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A note on terminology

Under the Care Standards Act 2000, the distinction between "residential care homes" and "nursing homes" was replaced by the single category of "care home". But it is not for this reason that I have used the phrases "care homes", "residential homes" and "residential care" interchangeably. Rather it is because very often the information I have drawn on makes the distinction, as, of course, does history. I have only made specific reference to either category - likewise, to dual registered homes - when it has been necessary to do so. To keep making the distinction throughout the text would be tedious.

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Surrey
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Introduction

In 2002 there were 50 religious orders providing residential care facilities [1], while some of the diocesan societies of England and Wales also offered this kind of residential care. Sometimes this is along with other kinds of care services for different age groups or other groups of people like those who are learning disabled. Yet anyone who has spent a period of time studying residential care for older people provided by the Church is struck by the fact of how little communication, liaison and co-operation there appears to be between providers. Given the structure of the Church, this may not be surprising: communication here reflects the wider situation - it tends to be upward and downward, rather than horizontal. The diocesan agencies are accountable to their bishops and the religious orders to their superiors. It is perfectly possible that a home run by one order in difficulties may not be in touch with a successful home, run by another order or society, no distance away – although the latter may well be able to assist the former. It may be significant that a decade ago the Care and Housing of Elderly Religious, now defunct but then a division of the Conference of Religious, attempted to set up a data base but received only a 15 per cent response. Observation and evidence suggests that providers who do not look within their own ranks are even less likely to seek help, advice and encouragement from outside. Given how progressive and successful some voluntary providers are, while Catholic homes frequently struggle to stay open, the parlous state of religious-run homes can only be described as a tragedy and an avoidable one at that.

This impression of isolation, of people seeking, often vainly, to deal with problems on their own or within their orders, was one which came over strongly as a result of the research, carried out in 2002 and published in 2003, in *On the Homes Front. The Catholic Church and Residential Care for Older People*. That report attempted not only to describe the quantative problems which the research revealed; it also collected the experiences and comments of the orders and those running homes. It was a depressing picture of mostly decline and difficulty, set in the wider context of the vicissitudes of private and voluntary residential care for older people that have occurred since the NHS and Community Care Act 1990 was implemented in 1993.

This report is not a follow-up in the sense of attempting to update the research and to look at where we have reached in the four years since publication. That has not proven possible. Suffice to say that later research would almost certainly have shown no improvement in the situation and, if anything, only further decline. This is partly because some of the factors that have determined the position of religious homes have continued unabated. Most notable perhaps has been the decline in vocations to the religious life. This has stemmed the ready supply of those who could work in the homes which, in turn, substantially lessened the salary costs that employing lay staff brings with it.

The residential home care market in even those four years has itself changed in some important regards. The private sector has seen a growth in larger providers who have come to dominate the market, while the share taken by the voluntary sector stays steady.

For these reasons, I have summarised the original research, set it in the context of the more recent history of the market, and also said something about the newer changes.

The 2003 report made no mention of the demographic facts of life: the growing numbers of older people and the advance in the growth of those likely to suffer from dementia (to mention but one condition largely, if not exclusively associated with old age). Understanding these figures is necessary to understand the context in which all homes – religious and secular – work because it influences the type of person who now comes into residential care. I have, then, devoted a chapter to those aspects.

But given the rather dire situation which the 2003 research reported, it is necessary to point forward and show how

1 Philpot T, (2003), *On the Homes Front. The Catholic Church and Residential Care for Older People*. London: Caritas Social Action Network

progress might be achieved and the sources which might assist it. A few general ideas were offered in 2003 but it is important to ask: what is happening? What can be done to stem the decline of religious homes? Who is doing it and what are they doing? This is an important part of this report, the more so because of the lack of communication and isolation mentioned above.

Obviously, I could not carry out a comprehensive survey of all the positive work being done, within and outside the Church, but I have been able to meet some people who have responsibility for homes that cater for the spiritual life of residents, as well as their physical and social well being. In reporting what they are doing, I offer some examples of positive action and how it has been achieved. There are many, many more but the problem is finding them: too many agencies and individuals work on their own and the solutions they have found are not widely known. However, it seems to me important not only that the Church should be able to look to its own resources and innovative work but also that it should look further a field to see what might be learned from what non-Catholic agencies are doing.

Time is running out for the Church when it comes to providing residential care for older people and there appears to be a lack of urgency to address this problem. It is not that this stems from indifference. It is more likely that it results from an inability to know what to do in the face of a seemingly relentless decline. Alas, this decline comes at a time of a steady growth in the numbers of the older population, when longevity is increasing, and when what the Church can offer will be needed all the more. Many of these older people actively desire that the residential care they seek should be one which offers them a Catholic ethos and the opportunity to practice their faith.

In 2000 the Catholic Agency for Social Concern (one of Caritas Social Action Network's predecessor bodies) published *Community Care: The Challenge for the Catholic Church* [(2)]. It recommended that religious congregations and diocesan welfare agencies, among others, should plan strategically for community care and that local Catholic providers should "explore the options" for developing their future role in the planning and delivery of services, where appropriate in partnership with a statutory and voluntary provider. It also noted the difficulties facing residential and nursing homes run by religious congregations, which included making up shortfalls in statutory funding from voluntary sources or face closure.
The report went on:

> Such closures constitute a major loss for the whole Catholic community and reduce the choice of homes committed to placing human need and dignity above profit.

However, it made no recommendations to tackle this.

To give another small but illustrative example of how this is a problem which rarely gets an airing in the Church: the Conference of Religious closed Care and Housing of Elderly Religious (admittedly a body that was catering only for those named in its title) promised that information which I sought about CoR's interest in these issues would be found on its new website. That website is not easy to find: one has to go to another site to access it. But when I clicked on "healthcare", the part to which I was directed, I found that it was password-protected!

This report necessarily focuses on residential care homes because they have been the major way in which the Church's work with older people has been expressed and that continues to be the case. The future here may be uncertain but other forms of residential care are being developed very successfully for older people who cannot continue to live in their own homes. Care villages and sheltered housing are two developments which meet need and attune with modern ideas of living. There will always be a role for care homes. The voluntary care homes sector as a whole is not one which looks like it will expand but it is not declining; it remains steady. This means that if the Church is to continue its work to meet the needs of older people it will have to preserve what is best in its care homes but also seek new and imaginative ways of offering care. It does not have to invent them. They exist here and now. They are being planned and developed here and now and some of this is being done by elements within the Church.

Thus, in some small way, it is hoped that this report can provoke those who have the power to act, but are uncertain what to do, to realise that all need not be lost. These are not only bishops and superiors but everyone in the Church who has the interest of its older members at heart - and in that I include all of us in the pews.

With some boldness and new thinking and an active policy of seeking to learn from others, there are ways to ensure that Catholic care homes for older people remains an important part of the social provision of the Catholic Church, while at the same time developing new kinds of provision.

