lack of support from local authorities, three by the lack of volunteers and another three by the insufficient uptake of places, which probably reflects the ability of people to pay for residential care. As will be discussed in the next chapter, some residential homes have empty beds not through lack of demand but because people cannot afford to pay and local authorities are reluctant to provide support.

Table 12: Main Problems and Challenges

Note: Respondents could tick more than 1 box

3. Outreach and befriending services

As we have mentioned before, the increasing number of people staying at home and facing loneliness and isolation has led the Catholic community to adapt the services offered to elderly people and develop schemes capable of reaching those forgotten by the system and, sometimes, by the wider society. In attempt to capture that type of provision questionnaires were sent to the main providers of outreach and befriending schemes, such as Saint Vincent the Paul, as well as to small and local voluntary organizations suggested by the Deans. A total of 50 organizations were contacted with 28 completing the questionnaire. As mentioned earlier, we were disappointed by the response rate. Despite numerous phone calls and follow up letters, it many smaller projects were too busy to complete the questionnaire.

Table 13: Type of Services

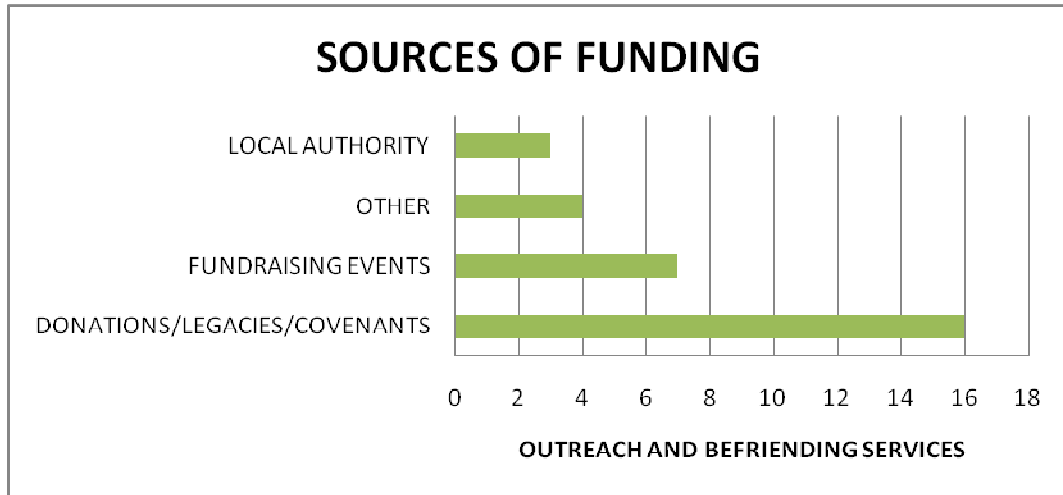
Note: Respondents could tick more than 1 box

20 of the organizations provide visits and help with domestic and personal care; however, 14 also provide services such as day centres, luncheon/social clubs and respite care. Many outreach services are attached to a parish or, in some cases, are part of a residential home. The services listed as 'other' included for example, providing transport to take older people to doctor appointments or social events. The contribution of these outreach projects is considerable but very difficult to map and quantify. Some larger organisations produce annual figures that capture the breadth of their provision. To name one example, the Saint Vincent the Paul made 75,398 visits to elderly people in England and Wales during the last year. This requires a significant amount of unpaid hours by volunteers.

Sources of Funding for Outreach and Befriending Services

As shown in table 14, the majority of organizations depend on donations/legacies or fundraising events. It is significant that despite the great contribution made in the form of unpaid hours of service only three of the 28 organisations that responded receive support from local authorities.

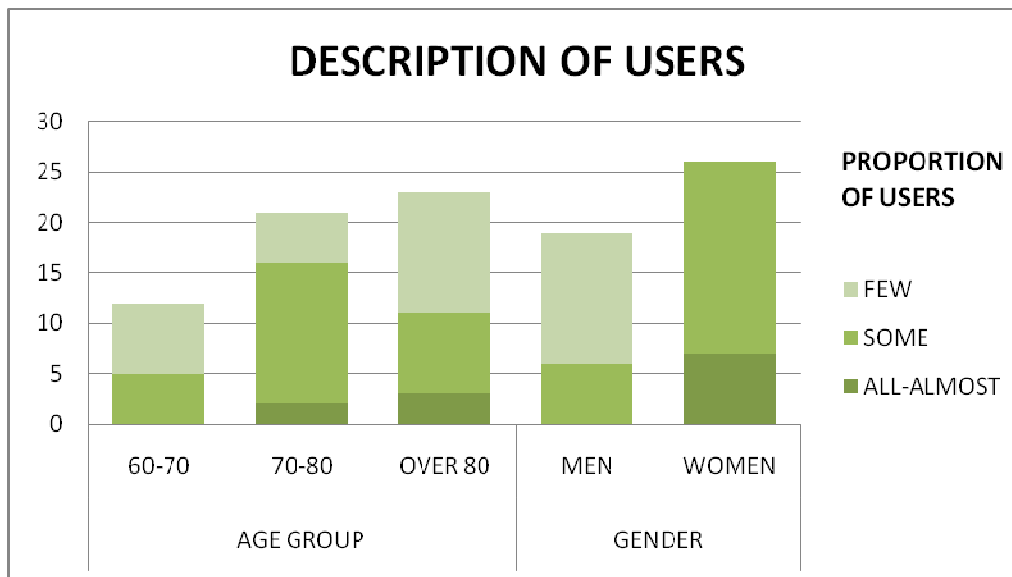
Table 14: Sources of Funding for Outreach and Befriending Services



Note: Respondents could tick more than 1 box

Description of Users

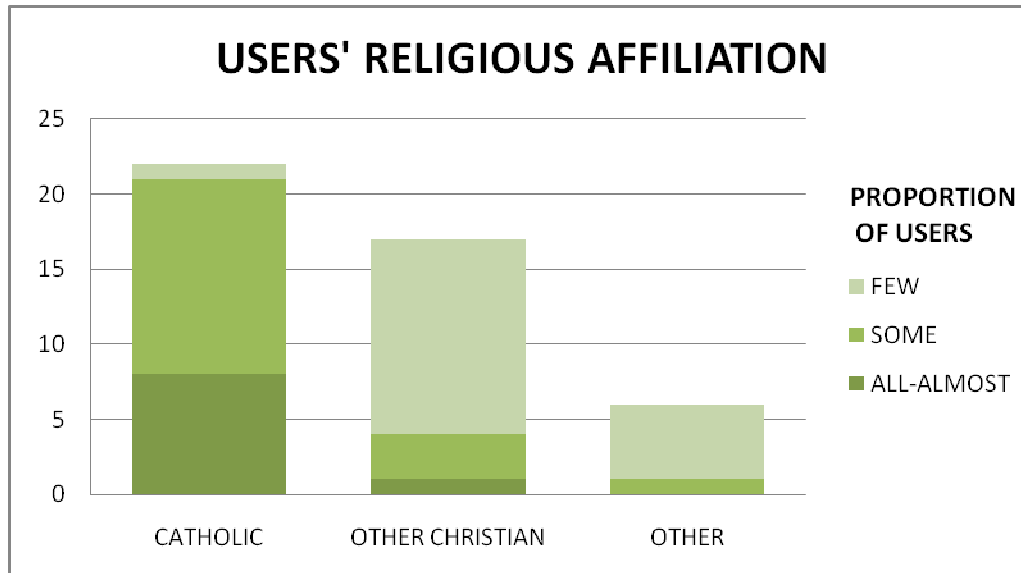
Table 15: Age Group and Gender



As table 15 illustrates, while reaching a good number of people aged 80 and over, the largest proportion of service users are aged below 80; this follows the trends of more older people staying at home and delaying the entry into residential/care homes until absolutely necessary.

Again as noted earlier, there is a gender imbalance with women making up the majority of users probably reflecting the longer life expectancy of women.

Table 16: Religious Affiliation



As noted earlier in relation to residential care, the Catholic community is increasingly catering for people of all religious affiliations. Despite having a high proportion of Catholics among their users, it is noteworthy that in 18 of the 28 organizations there are users of other religions being looked after, and in four of those organisations this number accounts for 50% of users. As CSCA (2000) states, 'there is a potential for exploring ways in which those involved in the provision of Catholic community care might work with Christian and other faith denominations in the future development of services'.