2 Catholic Agency for Social Concern with the Social Welfare Committee, Bishops' Conference of England and Wales (2000), *Community Care: The Challenge for the Catholic Church*. London: CASC

One How we got here

How we got here

In two decades the landscape of residential care for older people has been reshaped beyond recognition. While Catholic homes have had special problems to face, they have nevertheless also been deeply affected by what has happened in the wider world. That world has proved to be a volatile one and the fortunes of religious-run homes have exposed the realities of the so-called mixed economy of care as much as fortunes elsewhere in the sector, which, of course, includes the voluntary sector as a whole.

Until the mid-1970s the largest providers of residential homes for older people were local authorities, with nursing homes being offered by the NHS. This type of care within the welfare state had expanded and the state had largely financed both residential and non-residential provision. The voluntary sector existed as a provider of residential care, funded mainly through local authorities and such private care that there was tended to be used by those who could pay for themselves.

That has now changed so radically that many local authorities no longer provide residential accommodation and others provide very little. The changes were in the offing before the NHS and Community Care Act 1990 as other forces came into play. Britain's 1976 monetary crisis meant less money for local authorities which affected both their own provision and what they would pay the voluntary sector. Demographic changes, too, began to have their effects. But the 1990 legislation created a "market" in care, for both residential and community services and for all age groups and types of care. New private owners joined established ones and local authorities were actively encouraged to hive off their accommodation to not-for-profit agencies, which were sometimes, effectively, run by those who had been managers of the homes when the councils ran them.

The reason for such sweeping changes was simple – money. The legislation both capped the open-ended funding of care home places and, for the first time, introduced an assessment of need. The genesis of this was that in the early 1980s, the then Department of Health and Social Security had amended supplementary benefit regulations to make it easier for residents in private and voluntary homes on low incomes to claim their fees from the social security system. Assessment of financial need, not the social, physical or mental health needs for this kind of care, determined the public subsidy. The results of taking the lid off of social security spending was that state spending of £6 million in 1978 spiralled to £460 million in 1988 and £1.3 billion in 1991. (1) The number of places in privately owned homes for people with a physical or learning disability and elderly people (the growth was largely for the latter group) almost doubled (increasing 97 per cent) from 1979 to 1984 and by 1990 had risen by 130 per cent since 1979. (2) Using another source, the figures went from 46,900 places in 1982 to 161,200 in 1991. (3)

In 1986 the Audit Commission drew attention to the effects of social security funding of this sector (4) and the government appointed Sir Roy Griffiths to review the situation. His report (5) identified the "perverse incentive" which encouraged older people to enter residential care rather than to continue to live with support in their own homes. The government's almost immediate response was a White Paper (6) and the NHS and Community Care Act 1990 which followed quickly in its wake, although its implementation was delayed until 1993.

1 Walker, A, "Community care policy: From consensus to conflict" in Bornat, *J et al, Community Care: A Reader*. Buckingham: Open University Press/ Macmillan, 1992

2 Walker as above

3 Laing and Buisson, *Laing's Review of Private Health Care 1992,* London: Laing & Buisson, 1992

4 Audit Commission, *Making a Reality of Community Care,* London: HMSO, 1986

5 Griffiths, R, *Community Care: Agenda for Action,* London: HMSO, 1988

6 Department of Health, *Caring for People: Community Care in the Next Decade and Beyond,* London: HMSO, 1989

The Griffiths report's philosophy and the Act did two important things – they began the move of local authorities from being providers to being commissioners of care. This would affect the whole range of social care provision but it may be that the effect has been felt most in the residential care sector and, in particular, that for older people. This is probably because of the second important effect - to shift the social security budget for residential care for a period of three years to local authorities. The sums were "ring fenced" for that period to allow councils to create "packages of care" to suit the individual needs of older people and also to create what the Conservative government called a "level playing field" between the private and public sector. But the playing field was always severely slanted because 85 per cent of the transferred funds had to be spent on contracting private and voluntary services. This created what has already been referred to - a new, diversified market with local authorities hiving off their residential provision into self-governing trusts, management buy-outs and the private sector.

The results of legislative change

In 1976 for every one person accommodated in the independent sector in England there were five in the public sector. By 1982 that ratio had gone from one to three; in 1988 it was one to one. From 1989 the independent (but particularly the private, as opposed to the not-for-profit) sector dominated the market. In 1992 for every one public sector resident there were two cared for in the independent sector. (7) It is now believed that 91 per cent of care homes in England and Wales are owned and run by the private and voluntary sectors. (8)

The care homes market has traditionally been viewed as a haven of small business, with, typically, a husband and wife as the owners. Private sector homes and those run by the voluntary sector were lumped together under the heading of the "independent sector", a phrase coined by the Conservative government when piloting through the legislation. However, the varying fortunes in the market since the 1990 Act – for example, the failure of fee levels to keep up with costs and the additional costs arising from the imposition of higher physical standards in homes – have seen very large changes in the pattern of ownership. Some large providers have always been in the field, others have entered and flourished, and others (some of them newer entrants) have been absorbed by takeover in to ever-larger companies. Private equity firms, too, have shown an increasing interest. There is now clear evidence of further consolidation in the care home market.

More recently corporate and larger owners have become the dominant segment in the marker. In April 2007, according to Laing & Buisson, care providers with three or more facilities owned or operated 212,000 of the 411,000 places in independent sector care homes for older people. This represents a rise of three per cent over the previous year to a 52 per cent share of the market. The top ten providers now have 24 per cent, with Southern Cross alone holding eight per cent with 33,000 beds in 630 facilities. Of the top ten there are three not-for-profit providers, the largest of which is Anchor Homes with one per cent. (9)

It is worth remarking that figures for learning disability services show a similar trend with major providers holding a 52 per cent market share. The top ten providers account for 14 per cent with Craegmoor the market leader with three per cent. Eight of the top ten providers are for-profit. However, the number of medium-sized voluntary sector providers means that the not-for-profits have a 30 per cent overall market share. (10)

The trend toward dominance by larger and corporate providers seems likely to continue, although Laing & Buisson (11) state that it will be a gradual rather than a rapid change. The voluntary sector share of the market has remained constant since 2000 at slightly more than 16 per cent and is likely to remain so. There are, though, exceptions within the voluntary sector. For example, the MHA Group took over ExtraCare Charitable Trust's nine nursing homes and dementia care homes in November 2004. That same year Shaw Healthcare (Homes), a charity, took over eight homes from Northamptonshire County Council. The next year the Orders of St John Care Trust took over the management of 21 homes from Gloucestershire County Council and boosted the number of their homes by near a quarter to 74. That year, too, Shaw took over 16 care homes for older people from West Sussex County Council. (12)

7 Peace, S, *et al, Re-evaluating Residential Care,* Buckingham: Open University Press, 1997

8 Dyer, C (2007), "No human rights for old in private homes". News story, *The Guardian,* 21 June

9 Laing & Buisson (2007), *Long-Term Care Directory of Major Providers 2007.* London: Laing & Buisson.

10 Laing & Buisson (2007), as above

11 Laing & Buisson (2006), *Care of Elderly People.UK Market Survey 2006.* London: Laing & Buisson

12 Laing & Buisson (2006), as above

But to put this into perspective, one has to recognise that, as of 1 April 2006, the top four independent (voluntary and private) providers controlled 22.1 per cent of the independent sector care home capacity for older and physically disabled people. And while the top 10 (both private and not-for-profit) controlled 27.2 per cent, only three of those were in the voluntary sector.