Conclusion

The questionnaires provide an indication of the general trends in Catholic care provision for older people. For a more in-depth insight into what is actually going on among the various projects, agencies, organisations, homes, we have also undertaken interviews and focus groups with care providers which will be discussed in more detail in the following chapter.

CHAPTER 5: Voices from the Community: the perspective of service providers

Introduction

A key aim of this research is to uncover the range of care provision to older people by the Catholic community. In the original methodology it was decided that a good way of uncovering that provision was by asking all Deans about projects operating within their deaneries. However, as noted in the previous chapter, many Deans simply did not have that level of information. Thus, rather than attempting to cover the entire country, it was decided that qualitative methods would be used to get an insight into the variety of projects operating in various parts of the country. As described in the methods section of this report, we contacted a number of large service providers as well as smaller, local projects. This chapter presents the findings from the interviews and focus groups carried out with Catholic service providers. This material will elaborate and elucidate the quantitative data analysed in the previous chapter. A full list of all those who took part in focus groups and interviews is available in the appendix.

It is apparent that a nation-wide survey of all parish based activities would be necessary to even begin to capture the full range and diversity of provision at local level and such an enormous undertaking was beyond the scope of this research. However, in the absence of this level of detailed information, it is difficult for the Church to demonstrate the extent of its provision and thus to argue the case for being ‘a voice at the table of decision making’, as one participant put it.

There was a consensus among all the people interviewed that the Catholic Church makes a significant contribution to the provision of care for older people in this country. But, as one participant noted, the Church does not get the credit for all the work that it does ‘which is massive’ but largely ‘goes unnoticed’, but that it would ‘be nice to have that acknowledgement’. Part of the problem, as noted by another participant, may be that while Catholic communities provide a wide range of care, their contribution is difficult to quantify.

One reason for this may be because no one seems to have an overall view of what is going on across the country. As we discovered in doing this research, there are literally hundreds of local projects scattered across England and Wales but they are difficult to track down because no comprehensive list of such organisations exists anywhere.

Although this chapter cannot quantify the true extent or financial value of all the work done by Catholic care providers, it will provide a snapshot of the range and diversity of that care. In summarising and synthesising the key findings emerging from the qualitative data, this chapter explores the problems encountered by older people, the challenges facing Catholic care providers and the strategies they are adopting to deal with these challenges. In addition, we highlight not only the care provided to members of the Catholic community, but also the contribution that Catholic service providers make to the wider community, to people of all faiths and none. In so doing, we also examine the implications of this wider care provision for maintaining the Catholic ethos that sets these organisations apart from other service providers. This raises a pertinent question – what do we mean by a ‘Catholic’ organisation?

Pastoral Provision

Some of the participants in the interviews and focus groups represented pastoral services. Catholicity is at the heart of their identity and of the people to whom they minister. As Fr Christopher, Dean of Hackney told us: ‘The essence of parish life is pastoral care’. As an example of this work he referred to the ‘Pastoral Sister of the Parish’. She undertakes a huge amount of outreach work for older people particularly the housebound. She also coordinates a large number of lay volunteers who assist her work. Much of this kind of outreach work is sacramental.

We interviewed Sr Patricia Silke, a parish sister in Hull, from the Daughters of Charity congregation. Her main role is visiting elderly and housebound people in West Hull, there is a second parish sister, Sr Anne, who covers East Hull. As Sr Patricia said ‘it is a full time job’. She visits people in nursing homes, in their own homes and also in sheltered accommodation. She currently has approximately 33 people on her list – all are referred by the parish priest. Her role is pastoral – she is a Minister of the Eucharist and brings Holy Communion to these older people. A large proportion are bedridden and receive practical support from social services, with carers coming into their homes on a regular basis. Some of

them have family visits but these tend to be at the weekend, so during the week they have few, if any, visitors. Thus, as well as sacramental provision, Sr Patricia and Sr Anne are a source of companionship for many of these older parishioners in Hull.

Several research participants said that it is important to appreciate the sense of comfort that people, especially older people, derive from religion and rituals. There is a sense of familiarity with Mass and other ceremonies. As noted by other researchers (Lowis et al, 2005), in a context of changing life circumstances as we age, including loss and bereavement, religion is a source of constancy, continuity and certainty. As one interviewee noted, sacramental provision has a 'strong physical element', rooted in ritual and practice. It has strong association with childhood memory, the 'rhythms of life'. As older peoples' intellectual grasp may weaken, this familiarity with rituals and rhythms is even more important.

Similar parish-based sacramental outreach is provided by groups such as the Legion of Mary. Usually people are referred by the priest. In the Tintagel Mission in Cornwall, for example, 50 people receive regular visits from Fr Bryan Storey and his team of Legion ?? OF MARY volunteers. Their work is not materially oriented, instead it has a spiritual focus: 'comforting elderly and housebound people through prayer' (Fr. Bryan Storey). Unsurprisingly, nearly all the people they visit are Catholic, but some are non-Catholics who are, nonetheless, interested in a spiritual visit. The provision of services to non-Catholics is an important point to which we will return in more detail below.

The significance of this kind of spiritual and pastoral support for isolated, housebound, older people cannot be underestimated. However, this is only one type of care and our research included organisations offering the full spectrum of support and care from sacramental through to domiciliary care, advice and information, social activities, luncheon clubs, and health care. As we will discuss below, many of these organisations are catering not just for Catholics, but also for people of 'all faiths and none'. Several such organisations are increasingly working with other voluntary and statutory services as part of care packages. They tender for local authority contracts, for example, and submit applications to a wider range of funding bodies. Thus, they are operating as professional care providers conforming to government policy guidelines and official regulations. In so doing, the question of Catholicity and how they maintain their distinctive Catholic ethos comes to the fore.

Outreach and Partnerships – Reaching the wider community

Throughout the research process, we came across many examples of projects, services and centres set up with the support of the Catholic Church which had then developed into more general service providers. For example, in Newcastle, the St Anthony De Padua day care centre caters for a diversity of users many of whom may not be Catholics. As well as providing domiciliary care, the centre also runs a luncheon club which is open five days per week catering for approximately 30 older people per day.

In Manchester, St Joseph's Welfare Centre, provides support to a diverse range of people, including outreach and befriending for older people living in their own homes. In the beginning it was mainly Catholics referred by their parish priests but now most referrals come through social services and local agencies, NHS, etc, as part of a package of care for older people. At present the St Joseph's has about 250 people on their books. They have eight staff, many of whom are retired religious and also rely on volunteers. At present about 50% of users are Catholics (Tony Murray, Leeds Focus Group). Examples such as St Joseph's reflect the enormous 'added value' of Catholic organisations – designed for Catholics but now rolled out for other groups across communities.

Similarly, the Huddersfield Deanery Project aims to enable people to live independently, in their own homes, for as long as possible. The project organises social activities, outings, but also healthy eating campaigns, vegetable bags, etc. There are 12 luncheon clubs and four staff catering for about 350 people. There are also two houses for supported living for older people with learning disabilities. While this project grew out of the parish and received support from the diocese, now only about 20% of all users of these services are Catholic (Mark Wiggin, Leeds Focus Group). So, again this is an example of Church-based organisations reaching out beyond the Catholic community.

According to participants, people choose Catholic care providers because there is a perception, particularly among older people, that they will get a high quality of care from a Catholic organisation. It is believed that Catholic organisations provide care 'for the right reasons', that it is 'more genuine – being done out of goodness' not simply for profit. People

want to feel 'cared about not just cared for' (Graeme Riley, from the Fr Hudson Society in Birmingham).

The appeal of Catholic care is appreciated not only by older people themselves but also by some statutory bodies as well. Many Catholic groups work very well with local statutory bodies and voluntary agencies. For example, SVP members contact agencies to find out about other local sources of support such as day care centres that the older people can attend for more structured activities. One SVP member noted that, in general, social services departments cooperate very well with the SVP perhaps because such agencies are usually very glad that someone has the time to undertake this work with older people. SVP members see themselves as advocates. They listen to what the older person needs, do not tell the older person what they should do and in this way, the autonomy and dignity of the older person can be maintained (Siobhan Garabaldi, SVP interview).

In a similar vein, other participants noted that Primary Care Trusts (PCTs) are also contacting and working with Catholic care providers. This demonstrates that Catholic care providers are seen as valuable and are increasingly relied upon by statutory services. As one participant put it, the Catholicity of these organisations, which underpins their ethos of caring, makes their services valuable not just to Catholics but also across communities more generally (Br Mark, Leeds Focus Group). Thus, partnerships between Catholic organisations and voluntary and public sector organisations can be mutually advantageous, but maintaining that distinctive ethos is imperative.

Working with other care providers whether social services, health trusts or large charitable trusts, often means dealing with increasing bureaucracy and regulations. Some participants expressed the view that Catholic organisations are beginning to resemble the private sector in terms of responding to tenders and providing services.

The people interviewed had mixed views on the advantages and disadvantages of working with statutory and private sector organisations. For example, Tony Murray said that official regulations could act like a 'yoke' or 'straightjackets' that limit what organisations could do. In responding to the Deans' questionnaire – Rev Wilson from Southampton East said that while more volunteers are needed for home visits and befriending, the process of recruiting volunteers was 'somewhat hindered by government regulations'. However, some participants

argued that by not receiving any state funding they remain free from all that bureaucracy. However, others noted that not receiving any state funding could mean continually having to apply to various charitable trusts and engaging in an array of fund raising activities.

Among the questionnaires completed by Deans, several noted that strategic partnerships were an important and necessary aspect of developing future capacity for Catholic care providers. Fr Gerry Mulvihill of Streatham said: 'Combined action is needed by statutory and voluntary bodies, charities and the family'. This point was echoed by other Deans who also referred to a 'multi-agency approach' (Rev McDermott Northampton), while Fr Walsh (Clifton diocese) spoke about the need for 'a combination of the voluntary sector including the Church communities and local and national services'.

One of the aims of this research study was to identify what is distinctive about Catholic care providers. In the interviews and focus groups it was apparent that working in partnership with statutory bodies, becoming increasingly professional and indeed, for some, becoming 'mainstream', raises question about how organisations can maintain their distinctive Catholic ethos.

Catholicity

One organisation which illustrates the delicate balancing act of partnership with statutory services while maintaining its special ethos is Vincentian Care Plus. Set up by Sr Margaret Bannerton it became a registered charity in November 2004. It was started on 'a shoe string budget' with the help of the Daughters of Charity. The office space which they still use today was given, rent free, by the local church. Sr Margaret says they had no money and had to 'beg, borrow and steal the furniture'. The organisation was set up to provide visiting and befriending to older people living in their own homes in the south Westminster area, around Pimlico. In addition, it also provides domiciliary care to approximately 45 people. The project adopts a careful approach to matching appropriate carers and befrienders to the older person. The project coordinator always does the initial visit and care assessment and devises a care plan with the older person taking their needs and wishes into account. An appropriate carer is then identified is accompanied by the coordinator on their introductory visit, so 'they are not a stranger going into the person's home' (Sr. Margaret). The agreement is that the carer will always stay for one hour (Sr Margaret cites examples from other care providers

who leave after just 15 minutes). Befriending is also discussed as part of the care plan. Some people may have other regular visitors and may not need a befriender. But, if it is agreed that a befriender is needed, then a 'contract' is drawn up between the befriender and older person - to come once per week for two hours. It is also agreed what the visit should entail, such as going out to a café for example. The project emphasises the importance of matching the personality and interests of befriender and befriended.

In 2007, Vincentian Care Plus became 'an approved care provider' for Westminster social services which means that social workers can now refer clients to the organisation. However, Westminster can only do this if all their contracted agencies are full. The project is now aiming to become a 'contracted agency' so that they too can get referrals on an equal footing with all other domiciliary care providers in the borough and this will mean that carers can receive a higher rate of pay.

Not all the users or the carers are Catholic. Sr Margaret estimates that about half of the users are Catholic and knows that two are Jewish and one is a Muslim. Of the employed carers, about 16 out of the 22 are Catholic. Nonetheless, the organisation has a particular spirituality and ethos which makes it distinctive and different from other care providers. Sr Margaret talked about 'the Vincentian way' which is to see the dignity of each person - 'to see Christ in everyone' - and 'to go the extra mile' in providing care. All carers are instructed in this ethos at their induction and in regular seminars and training.

Another organisation whose Catholicity is central to its identity but who provides care to people of all faiths and none is Saint Vincent De Paul (SVP). We spoke to members of the SVP at St David's Nursing Home in Ealing. They described the work of the SVP as closely connected to the local parish - 'we are the *principal* caring arm of the parish'. However, as was the case with several care providers, the SVP was keen to assert that 'we don't speak about spiritual matters unless the older person brings it up'. They were quite emphatic that 'we do not proselytise'. The aim of the SVP is 'to offer a helping hand not to force anyone'.

In an interview, Siobhan Garabaldi also explained that although they are not a proselytising group, SVP members work through the guidance of the Holy Spirit. Members meet and pray together, have spiritual reflection together, 'then and only then do we discuss our work'. This is the 'Vincentian heart'. Members all share a belief that it is this spiritual guidance that

gives them the strength and confidence to undertake their work. They seek wisdom through prayer - 'our work does not spring from ourselves alone' and the ethos is 'practical action through prayer'. However, Siobhan acknowledges that their spirituality, although completely central to their work, is not always stated or made explicit.

Thus, in some ways, the Catholicity of many care providers may be implicit rather than explicit. As one participant said 'We neither evangelise nor proselytise, but endeavour to exemplify the tenderness of our loving God' (Tony Murray). Similarly, another interviewee noted: 'the Vincentian way is not to go around evangelising – faith should be caught not taught' (Sr. Margaret).

One participant related this to English society and the long history of being reticent about religious faith and spirituality. Going back to the Reformation the English way of coping with that event was 'to get on quietly'. 'It is inside you but you don't express it openly' he says. The Catholic Church in this country has tended to take on that reticent approach – 'it is not our way' to talk openly about spirituality (Fr. Christopher). This point has also been observed by historians and sociologists (for an over view see Hickman, 1995). However, another interviewee expressed concerned that: 'we are in danger of becoming a society where it is not possible to speak about God' (Fr. Bryan).

At the heart of this discussion there appears to be the challenge of maintaining the values of Catholicity while catering for the needs of a general community, including people of all faiths and none. While people may not feel comfortable with what one of the participants referred to as 'in your face' religion, many interviewees emphasised that service users, and indeed statutory bodies, value the care associated with a Catholic ethos. Many of the interviewees talked about this ethos in terms of spirituality.

One of the most interesting reflections on how Catholic organisations demonstrate their spiritual core took place when we visited the Irish Older People's Project in London. It was set up by the Irish Chaplaincy to provide outreach and befriending to older Irish people, irrespective of faith. Some of the people they visit may be lapsed or have no faith. In describing the project, Philomena Cullen (Director of the Irish Chaplaincy) says 'it is not religious with a big R, it is religious with a small r'. She explains it is built around respect, dignity and spirituality, where spirituality simply refers to the 'presence of God'. The project

aims to enable older people to ‘feel rooted in terms of bringing their past and present selves together’. This is a gradual process involving listening to the needs of the person. ‘We don’t walk in the door and immediately get out the rosary beads and the novena card’ (Philomena jokes). Because some people of this generation will have had negative experiences of a rigid and hierarchical Church in Ireland, the project is sensitive to the concerns and views of these older people.

Paul Raymond, manager of the Irish Older People’s Project referred to the holistic approach of the “*body, mind and spirit triangle*”. That is about recognising and respecting the spiritual dimension of people’s lives. Some people may want a regular visit from a priest and may want to receive the Eucharist in their own home so the project will liaise with the parish to arrange that. But not everyone will want such a religious dimension. The project team recognise that spirituality may take other forms such as a quest for peace and harmony. For example, one man visited by the project was a musician and enjoyed playing music and singing songs about Ireland. By sharing this with the befriender, the man found a great sense of satisfaction, peace and relaxation. Performing and sharing music could be seen as a spiritual, though not overtly religious, experience.

Who can be a Catholic organisation?