Of that top 10, the top four were private. Southern Cross Healthcare had 527 homes with 27,744 beds and took 8.1 per cent of the market. Bupa Care Homes were second with 294 homes, 21,036 beds and 6.2 per cent of the market. Third came Four Seasons (JDM) with 316 homes, 16,416 beds and 4.8 per cent of the market, followed by Barchester Healthcare with 156 homes, 10,021 beds and 2.9 per cent of the market. Anchor Trust, the largest voluntary provider, came fifth but was noticeably smaller (although the trust does run care homes for people with a mental illness and learning disability, which are not included in these figures). Anchor had 97 homes, 4,284 beds and a 1.3 per cent market share. After that the number of homes, beds and market share in the voluntary sector falls dramatically in comparison with the top five. The Order of St John Care Trust is sixth with 74 homes, 3,216 beds and a 0.9 per cent market share.

The costs of care

For some time now the biggest source of friction between the independent sector, government and local authorities has been the amount in fees which local authorities pay. This amount, the independent sector claims, falls seriously short of the money needed both to provide high standards of care for each resident and to allow private homes to be profitable and voluntary homes to make a surplus for reinvestment.

There is something of a buck-passing circularity about this argument in that local authorities, in turn, blame central government for not providing them with the cash. In this sense, the owners and local authorities are on the same side and much energy is wasted by the friction.

Although it is now five years old, a small survey published in 2002 is perhaps illustrative of market problems for (one assumes, as it does not say so) small providers. This was based on 143 responses. It showed that two-thirds of homes had considered refusing residents funded by local authorities and that more than half had considered closing in the past year. (13)

In that same year research showed that there was a £1 billion shortfall in homes funding and that fees paid by local authorities were no longer enough to provide good quality care and extract a reasonable profit. (14)

In 2006, a survey of baseline fee rates for homes for older people showed that significantly more councils were offering increases below inflation in 2006-2007 than those who were offering above inflation increases. (15)

Laing & Buisson and the Joseph Rowntree Foundation have devised a "fair price model" in which fee increases in the 3.5 to 3.8 per cent band typically represent a standstill in margins – that is, fees and costs keep pace with one another. Above that increases are likely to be real and an improvement in average margins. For 2006-7 in England, the Community Care Market News survey showed that:

- more local authorities gave increases below the 3.5 per cent band required to maintain average margins (16);
- 59 per cent of councils gave those running nursing homes for older people an increase below inflation;
- 61 per cent of councils did that for those running residential homes for older people;
- only four per cent of councils offered baseline increases at the "margin neutral" level of 3.5-3.8 per cent for nursing care and only three per cent did so for residential care;
- 23 per cent of councils gave increases above 3.8 per cent for both nursing and residential care; while
- only 2.5 per cent of councils gave more than 10 per cent for nursing care and 3 per cent for residential care. (17)

It remains a fact that local authorities largely expect to pay less a week for the accommodation, board and 24-hour care of highly vulnerable, and often very dependent, people than would be charged for bed and breakfast in a Travelodge hotel. This may account for growing use of "top-ups" (money made available to meet the difference between what the local authority pays and the sum required) and the encouragement of those who pay for themselves.

13 News report (2002), *Community Care,* 20-26 June

14 Laing, W, (2002), *Calculating a Fair Price for Care: A Toolkit for Residential and Nursing Care,* York: Joseph Rowntree Foundation/The Policy Press

15 Community Care Market News, quoted in Laing & Buisson (2006) above

16 Community Care Market News, as above

17 Laing & Buisson (2006), as above

Homes closures and bed losses

The annual survey by Laing & Buisson, the most authoritative source of information about the market, does not distinguish between homes for older people and those for physically disabled people. According to the survey [18], as of 1 April 2006 there were 180,100 private places in residential homes and 53,600 in voluntary homes. Local authorities offered a further 38,600 places. Nursing care places accounted for 161,000 in the private sector and there were 14,200 places in the voluntary sector. There were 500 nursing places run by local authorities.

The high point for local authority provision was 1984 with 136,500 residential places (the private sector then offered 54,700 and the voluntary sector, 45,300). The year 1999 marked the high point for private sector residential places at 180,000, with councils providing 68,500 and the voluntary sector 53,500. The voluntary sector achieved its high point in 1996 when councils offered 77,200 places and the private sector 172,000.

But while the voluntary and private sector places have fluctuated, those provided by local authorities have been subject to inexorable decline.

Council nursing home places are not listed by Laing & Buisson and those for the voluntary and private sector were combined from 1970 until 1986. In 1997 the private and voluntary sectors each reached their highest number of nursing home places with the former offering 205,900 and the latter 18,500.

The most recent returns from the Commission for Care Standards Inspection show that while the number of homes all round is decreasing, the number of beds is increasing, which indicates that new homes are larger than those which they replace.

New standards

In April 2002 the National Care Standards Commission replaced local authority inspection and regulation. Although the latter system had been at "arm's length" from the councils, in essence a local authority agency was regulating and inspecting the council's own homes. Fourteen days after the NCSC started work the government announced that it, too, would be replaced, as it was, in 2004, by the Commission for Care Standards Inspection. The CSCI is now itself to be replaced by the creation, in 2009, of Ofcare, an all-embracing regulatory body which will draw in the CSCI, the Mental Health Act Commission and the Healthcare Commission.

But even at the time when local authority inspection and regulation units were created, there were claims by some homeowners that the then existing standards and regulations imposed unreasonable costs on them. This argument began all over again with the establishment of the NCSC and the onset of the new standards. In fact, some homes closures have been attributed to the burdensome financial cost of bringing homes up to standard.

This is difficult to prove because although, as has been stated, large numbers of homes have closed, the reasons for those closures tend to be anecdotal. It has also been suggested that some homes closures have been brought about by owners wishing to cash in on a booming property market. However, on the basis of the Caritas research [19] the cost of bringing homes up to the new standards has undoubtedly adversely affected some Catholic homes. The tragic irony of this was that while many homes (secular and religious) took on the work of implementing the new standards, which were to have come into effect in 2007, the government then announced that the standards would not be mandatory.

The voluntary homes sector

While much coverage and comment relates to problems faced by the private (for-profit) sector, the voluntary sector is not immune. For example, in April 2002 the Church of Scotland, one of that country's biggest providers of social care, announced that it would close nine of its homes. It, too, blamed the gap between the cost of provision and the fees payable to meet it.

However, Catholic homes have been traditionally different from all others, both voluntary and private, in that they have the same kind of costs to meet with one exception – for those who have relied wholly or partly on members of religious orders to provide care, their staff costs have been lower. However, the proportion of lay staff employed has for some time been increasing and with the fall in vocations will continue to do so. (It remains the case that both statutory and other independent sector homes staff are among the lowliest paid of all social care employees.) Like other voluntary providers Catholic homes are not seeking a profit. However, they do require surpluses for reinvestment.

18 Laing & Buisson (2006), as above

19 Philpot, T, (2003), *On the Homes Front. The Catholic Church and Residential Care for Old People.* London: Caritas Social Action Network

Who enters residential care?