As our research progressed it became apparent that organisations not only have to negotiate with statutory bodies and funders but they also have to, in some cases, negotiate their position and identity in relation to the Catholic Church itself. The example of the Irish Chaplaincy which is headed by someone who is not only a lay person but a woman, illustrates the changes that are taking place within some Catholic organisations. Falling vocations to religious life and the increasing involvement of lay people have resulted in shifting roles and responsibilities. However, this can also result in some tensions. Questions arise about who can make decisions on policy and procedure. Some lay people may feel that while they are doing a huge amount of work, their voices are not always heard when it comes to decision making within the Church.

Several participants raised the issue of who can define what is and is not a ‘Catholic’ project/ agency/ organisation. This related back to the hurt and fall-out from the recent Equality Act (Sexual Orientation Regulations, 2007). Although this legislation referred to adoption, it is

apparent that the ripple effect has been felt by many Catholic care providers. One agency – Caritas Care, Preston - which disagreed with the Church's official stance on the new legislation had been divested of its Catholic status by the local Diocese. Thus, while continuing to regard itself as Catholic, it has been told that it is no longer in a position to call itself a Catholic organisation. The staff members that we spoke to were clearly hurt by this decision.

In the focus group discussions several people expressed the view that the Church tends to 'infantilise its members' and not allow questioning or dissent. Some people felt that there is a need for more empowerment of the laity. One of the aims of this research study was to explore how the laity could be engaged to work more effectively with older people. Later in this chapter we will return to the issue of lay ministries.

Clearly, the future holds many challenges for society in general and for Church in particular. In the context of an ageing population, falling vocations and the rising cost of care, the issue of residential provision will be a particular challenge. Having focused up to now on outreach and befriending services, in the next section we switch to look in more detail at the discussions which took place around residential services.

Catholic Residential Provision

As mentioned in the previous chapter, Catholic-run residential homes form an important element of care provision for older people in this society. As with the outreach provision discussed above, it is also apparent that residential homes cater for people of all faiths and none. For example, in the residential home run by the Fr Hudson Society in North Warwickshire, about 40% of the residents are Catholic (according to Graeme Riley, London Focus Group). As one participant said, faith is no longer a criterion of entry.

A number of interviewees pointed out that many of the people approaching Catholic care homes are not Catholics, but may include, for example, Muslims, Sikhs and people of others faiths. These people appreciate the Catholic ethos because they believe that 'the Church defends the weak and values life....they know they will be respected in a Catholic environment' (Br. Mark). Several people mentioned the new initiative being undertaken by

Sr Agatha at the 'The Bar' Convent working with Methodist Homes, to develop new multi-faith provision.

Some residential provision has ceased to be run by religious congregations and thus could no longer be formally classified as Catholic homes. A good example of this is St David's in Ealing. When we visited the home (to attend the SVP meeting) we noticed religious pictures and crucifixes on the walls. There is a chapel where mass is said twice a week and there is a close link with the local parish – St Benedicts. The number of residents attending weekly Mass varies between 10 and 15 but not all of these are Catholics, for example some Church of England residents also attend Mass. There is currently a discussion with the local Anglican minister about whether an Anglican service should also be organised at the home.

Another challenge identified by participants is when residential homes are no longer run by religious orders, it becomes harder to maintain links with the local parish and therefore older people may not get any kind of spiritual support. As noted in the literature, there is also evidence that people who live in residential homes experience social exclusion by losing or loosening links with family friends and neighbours, a low sense of belonging and diminishing ties with the local environment (Theobald, 2006). A number of our participants argued that it is necessary to get people in parishes generally to become more involved and proactive in making connections between residential homes and parish life. For example, families, neighbours or friends should alert church groups when someone goes into a residential home and would welcome a visit. It is difficult to support people without information about where they are and what kinds of help they might need.

By contrast, another home we visited, Maryville in Brentford is run by the Poor Servants of the Mother of God and clearly maintains a Catholic ethos. Daily Mass is said by the chaplain in the newly-designed chapel and there is a pastoral sister on site who can provide spiritual care when required and who organises prayer groups. There is no compulsion around religious practice in the home and peoples' wishes are respected. Residents are not expected to attend services but they are available if required. .

We asked Sr Rita and Sr Elizabeth what makes Maryville distinctly Catholic? This was quite a complex issue to explore but both agreed that the charism of their founder was the key to the order's ethos and that of their home. This was about supporting people, enhancing

dignity and the quality of life and respecting the autonomy of the person. The Maryville brochure states:

‘respect the dignity and uniqueness of every individual... we aim to work with and on behalf of individuals in need, not just by providing practical support or personal care, but also by encouraging a sense of worth and hope. We use every opportunity to understand and respect the culture and traditions of people.... We will promote the fundamental principles of human rights in all our activities by encouraging self determination, choice and advocacy’

As so many of the staff at Maryville are now lay people rather than religious, every effort is made to ensure that all are trained in the charism of the founder. Staff members are required to attend special courses, off site, and they are fully paid while undertaking this training. Thus even if staff are not people of faith, they agree to demonstrate the values of dignity, respect for the person and their . They are expected to ‘to give over and above’ rather than just the minimum required to do the job. No ‘sloppy practices or sloppy language’ is allowed and no demeaning of the older person (Sr Elizabeth Sheehan).

The challenges posed by increasing numbers of lay staff versus falling numbers of religious, were raised by several research participants and were also noted in the analysis of the questionnaire data in the previous chapter. It is very important that they see caring as a ‘spiritual act’. Caring for older people is about allowing ‘the Holy Spirit to work within you’, as one participant explained. Faith-based homes need to demonstrate that they have a different ethos, and the challenge is how to do that when all staff members are lay people, perhaps from different backgrounds and cultures, of all faiths and none. Ageing and getting closer to death may be frightening for people. In a faith-based home older people may feel that they can be prepared for death through this sense of spirituality. Thus, as one participant emphasised, it is imperative that all the carers in the home should see ‘Christ in the person they are caring for’ (Elizabeth Palmer, London Focus Group).

As discussed in chapter 3, government policy has emphasised enabling people to live independently in their own homes for as long as possible. We have discussed several outreach and befriending projects that also aim to do just that and it is apparent that many view going into a residential home as a last resort. However, this view that it is always best

to remain at home was contested by some participants in the focus group discussions. They argued that government opposition to residential care is largely driven by cost issues and not necessarily by what is best for older people. For example, Graeme Riley noted that residential care had attracted bad press in recent years because of some high profile abuse cases. But he questioned whether it was better for older people to be living alone, lonely and isolated, with just one visitor for one hour a day or to be in a residential home? A few participants also noted that elder abuse is more likely to occur out of sight, when people are living in their own homes, than in residential care.

Some participants expressed the view that outreach projects simply could not visit every older person in the country and even if they did, one hour per day was not enough for a housebound person living alone. It is important to emphasise that the 2000 Health Survey found that 81% of people over 65 living at home were visited by relatives or friends at least once a week (CSAN, 2008). Nonetheless, as many of our participants noted, family members often visit at weekends, leaving the older people with limited social contact during the working week. A few participants noted that there may be a deliberate campaign to undermine residential care. Cost is clearly a concern but, as one person argued, British society needs to accept social responsibility and pay higher taxes to cover the costs of giving decent care to all older people who need it (London Focus Group).

However, a number of participants spoke about loneliness and lack of stimulation within residential homes. In our discussion with the SVP at St David's Home, one volunteer argued that 'people want to remain in their own homes for as long as possible' and going into a care home can result in them 'going down hill rapidly'. He noted that especially in homes with a lot of dementia patients, an older person can be adversely affected by that environment. However, another SVP volunteer in the group gave an example of someone she had visited who was housebound and very isolated. For this woman going into a care home meant that she got the help she needed and her quality of life improved enormously.

Nonetheless, it would be inaccurate to suggest a stark choice between living alone, at home, or going into residential care. As mentioned in previous chapters, sheltered accommodation is often regarded as a more attractive alternative. Many of our research participants spoke about this type of semi-independent living as the way of the future.

Semi-independent living

Several care providers such as, for example, the Little Sister of the Poor, provide semi-independent living. At the facility in Headingley, Leeds, people can keep their own cars, come and go as they please, cook for themselves, etc. This shift in emphasis from residential provision to semi-independent living was mentioned by several people. The Little Sisters of the Poor have 25 flats in Headingley. The rental cost of each flat is approximately £125 per week, thus considerably cheaper than residential care. In their new London complex in Stoke Newington, the congregation also have flats ‘we are doing more and more flats because that is what people want’ (Sr Agnes). They are also converting wings in older homes into flats so there is a gradual movement in the direction of semi-independent living. One interviewee, who did not want to be quoted, said that this was a debate going on within his organisation and his personal view was that resources should be shifted from residential care to providing spaces for semi-independent living.

However, providing flats means that religious congregations may have to register as landlords and this can impact on their status as care providers. Regulations prevent landlords of property from also providing domiciliary care to tenants. These regulations were introduced to stop residential homes from de-registering as homes and de-coupling their landlord role from their care role. But now it has become difficult for residential homes which also include flats on their premise to provide care to their tenants. Some congregations act as ‘helpful neighbours’ visiting those living in the flats, being available if any problems arise, but cannot provide domiciliary care while being the landlords of the flats. Several people expressed concern that this reduces the opportunities to develop new ways of providing semi-independent care along a spectrum between residential home and living completely independently (Philip Mosley, Sons of Divine Providence).

The ways in which official regulations impact on residential care provision was mentioned by several participants and, as mentioned above in relation to outreach provision, there was a shared feeling that regulations can sometimes get in the way of good care. Several participants in the London focus group said that regulations can get in the way of a holistic approach to care. For example, residential homes are forced to close down because they don’t meet regulations around health and safety, access for disabled people, provision of

qualified staff, minimum standards of care or protection of vulnerable adults. Notwithstanding the importance of such matters for older people, the inability to meet regulations may result in the absence of any care provision at all.

Cost of residential care

Although some participants suggested that Catholic care providers were not profit oriented and tended not to operate on a business model, it is clear that residential homes cannot afford to ignore economic practicalities. As noted in the literature review chapter, the cost of residential care is very high although it varies enormously by region and across local authorities.

For example, the Fr Hudson Society home in North Warwickshire charges £495 per room per week and £625 per week for a dementia care bedroom – reflecting the added care costs associated with dementia. All rooms are ensuite. The home at Hampton Wick run by the Sons of Divine Providence charges £685 per week for an ensuite room and £650 for non-ensuite rooms. At the London focus group, Graeme Riley was visibly shocked when Philip Mosley mentioned London prices. Graeme spoke of the ‘London-effect’. In Warwickshire where prices are considerably lower, the top up can vary depending on the local authority. For example, Warwickshire social services will pay around £395 per week (meaning that the person or their family must pay £100), while Birmingham will pay £368. Solihull will pay more if all the staff have NVQ qualifications. So there is huge variation not only between London and elsewhere but also between local authorities even in the West Midlands.

Thus, one of the biggest challenges for the future is the rising cost of care. For residential homes in particular, costs are increasing yet homes must be viable. The Poor Servants of the Mother of God recently sold their residential home in Streatham, south-west London. Because many of the people there were local authority funded, they were paying the lower rate per week and could not supplement that amount, thus over the years the home ran at a loss. Eventually, this was judged not to be financially viable and hence it was sold off. The Sisters of Mercy recently sold off one of their homes. As noted by other sources, it is not unusual for Catholic-run homes to charge below market prices and thus risk incurring a loss (CSAN, 2008).

Some participants suggested that there could be more coordination and oversight so that these facilities could be taken over by other religious to ensure that the Catholic ethos is maintained. This is an area where St John of God has been developing a role in management and consultancy services to congregations running residential homes. With falling vocations it is more difficult to sustain religious-run facilities. St John of God provide advice, support, staff training, expertise, etc so that the Catholic ethos can be maintained even when the numbers of religious are low and continuing to fall.

Many participants also expressed concern about how local authorities assess people for residential care. There was a general consensus that the bar has been raised substantially so that social workers are now more likely to assess quite dependent people as being able to live at home and not requiring residential care. This chimes with findings from other research. For example, as CASC (2000) states, 'more older people, including those aged 80 and over are living in private households and have mobility or care needs. 20% of those could not manage to get out of doors at all even with help'. It is now difficult to persuade social workers that older people need to go into residential homes. This can mean that residential providers have empty beds – not because people do not need them but rather because people cannot afford to pay and are denied local authority support.

In addition, another participant noted that because convents often look after their own retired members and are not registered as residential homes, they may actually miss out on money that they are entitled to claim from the local authority. Their work in caring for older members is thus rendered invisible, falling below the radar. As noted in the previous chapter, several congregations we contacted were looking after elderly religious in their own convents as 'family members'.

For example, at Maryville in Brentford, in addition to the religious who are residents of the residential home, usually from other congregations, the Poor Servants of the Mother of God also have several of their own elderly sisters living in the adjacent convent. They are not deemed to be members of the residential home and thus the convent is regarded as 'a family' and not required to register as a care home. However, if a lay person were moved across to the convent – for example, because of lack of space in the residential home - then the convent would have to officially register as a care home. Thus convents are often involved in 'invisible' caring for their own elderly members for which they are not in receipt of any

financial support. This may represent a significant saving to local authorities, but precisely because so much of this work is invisible it is impossible to quantify.

There are many other hidden contributions – such as the volunteer work done by retired sisters. At Maryville, for example, the reception desk is ‘manned’ by a retired sister who works about 37 hours per week, while another older sister volunteers in the kitchen, again at no charge.

So far the discussion has focused on older people as recipients of care, but as the above examples suggest, older people are also carers. One of the most striking things about meeting members of the SVP and talking to other care providers was the fact that many of those people involved in caring, especially on a voluntary basis, are themselves older, retired people – what we might call the active aged.

The active aged

As an ageing society, there are many challenges facing all of us. A particular problem is the fact that ‘this is a youth obsessed society’, as one participant put it, ‘we don’t do old age very well in this society’. There is a pressing need to change this attitude and approach. Instead of being seen as a burden, older people will have to be recognised for the great source of knowledge, wisdom and experience that they are.

Many of the projects we contacted rely on older volunteers. For example all of the befrienders at Vincentian Care Plus happen to be nuns, usually older, retired sisters – for example, one of them is 78 years old. Recent research on SVP members suggests that they are ‘quite mature’ with only 6% of those in the sample under 50 years and nearly 60% over 66 years old (Rossiter et al, Von Hugel Institute, 2009). The SVP clearly values the knowledge, experience and wisdom of its members. They are drawn from a range of backgrounds and have wide ranging expertise and skills - from professionals to those without any formal qualifications at all.

Many of the SVP members in Hull are themselves quite old. The challenge now is to encourage more middle aged people in their 50s to get involved in parish life and contribute

more to outreach work. This is the age group with more time on their hands, their own children were grown up and they may be retired or approaching retirement plus they were still young enough to be very active (Sr. Patricia, Hull).

Similarly, many of the Legion of Mary volunteers are themselves older people, but there are a few younger ones too. However, as Fr. Bryan noted, older people often enjoy having a younger person as a visitor – ‘older people enjoy the company of young people’. However, he added that Cornwall as a whole is an ‘elderly county’ many of its young people move away for employment. It is quite rural, there is little industry and there is also a large retired population, some of whom move into the area upon retirement. In Truro, the county town, there is larger population of young people and the Legion has managed to attract some younger members.

Inter-generational work

While acknowledging the enormous contribution of older people as carers, volunteers, and befrienders, it is important to note that many projects are also endeavouring to bring people together across the generations. The Youth SVP for example arranges for young people to go into care homes to talk to older people and to run various activities such as music and other entertainment.

A particularly interesting example of inter-generational work is Maryport Memories which takes place in the very deprived Maryport area of Cumbria,. An inter-generational project was funded by Heritage Lottery and set up to engage young people in the area to work with older residents by interviewing and collecting memories of Maryport. This was overseen by a local historian, Mike Gregson and the results were organised into an exhibition at the local museum. Projects such as these suggest strategies for overcoming some of the main problems facing older people in society, loneliness, isolation, feeling unvalued and forgotten.

Problems facing older people

In this section we turn to the key problems identified by all our respondents. This list is not exhaustive but rather to highlight the wide range of different, but related, concerns that were raised in the course of doing this research.