One modern myth is that in our modern, prosperous, fluid and mobile society the family eschews caring for its older members. This is said to be partly because large numbers of women, the traditional care givers, now work and also because divorce is now more prevalent. This is, however, not the case. The General Household Survey in 2000 showed that 16 per cent of adults in Britain (6.8 million people) cared for a sick, disabled or older person. Women were more likely to take on this role but not by the margin that one might suppose (18 per cent of women to 14 per cent of men). Various reports indicate that neither greater numbers of women working nor higher divorce levels have resulted in family responsibilities being shunned. (20)

As Parker wrote:

> One of the most persistent misconceptions about "modern" society is that the family no longer cares for its dependents, especially the elderly. (21)

This myth is further undermined by the numbers of older people who actually make use of residential care: it is only four per cent. (22) In fact, the proportion of older people using residential care has not changed since homes came into being.

But who uses residential care and why do they enter a home? The typical characteristics of those who are admitted are that they are over 80, female, unmarried, live alone, and live in house rented from either a local authority or a housing association. They are also in receipt of Income Support and Housing Benefit, and an Attendance Allowance, and live in a poorer neighbourhood. Forty two per cent are functionally disabled; 38 per cent are in residential care because of stress caused to their carer; two per cent have been abused; and one per cent are homeless. They suffer a variety of illnesses including dementia (38 per cent); arthritis (32 per cent); and cardiovascular disease or stroke (20 per cent). (23) According to another source, 50 per cent of residents have dementia; 76 per cent require assistance with mobility or are immobile; and 71 per cent are incontinent. (24) There is some evidence that they are older and more dependent than a decade ago. (25)

One survey showed that only 1.2 per cent of residents were from an ethnic minority. (26) But they are different, both negatively and positively, from their white counterparts. They are likely to be younger; male; living with their family prior to admission; have a higher incidence of cognitive impairment, dementia and incontinence; and be generally more dependent. Mental health problems are more likely to account for their admission or they are more likely to have problems with their housing or carers, rather than have physical health problems.

The future

While larger (and very large) companies have dramatically increased their share of the market (as shown, they are said now to own 52 per cent of the private care market for older people) and takeovers are very common, the less well-protected part of the independent sector - the small owners and some of the voluntary homes - is in a state of crisis not of its own making. Catholic homes are a part of this. It is arguable that successive governments are partly to blame not only because of their inability to make money available to meet at least adequate fees but also by making the residential care of older people so reliant on the private, for-profit sector, as well as the strains this has brought to the vulnerable voluntary sector.

But whatever may be the prospects for matters as diverse as fees and vocations, in the longer term changes in society offer possibilities for the future, all of them possibly co-existing. There may be less call for residential and nursing homes as we know them. Even today some are re-inventing themselves as places of specialist provision like, for example, for dementia care and end-of-life care. There may also be more diversity than currently with the development of intermediate care.

20 See Laing & Buisson (2006), as above

21 Parker, G, (1990), *With Due Care and Attention: A Review of Research on Informal Care.* London: Family Policy Studies Centre

22 Bajekal, M (2002), *Health Survey for England: Residents and Their Homes.* London: The Stationery Office

23 Help the Aged (2006), *My Home Life. Quality of Life in Care Homes.* London: Help the Aged

24 Bowman, J et al (2004), A national census of care home residents. *Age and Ageing.* Vol 33

25 Netten, A, Bebbington, A, Darton, R and Forder, J (2001), *Care Homes for Older People. Vol 1: Facilities, Residents and Costs.* Canterbury: Personal Social Services Research Unit.

26 Bebbington, A, Darton, R and Netten, A (2001), *Care Homes for Older People. Vol 2: Admissions, Needs and Outcomes.* Canterbury: Personal Social Services Research Unit

Again, the growth of privately provided sheltered housing accommodation has depended on older homeowners selling their homes to buy into this sector. The spread of home ownership for a younger generation which itself is now approaching retirement may mean that such an option will become even more desirable for people when they contemplate their living arrangements in old age. If sheltered housing is desirable for older people who can afford to buy, it is also desirable for those who cannot.

These considerations are only some which point to how care may be provided in the years to come. But prospects, which indicate a more positive future for different varieties of residential care, need not leave the Church stranded. The Church can be (and, indeed, parts of it already are) involved in this. Such developments cast a light on what the Catholic Church is willing to do for its older members as much as what it means for other providers.

Two What we know

What we know

While, as has been stated, it has not been possible to return to the field and update the research, nevertheless the original research remains valuable: it is the only source of what we know of the state of Catholic homes. It is, therefore, worth repeating some of those findings to understand where we are and the task ahead, as well as reporting some interesting academic research on closures, which has since been published, as well as a couple of developments within the Church.

The research involved contact with 238 religious orders. Two hundred superiors and three bishops were interviewed and two focus groups of parishioners were held in two dioceses. (1)

Despite the fact that the overall outlook for the future of this kind of care was not encouraging, the research found that residential care for older people provided by the Catholic Church is extensive. Religious orders also provide such homes for their own members as well as for older priests. Even many of the orders which do not provide residential care as part of their mission, do so for their retired members.

Fifty of the orders ran homes for older people and 45 per cent of them had not been involved in the closure of homes or withdrawal from the field, nor had plans to do so. New homes had also opened: six congregations and one large lay body were building purpose-built homes that would, typically, have lay management assisted by religious staff. However, of the congregations who had not closed homes or withdrawn, a quarter said that they were "just surviving" while 55 per cent were concerned about the future of their homes. Of those running homes, 23 orders had been involved with closure or withdrawal of residential or nursing homes.

A quarter of the orders facing closure felt that they had no other option but three-quarters did spend much time considering alternatives. The report commented: "Perhaps it says much about the sector generally that they never met with success." When closure or withdrawal was being considered the new Care Standards had tipped the balance against continuing. Like other providers in this sector, the Church's provision was affected by both the new standards and inspection regime, which came into being in April 2002, and inadequate funding by local authorities. However, fewer vocations, in particular, exacerbated the problems that homes faced.

Another special factor is that, unlike the private sector, while fee levels are critical, Catholic homes are not a business: they take people with little or no support. One congregation had four residents paying £120 a week, even though the nursing home place cost £459. In financially healthier times, congregations would not have blinked at such a subsidy; in times of financial stringency, it caused problems.

In some important ways, religious-run homes face the same problems as secular homes – with the important exception of the fall in vocations – and so reasons for closure are often the same. For example, at about the same time that the research into Catholic homes was being conducted, the Personal Social Services Research Unit at the University of Kent carried out a study of care home closures. (2) The sample of providers who had closed homes consisted of six nursing homes, 11 residential homes, and three dual-registered homes from both parts of the independent sector - ownership (private (x17) and voluntary (x3) – and across geographical regions. Providers ranged from sole traders to partners owning single organisations or groups of two or three units through to representatives of large organisations. (The researchers do not state how many, if any, homes, were religious-based.) Homes ranged from nine to 99 places.