Isolation:

As noted in the previous chapter, questionnaire respondents identified isolation as the biggest problem facing older people. Unsurprisingly, this was also the main factor discussed in the interviews and focus groups. Elizabeth Palmer spoke about the recent SVP research (carried out by Von Hugel Institute) which also found that older people are more worried about isolation and loneliness than anything else. In the interviews and focus groups we were able to explore in more depth the causes and consequences for this isolation.

As Kim Cuthbertson in Newcastle noted, some people have contact with their families but others either don't have any families left alive or have little contact with them – so the situation is quite varied. Lack of contact with family can be a real problem. This point was also raised by respondents in the questionnaires. In rural areas, especially, lack of local employment opportunities means that younger people have to move away. This was noted by Rev Lordan, Dolgellau, in Wrexham diocese: 'many older people have few or no younger relatives living nearby because there is little employment for young people in rural/central Wales'.

Mobility:

Analysing the data from across a wider geographical area it is apparent that older people may feel isolated in rural areas, as respondents in Wales and Cumbria noted, but also in urban centres such as London, although the reasons for that isolation may be different. One participant noted that in many parts of rural England and Wales there is no public transport and this adds to the social isolation of older people living alone. In city areas, by contrast, it may not be the lack of transport but the crowded and generally busy environment, especially at peak periods, which deters older people from venturing out. For example, the new initiative 'Growing Old Grace-fully' aims to raise the concerns of older people in the Leeds and Hallam dioceses such as for example, lobbying for a mid-morning Mass, at least once per week in parishes so that older people can attend when it is easier for older people to get on public transport. Mid-morning mass could be a social occasion followed by lunch, for example. This is a simple idea but could have a big impact on people's social lives.

Fear:

Moving around in urban places can be frightening for older people. People who live on estates are scared of gangs, drugs, shootings – the fear of crime is probably greater than the reality of crime but nonetheless that perception stops people going out and about.

Absence of Community:

The lack of a sense of community was referred to by several people. Several participants noted that older people can experience a loss of belonging – not fitting into their community anymore – particularly when parishes close down and people lose their connection to local area. Out-migration, increasing numbers of migrants, industrial decline and urban decay mean older people may not be able to make a contribution to their local area any more as there is no avenue for them to get involved in local events/ initiatives. In addition, in areas with a transient population, for example in housing estates in inner city locations such as Hackney, it is difficult to build up trust and a sense of neighbourhood. ‘Most people are just struggling to exist, they don’t have time or energy to invest in building links with neighbours’ (Fr Christopher).

Bereavement and Loss:

Fr Storey from the Legion of Mary says that ‘insecurity’ is a big problem. ‘There is a need for hope’ and people are worried about death, the loss of their friends and relatives. Someone said to him recently ‘I am the only one left now’. People need to be given hope – ‘not to worry about the future, but to live in the present, and the future will take care of its self.’ ‘We need to live in the present in faith’, Fr Bryan said. Through building up and sharing of faith people can become more hopeful.

Language and cultural sensitivity:

Language can also be a barrier to social interaction. For example, many new comers particular in urban areas may not speak English as a first language and this may hinder communication with older neighbours. Of course, many people working in care for the elderly, for example staff in residential homes, are also migrants who do not speak English as a first language and may be new to this country. That may make it harder for older people to relate to them and share a common bond of experience or memory. For those with dementia, the opportunity to talk is particularly important.

Of course, migrants are not only providers of care, many older people particularly in large cities such as London and Birmingham are also migrants. For these older migrants language and cultural differences may be especially important factors in defining their care needs. At the SVP meeting at St. David's Home, language was also addressed. Older migrants may feel more comfortable speaking in their mother tongue especially as their memory of more recently acquired language may be affected by the ageing process. The SVP had matched an older Polish woman with a young Polish migrant. This young woman was not only able to communicate with the older woman in her native tongue but was also able to use her contacts in Polish community organisations to help the older woman arrange her funeral.

Cultural sensitivity is also a concern for the Irish Older People's Project. Paul Raymond says that most people 'love to talk about Ireland with someone who will understand'. The project provides 'listening, support and building up a relationship with older people over time'. For example, many older people may have concerns related to death, dying, funeral arrangements and may wish to be buried in Ireland or to return to die in Ireland. It is probable that this is not unique to the Irish community.

Several participants spoke about migrants and their cultural needs – for example, Fr Christopher mentioned the large number of Irish and older Caribbean migrants in the Hackney deanery. The 1950-60s generation of migrants are now retired. Having lived in Britain for most of their adult lives they may have become disconnected from their home country and yet may not feel at home here either. Retirement may result in a dilemma about whether to return or remain now that their main reason for coming to Britain, work, has come to an end. However, return may be an impossible dream after decades of migration. This kind of dilemma and its impact on older people needs considerable sensitivity.

Dementia:

As mentioned in the literature review chapter and in the analysis of the questionnaire data, dementia is becoming a huge issue that must be addressed. One focus group participant said that in years to come there won't be a family in Britain that will not have at least one dementia sufferer. At least one of the residential homes we spoke to, Hampton Wick, is moving towards becoming a specialist dementia care home. However, as we noted earlier the costs of dementia care may be considerably higher than ordinary residential provision.

For outreach projects recognising the early signs of dementia can be a challenge. As noted by other researchers, the detection of dementia may be delayed among older people who are living alone (Allen, 2008). For example, at St Anthony de Padua in Newcastle domiciliary carers are now being trained to enable them to spot the early signs of dementia.

The focus groups discussed dementia, spirituality and cultural sensitivity. For older people with dementia, the familiarity around religious rituals may be particularly important. Several people felt strongly that while Catholic care provision is including people of other faiths and none, it is very important that the Catholic focus is not lost and that these ceremonies and rituals are available to older people who want them.

Financial/ entitlements:

It was interesting to us that most of the participants in this research rated isolation, rather than financial worries, as the main problem facing older people. However, that does not mean that money is not a problem. Research by Help the Aged suggests that 2.5 million pensions in Britain are living in poverty (Help the Aged, 2008). Indeed, as the questionnaire data indicated, for some older people finance may be a real cause for concern. While many of the older people visited by the SVP are poor, their expectations tend to be quite low. They are the ‘make do and mend’ war-time generation and are not part of the wider consumer culture. Because they do not complain about money does not necessarily mean that they have plenty (Elizabeth Palmer, London Focus Group).

One participant in particular made the point that some older people are very worried about money, and that is a real ‘obstacle’ to accessing good quality care. She has come across several people who are ‘cancelling their care’ because they are worried that they can’t afford it. This participant expressed concern about how personalised budgets are going to affect older people. Recent changes in how care is paid for mean that older people are now paid the money which they then have to use to pay for their own care. But many don’t realise that and then panic that they cannot afford to pay for carers. While direct payments can be liberating, they can also be bureaucratic and difficult for older people to manage without help.

Financial assessments are also considered very intrusive and stigmatising by many older people – harping back to old means tested benefits. People are sometimes reluctant to reveal their personal finances and then find that they are denied benefits to which they are probably

entitled. They then receive a bill for the entire amount of their care which they cannot afford to pay so they panic and cancel their carers (Kim Cuthbertson, telephone interview).

This point was echoed by several SVP volunteers. Some of their work involves advocacy – being ‘someone to speak up for’ the older person. But, in order to do that effectively the SVP volunteers need to know what the old person is entitled to receive and where to get it from. Thus, they need to be able to signpost to other sources of information. However, the benefit system is very complex and because it keeps changing, it is difficult for members to keep up to date. Although SVP members have training, there is still a sense of frustration about being able to keep up with ever-changing regulations.

Another participant made the point that income and home ownership may be a ‘grey trap’ since people may not qualify for support because they are just above a minimum threshold. A real problem, noted by several research participants, is the complexity of provision and entitlements, people simply don’t know what to claim and how. For example, one person said that only recently she discovered there is an extra payment available for people who are dying – she did not know about it and was not claiming it. There is a sense that these entitlements are not publicised as a way of reducing demand on public resources.

The Church: Facing future challenges

Within the Church there is clearly concern about capacity. For example, in the questionnaires, many Deans, such as Rev McGinnell of Luton and Fr Clayton of Sheffield North, stated that parish priests are already working at full capacity and that their time and resources are stretched to the limit. It is clear that the needs of older people are complex and growing as the population ages, many Deans and parish priests feel that need is outstripping their resources.