Several reasons given for problems were not relevant to comparisons with Catholic homes, like, for example, property prices, concerns about the increasing dependency of residents, or loss of motivation. However, all but one of the homes (which closed due to an

1 Philpot, T (2003), *On the Homes Front. The Catholic Church and Residential Care for Older People.* London: Caritas Social Action Network.

2 Williams, J, Netten, A, Hardy, B, Matosevic, T and Ware, P (2002), *Care Home Closures. The Provider Perspective.* Canterbury, Kent: PSSRU

enforcement notice) closed either to avoid further losses or because the business was earning an inadequate return. The two most decisive reasons were the costs of the National Minimum Standards (x15) and local authority fees not meeting costs (x14). Over half the respondents were influenced by past increases in running costs (x11) and the expectation that local authority fees were unlikely to cover future costs. (x13).

Evidence from the research into Catholic homes revealed that when religious superiors looked for alternative, secular care for their retired members, they found the lack of sacramental and spiritual life "distressing". Indeed a third of the congregations recognised the need to start planning now for their older members. However, it was also the case that for most, it was too costly to create their own residential and nursing homes and this was also the case for most congregations when it came to considering a scheme proposed by the Congregation of Religious. This would have allowed congregations to join together to set up homes for those members who required such care. A quarter of the congregations would have liked to have participated in such a scheme.

Of course, the distress caused by the lack of a sacramental life would also apply to lay people who went into many secular homes. But, interestingly, while the CoR's collective approach would have helped provide care for retired religious, there has never been any suggestion that congregations might band together and pool knowledge and resources to develop (and save) care homes more generally. It could be that this scheme floundered because the numbers of homes for retired religious is not great so there are fewer economies of scale or it could be that insufficient thought was given to imaginative planning or making use of professional advice. These are matters which this report will emphasise.

But with that and the CoR's suggestion still in mind, 50 per cent of congregations felt that working in partnership with other congregations and secular organisations would be the most effective way forward for Catholic social care and some had done so. In addition, the bishops and the focus groups identified sheltered housing as a possible part of future provision for older people. But again these ideas remain, for the most part, aspirations. In the past five years no steps have been taken by the Church collectively to make them a reality.

The problem of homes closure was one which featured prominently and interviews with superiors revealed that there was no "right way" to close a home. It was always traumatic, "dreadful", and left some religious and their superiors distressed for years. Some referred to closure as "a great loss" and some sisters were said to "have never recovered" and "are sad in their own way all the time". Closure always came as a shock to residents who had expected to end their days in the home. They often felt "let down", "distraught" and "very vulnerable". There was alarm at the prospect of moving but the majority (90 per cent) went to other nursing and residential homes.

Slightly more than a third (35 per cent) of religious entered new areas of work when homes closed or orders withdrew from the sector. This included running retreat houses, hospital chaplaincy, parish catechetics, work with drug misusers and with prisoners and their families, teaching, and counselling. Eight per cent of religious continued the same work elsewhere and four per cent stayed to work under the new management. Some of those aged 70 and over retired.

Both lay and religious interviewed in the report felt that Catholic homes offered a different ethos from other kinds of home. They allowed residents to maintain links with their parishes and gave them the opportunity for daily mass attendance. Residents had a shared sense of values, experience and outlook. The provision of homes was also felt to be a witness to local communities. Catholic homes offered a sacramental and spiritual life in a society that does not find it easy to accept spirituality generally, as well seeing it as integral to good social care.

It is clear that next to other kinds of social care provision by the Church this work is overlooked. It is neglected by the media, politicians and the public. It was ironic that at a time when the government seeks a greater role for the voluntary sector in social care and places emphasis on faith-based schools (something which has been emphasised even more by government since *On the Homes Front* was published), it has nothing to say about faith-based care for older people, and leaves such care to the whims of the market.

The report stated that "it should also be noted that there is yet to be a united Catholic voice to make the case for Catholic care and draw attention to its special problems". Since then Caritas Social Action Network has taken a step in that direction and revived its older people's forum. However, at the same time, the Congregation of Religious' Care and Housing for Elderly Religious has been wound up and nothing appears to have replaced it.

Three Old age and the crystal ball

Old age and the crystal ball

For some years now it has been common to claim that the UK faces a "demographic time bomb". Such a phrase suggests crisis while also implying that older people are a burden both to their families and to society through the undue pressure they place on public services. There is a further implication: that the lot of this growing population of older people is one of increasing disability and dependence. Old age, it is true, can bring with it many physical and other problems but many older people live relatively healthy, fulfilling and independent lives, many of them into extreme old age. This may be even more so in the future as the immediate post-war generation ages: this is the one which has most fully benefited from a free health service and, at one time, different kinds of free provision at school, like free school milk, and meals and other nutrition.

There remain, however, many worrying uncertainties about the future, not least in the field of pensions and the health risks which may become apparent in many years time for a younger generation which appears to suffer from higher levels of obesity and excess drinking. But forebodings about pensions are still at the point of solutions being sought and it is probably too early to assess whether eating and drinking habits have changed so radically for the worst that there will be a reversal in the health of the third and fourth post-war generations.

There are, though, some things we do know beyond doubt. These concern the growth in the numbers of older people.

Let us take some bald facts [1]:

- In 1971, in a UK population of nearly 56 million, there were nearly 7 1/2 million people aged 65 and over and more than 1 1/4 million people aged 80 and over.
- Thirty years later (2001), our population had just topped 59 million but the numbers of over-65s had risen to more than 9 1/4 million and those over-80s to almost 2 1/2 million people.

The projections are that:

- In 2011, in a population of just above 60 1/2 million, there will be nearly 9 3/4 million people aged 65 and over and nearly 3 million aged over 80.
- Twenty years after that – that is 2031- our population will be just over 67 million, with more than 15 1/4 million aged 65 and over and more than five million aged 80 and over. To put this last figure in perspective: this will come about when a child now in Year 6 at school will be 34 years old, probably with children not much younger than they are now.

These figures, then, do not suggest that there is the "demographic time bomb" or a "tidal wave" of older people that we are always being warned about. It looks more like a gradual, steady growth. In fact, this rising number of older people is incredibly heartening news: those living in the UK today have a very good chance of living far beyond the biblical three score years and ten; even a great age is a possibility. In the West, medical science, better living conditions, and the welfare state have lengthened our lives. Longevity is something we are now far more likely to experience than not. Even allowing for the inequalities in health, which see poorer people in worse health and with lower life expectancy than others, longevity is still what most people, even poorer people, are likely to know. For many, many people, with increased affluence, this will mean the years which we designate as those of retirement will be ones not of worry and penury but of material comfort and opportunity.

Thus, a society which has larger numbers of older people is not one which should see a large section of the population as inevitably a "burden". Instead, it is one that offers longer life and a better quality of life, and brings with it unprecedented opportunities. These opportunities are the not uncommon possibility of enjoying one's great-grandchildren when they are at comparatively mature age; of retiring earlier on a secure income to enjoy many opportunities which working life may have denied; or,

1 National Statistics (2006), *National Population Projections 2004-based.* London: Palgrave-Macmillan

alternatively, to continue in work for those who wish to do so; and, importantly, to have the chance to contribute to the society in which one lives.