Of course, the Church itself is an ageing institution with many older priests and few new recruits to replace them. One way in which the Church is meeting the challenge of falling vocations is by relying increasingly on overseas vocations. For example, the Little Sisters of the Poor manage to have about 30 sisters taking final vows each year, mostly from Africa and Asia (Sr. Agnes, Leeds Focus Group). The Poor Servants of the Mother of God also have many new vocations in their convents in East Africa (Sr. Rita).

Another way in which the Church is meeting future challenges is by developing new ministries. For example, the Daughters of Charity aim to develop new ministries that involve people from the wider community. These new ministries are intended to 'reflect present reality' as an ageing congregation with falling vocations. The idea is to set up projects that can then become self-sustaining when there are no longer nuns available to run them. Another motivation was to set up projects that older sisters could be involved in – as 'they have a lot of life skills', as well as professional skills – for example, many of the retired sisters used to work as professionals in the caring sector such as nurses and social workers. Vincentian Care Plus is intended as precisely one of these projects that will eventually become self-sustaining while retaining its 'Vincentian heart' (Sr. Margaret).

Several interview and focus group participants spoke about the need to develop lay ministries. Mark Wiggin suggested a 'ministry of older people' which would enable this group to extend their work in the Church and gain wider recognition. Several participants noted that parishes often focus on young people, and youth activities, while older parishioners may be taken for granted. But there is also an issue about formation. Almost all formation is focused on children and there is little or no formation for adults. One participant suggests that some older people have not kept up with changing church doctrine. For

example, older people who grew up in the 1940s-50s, may have a pre-Vatican II view of religion. There is a need for on-going formation.

However, while the 'old ministering to the very old' need to be recognised, younger people also need to be engaged. There is a need for more inter-generational work to get younger people more directly involved with older people to the mutual benefit of both. While appreciating the work of older people and the contribution they make to a range of voluntary groups, several questionnaire respondents also highlighted the need to recruit some young volunteers. However, it was not always easy to attract younger members as Elizabeth Tindley of the Union of Catholic Mothers noted.

These challenges may be felt most in areas of the country where the Catholic community is not very big. For example, in Hull where the Catholic community 'is not large', there are more Catholics from ethnic minority groups than among the local British population. These migrants – including Polish and Filipino, as well as Indian – are very hard working people with little free time to contribute to voluntary work. In addition, most are young people with families of their own to look after. So it is very hard to encourage such people to become involved in parish activities (Sr. Patricia).

Similarly, in Hackney, there is a young, vibrant population of migrants, many of whom are Catholics but they tend to be a transient population, with over a third of the electoral register changing every year. This transience means that it is difficult to develop a sense of community spirit. It also means that Hackney is often regarded as a first point of entry and people aim to move on as soon as they start to do better financially. The people left behind are often the most disadvantaged (Fr. Christopher).

However, Fr Christopher added that although society in general is often presented as secular, many people regard themselves as 'people of faith'. He suggested that religion often played a role in how people defined their identities even if they were not practising as such. He added that faith groups needed to raise their profile more generally in society and overcome some of the reticence about discussing faith in public. He went on to say that the Church is in a 'unique position' to do this since the Catholic Church in Britain is probably the most diverse of any organisation – certainly more so than other religions. In his parish they had a world map with 92 different nationalities in one parish! The church is therefore a 'microcosm of

society'. Catholicism is a truly universal religion – regardless of language, people all have a shared faith and a shared liturgy in contrast to many other religions who tend to be more ethnically defined. 'This creates the possibility for cohesion you don't find anywhere else'. However, as a number of participants noted, the Church does not make enough noise about this. The Catholic Church does not 'sell itself' and does not highlight the contribution it makes to society, and its capacity to bring such diverse people together.

Another participant noted that 'the Catholic Church gets a lot of bad press, Others made the point that in society today there is a lot of cynicism about faith. Secular society is very negative about anything faith-oriented and the abuse scandals are often used as a reason to discredit all Catholic organisations. Participants argued that the Church itself was partly to blame, for not being very good at public relations and does not representing itself effectively and positively in the public domain and the media. Several participants claimed the Catholic Church has a tendency to 'shoot itself in the foot' on controversial issues such as gay adoption. However demonstrating 'Catholicity in action', such as through the work of the SVP could show a different and more positive side of what Catholicism can mean. It could use issues precisely like care of older people to reach a wider audience, highlighting services for all people, not just Catholics , thus raising its profile and gaining a stronger position in the policy arena. One participant said that rather than appearing to 'pontificate from on high', the Church could speak from a more grounded position, based in the practical work it is actually doing with older people.

Certainly, our research findings suggest that Catholic care providers are ideally placed to speak on issues affecting older people and their care needs in this society. Nonetheless, it is also apparent that a lack of coordination between all the various projects, agencies and organisations across the country, means that Catholic care providers rarely speak with one voice.

In the next sections we draw together our conclusions and make recommendations.

CHAPTER 6

Conclusions

This study aimed to map the range and diversity of care for older people provided by Catholic communities. In so doing it also sought to identify what is distinctive about Catholic care provision. As well as focusing on residential care, the research also aimed to highlight examples of innovative and effective outreach and befriending projects. The findings presented in this report reveal the diversity of care across the spectrum from residential, to semi-independent living to domiciliary, outreach and befriending. The Catholic community provide a range of services including health care, respite, information and practical support, social and emotional care, as well as sacramental provision.

As discussed in chapter 2, over the next 10 years the population over 65 is projected to grow by a further 25%, reaching 11.1 million in 2019. As we also noted, the older population is becoming more ethnically, religiously and regionally diverse. In addition, although the population is living longer, not all the time gained is made up of happy years lived in good health. As shown in Chapter 2, statistics suggest that ‘Healthy Life Expectancy’ – i.e. years of life spent in ‘good health’ – is usually lower than life expectancy overall.

An ageing population raises questions about the kinds of facilities and services that are needed. What options do we want to offer as a society? At present some people may be hanging on in their own homes, perhaps feeling quite isolated, because the alternative of going into a residential home is too awful to face or is simply an unaffordable option. Sometimes quite small interventions can make a huge difference and can enable people to go on living independent lives. For example the outreach and befriending provided by the SVP can help address many of the social problems older people face.

The ideal balance between being alone and going into a residential home, might be more care villages with different degrees of help according to people’s needs. The kind of sheltered accommodation where people can retain their autonomy but where help is on hand should they need it, such as the flats provided by the Little Sisters of the Poor. This accommodation

could also meet people's spiritual needs by having daily Mass or drawing upon lay ministers including older people themselves.

One of the most interesting findings of our research was the extent to which Catholic organisations are providing care to a diverse range of people, including those of different faiths and non-believers. It is clear that the Catholic ethos is appreciated by many people, including those who are not of the Catholic faith. Thus, as many participants noted it is important to strike the right balance between serving the needs of the wider society and maintaining the core values that makes Catholic care distinctive.

In summing up the strengths of the Catholic community our participants highlighted:

- **The ethos and values of dignity and respect, which are applicable to everyone and thus are not faith-specific.**
- **The Church is both universal and local. It is geographically dispersed and locally rooted in parishes. Thus, it can access people that other groups may not be able to reach.**
- **Added value – unlike many private sector care providers who are looking to get value, Catholic organisations are looking to 'add value' to people's lives.**
- **Unity and collegiality – the Church as an umbrella brings together a wide range of groups with the potential to work together effectively across social and geographical boundaries.**

It is clear from this research that Catholic communities have enormous potential to contribute to wider policy debates in British society. As we have noted, the Catholic Church in Britain is probably the most diverse of any organisation – certainly more so than other religions. The Church can therefore be described as a 'microcosm of society'. In addition, Catholicism is a truly universal religion – regardless of language, people all have a shared faith and a shared liturgy - most other religions tend to be more ethnically defined.

However, many of the people who took part in this research expressed frustration that the Church does not do enough to publicise its work. Several care providers noted that up to now they have been following legislative changes but there needs to be a more pro-active approach so that they can engage with these policies before they are made.