But, of course, we have also to recognise that an ageing society does bring problems, although less so for a society which is willing to invest in good health and social services for its older members. Of the problems which will arise I will refer only to dementia. While dementia is not confined only to older people, nevertheless they are disproportionately subject to it. Today there are 700,000 people in the UK with dementia and 685,000 of them are over 65. In terms of prevalence, one in 1400 people aged 40-64 will suffer from dementia. This rises steeply to one in a 100 for those aged 65 to 69; one in 25 for those aged 70-79; and one in six for those aged 80 and above.

To set this in a global context, today, in Europe, there are five million people with dementia and nearly 18 million worldwide. In 2025 there will be about 35 million people with dementia in the world but 71 per cent of them will live in developed countries. (2) By a later estimate the global numbers will increase to 160 million by 2050, 17 million of whom will be living in the UK. (3) (This news story, based on an address at an academic conference on dementia, somewhat confusingly uses “dementia” and “Alzheimer’s disease” interchangeably.) The increase in the number of people with dementia is a world-wide phenomenon but one which bears down disproportionately on prosperous, western, industrial countries like the UK.

The Church has a mission and challenge now which only increases with such changes. Much imaginative work is taking place in residential work with older people. What kind of living environment can the Church offer some older people who will need and want it? What examples are there to learn from within, as well as from outside the Church? These are the questions to which I will now turn.

Three ENDS

2 Knapp, M, Prince, M et al (2007), *Dementia UK. A Report to the Alzheimer’s Society on the Prevalence and Economic Cost of Dementia in the UK.* London: Alzheimer’s Society

3 Sanderson, D (2007), “Alzheimer’s cases around the world to quadruple by 2005”. News story, *The Times,* 11 July

Four Learning from others: examples of imagination and good practice

Learning from others: examples of imagination and good practice

There is no lack of concern among religious, clergy, the hierarchy, superiors and others at the severe problems faced by Catholic residential homes. But there is little sense that these concerns are being translated into solutions or even that solutions, at any collective level, are being sought. And yet there are solutions to be seen. This chapter looks at the experience of seven agencies, Catholic and non-Catholic, which show what can be learned and what may be the way forward. All of these organisations provide services except Quaker Housing Trust, which is included because it shows how useful, in financial and other ways, a small agency can be in sustaining residential homes, as well as giving support to otherwise separated homes.

Each of these agencies operates in different ways, with varied methods of financing their work and each often seeks different strategies to get to the same place: better residential care for older people. None of this work can be considered the only or the best way to solve problems because they are different ways to suit different problems and challenges. Instead what is offered here is an opportunity to learn from varied experiences. Catholic agencies running homes have different histories and face different challenges; they may profit from what others have tried. Just as the current situation of care homes run by orders can only be explained by their history, it is also instructive to see where history has led some of the organisations featured here.

Augustinian Care

The mother house, which is also the largest care home of the Sisters of St Augustine of the Mercy of Jesus, betrays the order's origins in Belgium in 1842: an imposing, turreted, white building in the Belgian style, incongruous in the English countryside.

The order was established at St George's Retreat, East Sussex, to continue in England the vision of its founder, which was the care of mentally ill people. Today, it has six homes: four at St George's (120 people in the main house and 60 in the other two), and others in Devon and Buckinghamshire, and one a few miles north (all of which also have 60 beds). They offer care for people who are elderly frail, older people with dementia and people with a history of mental health problems and a smaller group with learning disabilities. The Augustinians, 28 of whom continue to live in the convent attached to the main house, employ 480 lay staff. At St George's Retreat there are 150 such staff, some of whom have recruited from Poland, and some of those live on site in what was formerly a care home.

Fees range from £640 a week for a single room to £670 for a single en suite room, with twin-bedded rooms are available for £610. Forty five per cent of residents are funded by local authorities and primary care trusts. Ten per cent of those who are statutorily funded pay a top up fee, but if they or a relative are unable to do so, the charity meets the difference. The remaining 55 per cent of residents pay for themselves.

Eight years ago it became apparent to the Order that the cost of improving their homes to meet the new care standards would be too great. And, as Sister Thomas, care manager at Augustinian Care, puts it: "You cannot run a business that's losing money but we did not wish to close down our homes." There are no plans at the moment to refurbish other homes in the Order but this may be given consideration when work has been completed work the development on the site known as St George's Park.

Thus, not wanting to give up their historic vocation of care, the sisters eventually came upon the idea of meeting the cost of replacing the homes at St George's Retreat by building a care village, with apartments for sale, within the 250 acre estate (complete with cattle farm) where St George's Retreat is situated.

To get ideas members looked at other developments like Hartrigg Oaks, the first continuing care retirement village in the UK, opened a decade ago by the Joseph Rowntree Foundation in York, and the Auchlochan Trust's Christian care homes and village in Scotland. They sought proposals

from firms of architects and eventually gained planning permission to build 225 one- and two-bedroom apartments (80 of which will be in the main house when it is refurbished as the final stage of the work). A staged loan was secured from the Bank of Ireland, explains Sister Thomas, and a project management firm was appointed. A partnership with developers was rejected.

At first sight this looks like any other upmarket commercial development: the first phase of St George's Park, as the new project is called, has been completed and sold and the new owners have moved in; builders and construction work are seen everywhere; a sales office offers glossy brochures and a show flat; and familiar yellow signs for new housing point visitors from nearby towns.

However, St George's Park properties can only be purchased by people aged 60 and over. Prices in the first phase range from £289,000 to £290,000. Also, the building of the apartments goes hand in hand, in phases, with the erection of the new care homes, the demolition of the old ones, and the removal of the residents to the new homes. Thus, the new en suite, one person bedrooms are being funded by the profits from St George's Park. Each of the four building phases also contains some social housing apartments, and there will be 10 when the project is completed in three years time.

Sister Thomas sees the whole development as continuing care. The hope is that one of the care homes will eventually be converted to sheltered housing. It is designed that way: the 60 rooms are planned so that they could be become 30 two-room apartments. Some people see this as a good way off because demand will always be such that the third home will be needed. However, even if sheltered housing did not come about, for any St George's Park residents who did eventually require residential care, the care homes at least are there to ensure that they would have no need to leave the estate. For those who would be able to stay in their own homes but might need help, the Augustinians can offer domiciliary care.

"Estate" suggests remoteness. But St George's Park is served by bus to the nearest train station four miles away in Haywards Heath, while the development has its own bus service to the town, and as planning rules discourage car ownership by having limited parking spaces, there is an arrangement with a company to supply a car pool. But there is also much that makes St George's Park self-sufficient: the community centre has a bar, restaurant, coffee shop, gym, hairdresser's, shop, library (stocked by books which residents have donated), and a room for beauty treatments and alternative therapies. A swimming pool is planned.

The Augustinian ethos is at the heart of the development and all the care facilities at St George's Park. However, this is in no way intrusive and the sisters respect the rights and choices of all the residents. The sisters offer spiritual care when needed. Residents have the opportunity to attend mass daily in the chapel at St George's Retreat. Mass is also held in the care homes for residents who are unable to attend chapel.

But while these changes have taken place the existing care homes have been sustained financially by increasing the number of residents by making better use of accommodation – for example, converting unused rooms and offices – in the main house.

Sister Thomas says that the trustees had considered developing rented sheltered housing but this was not feasible at the moment because the first priority had to be the continued welfare of the care homes residents.

Contact St Thomas, care manager, Augustinian Care, St George's Retreat, Ditchling Common, Ditchling, East Sussex RH15 OSF. Tel 01444 235874 www.anh.org.uk

The Hospital Management Trust

HMT is a unique charity founded in 1985 to help sustain the then dwindling numbers of Catholic and other voluntary hospitals, of which HMT now owns three. Apart from advice offered to hospitals, over the years HMT has also advised 30-40 care homes run by religious orders and now owns four.

The arrangement which the trust enters into is that orders which formerly owned the homes provide pastoral care or where they cannot, they seek it from a local church or churches. The orders also meet capital costs. HMT takes a lease on the care home and provides management and staff, and takes the financial risk, and pays a (not fully commercial) rent. After the deduction of costs, any surplus is divided 50-50 with the order. Each home has a joint consultative committee, with two trustees each from the order and HMT. This meets not less than twice a year and not more than six times. It discusses matters like quality and standards. The level of fees is set by mutual agreement between HMT and the order and leases are 15-20 years with review clauses and options to renew.

HMT's homes are all purpose built. The newest are the 62-bed Coloma Court, West Wickham, Kent, and the 46-bed

Marie Louise House, near Romsey Abbey, Hampshire. The Daughters of Wisdom helped create Marie Louise House when they closed a school, and sold half the land for residential development, while building on the other half. Coloma Court was funded by the Daughters of Mary and Joseph's own financial resources.

Coloma Court charges £800 a week, which is slightly between the local council fee of £550 and a commercial fee which would be about £1000. There is no hardship fund: top-ups come from families or charities. Self-funders take about 75 per cent of beds so there is some subsidy from them for those whose fees do not meet charges.

HMT is responsible for a total of 220 beds and needs to run at a 95 per cent of occupancy to make the return required. The aim is for a 15 per cent gross annual return to cover at least costs, depreciation and a modest reserve. A commercial return would be something like 25-35 per cent.

John Randle, executive director, says that "middle England" is the target population. The organisation, he says, could not afford to run homes in very poor areas because too many people would not have resources for self-funding or to top up local authority fees.

The trust is not prescriptive about the kind of spiritual care offered but places emphasis on that aspect of residents' lives. However, each home has a chapel and pastoral care is provided and it is understood that homes will offer spiritual care.

The experience of HMT in dealing with religious orders facing problems running their own homes, says John Randle, is that problems tend be over the day to day financial control: staff paid too much or too little; too much spent on food and not enough on linen; or standards good but not compliant. In short, such orders tend to lack business acumen and managerial expertise.

John Randle adds, too, that there can be a degree of naivety about reserves: "The understanding of money is very hard because they [orders] don't have to go out and do the shopping."
HMT offers free consultancy as part of its charitable objectives.

John Randle sees great demand for homes with a spiritual dimension. The fact that they are not-for-profit, have a chapel, as well as the presence of the sisters is often a greater consideration for those seeking a place than the physical standards, he believes.

Contact John Randle, executive director, Hospital Management Trust, 14, Queen Anne Street, London SW1H 9AA Tel: 0207 222 1177 www.hmt-uk.org

MHA Care Group

MHA was founded in 1943 as Methodist Homes for the Aged. It is one of the largest and most successful providers of care services for older people. It is also one which places great emphasis on the spiritual life of its residents.

The charity was not founded exclusively for Methodists and (in a survey in November 2006) 25 per cent of residents said that they had a Methodist connection; a further 25 per cent said they were Christians of another denomination; and 50 per cent had no faith or had no faith connection. Eight per cent of the residents, about 200 people, in MHA homes said they were Catholic.

Roger Davies, chief executive, says:

> We would like people who are not Methodists or Christians or of other faiths or no faith to feel comfort able in our home and to cater for their spiritual well being in whatever way they choose.

The group retains a close connection with the Methodist Church and Roger Davies gives a report to Methodist Conference, the Church's governing body, every year. A third of representatives on the group board represent the Church, with the other two- thirds representing the MHA, with half of those being independent. The Church also has the ultimate say on board membership.

The first home was opened in 1945 in Wallington, Surrey. That has since been demolished and on the site, which included a large garden, has been erected a care home with 15 dementia places and 33 residential places, with 25 flats for sale. MHA Care Group's work is funded 70 per cent from borrowing and 30 per cent from reserves. Building for sale also allows surpluses to be reinvested.

MHA was founded in 1943 and until 1993-4 homes were run locally so management, payroll and employment practices were devolved to local volunteers. The group also embraces a housing association.

Homes offer bible study, prayers or worship. Each housing scheme, created by the housing association, and home has attached to it a Methodist minister or, more commonly these days, a non-ordained chaplain. "A focal point", as Roger Davies calls them. They are volunteers but, increasingly, they are being paid.

Those who come to MHA homes mirror the population of residential care generally: they enter care later, are older, frailer, and more likely to have dementia. This may demand different ways of organising worship. This may mean, for example, a greater emphasis on pastoral care, talking one to one and in groups rather than relying on the traditional service of worship.

All managers and staff are trained for end of life care so that, at that point, such care can be regarded as "a hospice at home".

Roger Davies says that fee levels from local authorities are better now but they started from an inadequate base. This problem can be offset to a certain extent by economies of scale; and a "more businesslike approach" which has meant the organisation doubling in size in terms of the number of older people served in the last four to five years.

Half the residents are funded by local authorities and half are self-funded. MHA is keen to serve more older people under contract with local authorities who understand and value the service and is less keen on spot purchasing where fees are lower. The fee charged to self-funders is calculated on a fair price for care basis. Local authorities often pay less, leading to a lower financial return to the charity. Third party top-ups are sought. There is no debt on older homes and the group looks for a 15 per cent return overall on care homes.

Voluntary funds are used for capital development rather than to subsidise individuals and this type of funding also pays for those things that can't be charged for, like chaplaincy, befriending, and the Live at Home scheme. (This is not, as its name might suggest, a domiciliary care scheme but one of social support, befriending, lunch clubs, and personal support. Most volunteers are Methodists.)

In the financial year 2005-6 voluntary income was £5 million on a £75 million turnover or seven per cent.

Half of MHA Group's homes have been built in the last 15 years and the other half in the period prior to that going back to1943. More recent properties have been purpose built with en suite facilities but all properties, whatever their age, have been improved to meet and exceed the Commission for Social Care Inspection's standards. Building care homes and housing association properties on same site allows an easy transition and the chance to stay in a known community if infirmity in later years means that a move is desirable to a care home.

MHA also offers market intelligence and operates as a consultancy for other charitable and Christian-based care and housing providers.