The Church is also an ageing institution, priests and sisters are ageing and needing care, but vocations to religious life are declining (though not in many Developing countries). In focusing on care provision by Catholic communities, our research has highlighted the role of lay people who are already delivering all aspects of care, including sacramental provision. Clearly, there is a need to further develop lay ministries so that the full potential of the laity can be realised.

This report has focused largely on older people as recipients of care, but it has emerged very strongly from our research that in many ways older people are also carers. In the context of an ageing society, it is important to recognise the contribution that older people can make as active members of society. It is necessary to overcome the 'youth obsession' that underpins our society. As well as acknowledging the role that older people already play it is important to provide more opportunities for them to feel connected to social and community life, so that their experience can be valued as a source of wisdom.

Recommendations

Care and Support for Older People

1. Demographic changes

Given the population projections for 2020, it is imperative that the Church community consider now, as a matter of urgency, how they will respond to these emerging needs.

2. More innovative forms of care for older people

In the context of an ageing population, the cost and nature of care is a source of on-going debate. Living alone at home versus residential care represent the polar extremes of this debate. A range of alternative forms of care, such as retirement villages, semi-independent living, sheltered accommodation or support to stay at home need to be further explored and developed.

3. Measures to tackle loneliness and isolation

All the people who took part in this research highlighted the problems of loneliness and isolation, especially for older people living alone. Obstacles of mobility, fear, and a sense of disconnection from the local neighbourhood may exacerbate social isolation. There is a need for more resources at local level to provide opportunities for older people to engage with the community around them.

4. Clearer information about entitlements

It is apparent that many older people and their carers are baffled by the array of documentation relating to entitlements and this is compounded by constantly changing legislation and policy. More resources are needed to sign-post services so that older people and their carers can be given the information that enables them to claim their full entitlements.

5. Migrant care workers

Given the large numbers of migrants working in care sectors it is imperative that the rights and employment conditions of these workers are safeguarded. In addition, it is necessary that adequate training is provided not only to ensure that workers can communicate appropriately with older people but also that local customs, colloquialisms and cultural specificities are understood.

6. Dementia

More work needs to be done to improve the early recognition and treatment of dementia especially for older people living alone, where the diagnosis of dementia may be delayed. Carers need more training to recognise the early warning signs so that treatment can begin as soon as possible.

7. End of Life Issues

The end of life is increasingly more complex as people are living longer, albeit with greater frailty and multiple health conditions. There is research evidence that the wishes of older people are not well catered for and although most would wish to die at home, the majority die in care homes and hospitals. More needs to be done to enable older people to prepare for death and discuss issues relating to end of life.

8. Developing Strategic partnerships

It is necessary for Catholic organisations to develop strategic partnerships with both voluntary and public sector organisations so that the most effective services can be delivered to people in need. However, in forging such partnerships it is important that the distinctive ethos of Catholic organisations is not lost.

9. Developing Inter-generational work

While acknowledging the enormous contribution of older people as carers, volunteers, and befrienders, it is important to note that many projects endeavour to bring people together across the generations. Older people benefit from the company of younger people, while young people benefit from the wisdom, knowledge and experience of older people. Following the examples of good practice highlighted in this report, it is important that more opportunities for inter-generational work are developed.

Faith and Spirituality

10. Faith groups need to raise their profile more generally in society and overcome some of the reticence about discussing faith in public. Inter-faith projects and initiatives such as those being undertaken by the Bar convent may provide an opportunity for faith groups to work together, pool resources, reach a wider community, and lobby to influence policy decision-making.

11. Raising the Catholic voice at the table of decision making.

Catholic care providers have a significant role to play in policy making but need to be strategic, proactive and assertive in ensuring a voice in decision making circles

12. Maintaining the Ethos of Catholic Residential Care

In the context of falling vocations to religious life, it is important that the distinctive ethos of Catholic residential care is not lost. Groups such as St John of God have expertise which could be captured around service development and the training of lay staff.

13. Serving people of all faiths and non-believers

It is apparent that Catholic care provision is serving people of other faiths and those who have no religious beliefs or affiliations. While this is laudable and appropriate, it is important that the Catholic focus is not lost and that religious ceremonies and rituals are available to older people who want them.

14. Lay Ministries

Given the fall in religious vocations and the real contribution of lay people to the Catholic Church, it is important to develop more Lay Ministries. A ministry of older people should be developed to capture the skills and energy of the older population and to address the shortfall in ordained ministers.

15. More lay formation for older people

There is a tendency in parishes to focus on young people, and youth activities, while older parishioners may be taken for granted. Almost all formation is focused on children and there

is little or no formation for adults. Thus it is necessary for the Church to develop on-going formation throughout the life course and especially in the later stages of life.

Networking

16. Religious congregations should work more collaboratively on bigger projects and share resources and expertise rather than working in isolation. Working more closely together not only shares expertise and resources but affords a stronger voice with which to lobby local and national governments. Should one congregation be forced to close there may be an opportunity for other congregations to step in and take over operations.

17. Connecting parishes and residential care homes

People in parishes generally need to become more involved and proactive in making and maintaining connections between residential homes and parish life. For example, families, neighbours or friends should alert church groups when someone goes into a residential home and would welcome a visit. This is particularly necessary as residential homes cease to be run by religious congregations.

18. Developing the Role of Caritas Social Action Network (CSAN)

The findings demonstrate a lack of awareness about the existence of CSAN, the work it does or the support it could offer. Those who knew about CSAN felt it had the potential to have a greater role in raising the profile of Catholic Care givers, facilitating networking opportunities and providing relevant information and forums for debate. The findings suggest that CSAN might have a role in providing information about funding streams and assisting Catholic organisations to access funding for the services they currently deliver.

19. More coordination needed between Catholic care providers

As noted above, many Catholic care providers are small and scattered throughout the country. But even larger providers can also feel isolated and marginalised at times. There is a need for more networking and coordination at a national level so that these many providers can share their experiences and resources. This suggests that CSAN has a bigger role to play not only in providing a forum for networking but also in helping Catholic organisations to become a 'loud advocate for the needs of older people in society. Many Catholic groups are currently feeling demoralised and this may explain partly why they have been reluctant to get involved in wider initiatives like CSAN.

20. Further research needed

As we noted in this report, it has proved difficult to map the full range and diversity of Catholic care provision, especially outreach and befriending, throughout the country. This can only be done by a detailed, nation-wide parish survey. This would be an expensive and time consuming project but would clearly demonstrate the exact nature and extent of the work being done and the support being provided by Catholic communities.

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APPENDIX

QUALITATIVE DATA:

LIST OF PARTICIPANTS AND ORGANISATIONS

INTERVIEWS

1. SR. MARGARET BANNERTON, VINCENTIAN CARE PLUS, LONDON.
2. FR. CHRISTOPHER COLVEN, DEAN OF HACKNEY.
3. PHILOMENA CULLEN AND PAUL RAYMOND, IRISH CHAPLAINCY, LONDON.
4. KIM CUTHBERTSON, ST. ANTHONY DE PADUA COMMUNITY ASSOCIATION, NEWCASTLE
5. SIOBHAN GARABALDI, WESTMINSTER DIOCESE, SVP.
6. SR. RITA AND SR. ELIZABETH, MARYVILLE HOME, BRENTFORD.
7. SR. PATRICIA SILKE, PARISH SISTER, HULL.
8. FR. BRYAN STOREY, LEGION OF MARY, CORNISH COUNTY BRANCH.

FOCUS GROUP PARTICIPANTS:

LONDON FOCUS GROUP:

ELIZABETH PALMER, SAINT VINCENT DE PAUL.
 PHILIP MOSLEY, SONS OF THE DIVINE PROVIDENCE, LONDON.
 GRAEME RILEY, FATHER HUDSON SOCIETY, BIRMINGHAM DIOCESE.

ST. VINCENT DE PAUL MEETING AT ST. DAVID'S NURSING HOME, EALING,
 WEST LONDON (APPROXIMATELY 12 MEMBERS PRESENT).

LEEDS FOCUS GROUP

SR AGNES, LITTLE SISTERS OF THE POOR, LEEDS
 BR MARK MORGAN, ST. JOHN OF GOD CARE SERVICES,
 ANNE FORBES, GROWING OLD GRACE-FULLY, DIOCESES OF LEEDS AND
 HALLAM.

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PHIL MOORE, CARITAS CARE PRESTON.

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