Contact: Roger Davies, chief executive, MHA Group, Epworth House, Stuart Street, Derby DE1 2EQ Tel: 01332 296200 www.mha.org.uk

Orders of St John Care Trust

OSJCT is an ecumenical organisation sponsored by the Catholic Order of Malta and the Anglican Venerable Order of St John who share their common root in the Hospitallers of St John of Jerusalem, founded in 1048 to care for the sick and needy without distinction of religion, race, origin or age. The trust was created in 1991.

The trust declares itself Christian. Its statement of purpose is tailored to what is available in each area but says: "The religious, spiritual and cultural choices that residents may wish to make are identified in the home's assessment and care planning process." Its care is offered irrespective of race or religion.

The "Ethos of Care" states: "We believe that all older people living in our care homes should be given care, both material and spiritual, that suits their individual needs." Private facilities are available for anyone wishing to meet a priest or minister and each home provides information of where services are available.

The trust has two chaplains, a Catholic and an Anglican.

OSJCT does not analyse the faith, if any, of residents but anecdotal evidence suggests that the homes probably have a slightly higher than average percentage of Catholic residents. There is no evidence, though, that residents choose the trust's care because of its spiritual ethos.

About 70 per cent of residents are funded by local authorities.

The Trust has not expanded by acquisition in the normal business sense in that it does not acquire the business and assets of other trading entities. However, it does have long-term arrangements with four local authorities to lease and operate their care homes. (In 2005 it "acquired", in this way, 21 homes from Gloucestershire County Council.)

Where expansion has come about by building new homes (for example, as part of a contract with Oxfordshire County Council), these have been funded primarily by long-term

borrowings through the formation of special purpose joint venture arrangements with BPHA, a medium-sized housing association.

OSJCT foresees growing demands for nursing and dementia care, as well as extra care housing, and it is on these areas that it will be focusing. For example, it is are currently engaged in the redevelopment of the community hospital site in Malmesbury, Wiltshire, which, when completed, will provide a new 80 bed care and nursing home, and 28 extra care apartments alongside a primary care centre. At this stage, it has no plans for a full-scale residential village.

Contact Nigel Reed, chief executive, OSJCT, Wellingore Hall, Wellingore, Lincolnshire CN5 0HU Tel: 01522 810524 www.osjct.org.uk

St Cuthberts Care, Newcastle

St Cuthberts Care was founded as the Hexham and Newcastle Rescue Society, a diocesan agency, to care for orphans after the Second World War. It changed its name in 1997 and over the years it has expanded and diversified. Its one residential care home for older people sits within a range of other services. These include day care facilities for older people and those with a learning disability (as well as residential care for the latter); children's and family services such as residential care, support, adoption and fostering; an activity centre for children and others with disabilities; and services for young people leaving care. The agency is featured here as an example of how residential care, with a very strong Catholic ethos, can be successfully provided, while also being part of a service that meets the needs of people of other ages and conditions.

St Catherine's Home has 45 residents, which Austin Donohoe, chief executive, reckons is the absolute minimum number to make it viable. It charges a standard fee of approximately £450 a week. Nursing care adds approximately a further £100 a week to the cost of a bed. The local authority rates for the home are £61 per week less than the standard charge. This amount is topped up by families, or the resident pays the entire amount themselves. For families who do not have the resource to make up the difference, St Cuthberts Care offers a hardship fund, to which they can apply.

Austin Donohoe sums up the reason for the home's success, financial and otherwise, by saying:

> "It's easy enough. It's a question of will – there are no obstacles that cannot be overcome but the quality of leadership is important. There is a clear unmet demand for a nursing home that offers a Catholic ethos."

However, the home does rely, he says, on having a good catchment area to draw on but even then only a third of residents come from outside of a five mile radius (which includes the city of Newcastle). Vacancies never last longer than two weeks because, according to Austin Donohoe, the home is Catholic and the care is of such high quality.

The project cost of St Catherine's was £2 million. This was financed by a bank loan of £750,000 and a £500,000 loan at commercial rates from the diocese. The balance came from the charity. The home which it replaced was housed in an old convent, owned by the Dominicans, on other side of city. This was sold for development. Eighteen of the original residents came from the former home and it took two years to fill the remaining rooms.

Land on which the new St Catherine's stands is owned by diocese, but leased to St Cuthberts Care under a 125 year lease, signed long before the nursing home was built The land was almost worthless when St Cuthberts Care agreed the lease as obtaining planning permission was thought problematic. The grant of planning increased the value of the site significantly.

Mass is held five days a week (including Sunday) and is restricted only by the number of priests available. There are two religious sisters who are residents (one of whom takes responsibility for a rosary group) and there are three nuns from overseas who are members of the 40 full-time staff. Eighty per cent of costs are staff costs. Boys from the adjacent Catholic boys' school work as volunteers.

Austin Donohoe says: "It is a question of valuing people – staff and residents – and investing in them in terms of things like training."

St Catherine's, on the main road 15 minutes from city centre by bus, is a single storey home on the ground floor of the same building which houses the headquarters of St Cuthberts. It has four corridors set around a court yard, which has sitting area and a statue of the Virgin. In the warm weather this must be a pleasant and safe place to sit. It looks out on green fields and across to a former St Cuthberts property, a large, former priest's house, which is now let to charities, and the school. Rooms are pleasant and a good size for care homes. There are three dining rooms (one usually used by those in wheelchairs)

with a rest room where smoking is allowed. There are a number of rooms with adjoining doors to allow for married couples. There is an air of intimacy created by the design and size of the home. The walls are brightly decorated, some being personalised with a map of the city surrounded by photographs of residents showing where they went to school, lived and worked.

St Cuthberts Care is now investigating the possibility of developing a care village, which would include a nursing home, sheltered accommodation, a church, and various community amenities.

Contact Austin Donohoe, chief executive, St Cuthberts Care, St Cuthberts House, West Road, Newcastle upon Tyne NE15 7PY Tel: 0191 2280111 www.stcuthbertscare.org.uk

Quaker Housing Trust

Quaker Housing Trust, which was founded in 1967, expresses "spiritual concern in practice". It refers to its combination of "flexibility, discernment and spiritual vision". It offers a good example of how advice and financial support may help those who provide services. Its reputation rests very much on its support for small-scale, community-based housing projects that larger bodies tend to ignore. It supports a range of provision for people of all ages from sheltered housing, housing association accommodation for young people with problems and housing for people with special needs through to residential care homes. It funds everything from every day work like the upgrading of lifts and fire escapes to repairs to furnishing; refurbishment and redecoration; rehabilitation, conversion and alterations to existing property; capital costs for land and property; and seed corn grants to test the viability of projects.

In 2006 the trust gave £48,000 in grants and £80,000 in interest-free loans but sums vary significantly from year to year depending on applications. The trust receives no funding from any statutory agencies and its resources come from donations from Quakers and others, legacies and interest-free loans.

The trust also offers advice and works as a network for Quakers and others involved in charitable housing.

QHT has four criteria for financial help:

- the project has local Quaker links and support;
- the project has charitable status;
- the funds are sought for the actual provision of housing; and
- the funds are for capital cost only, not revenue expenditure.

It offers:

- advice on an early stage of new housing provision and to existing housing projects experiencing difficulties and seeking to expand;
- grants or feasibility studies to test specific proposals;
- a Health Check service to evaluate potential problems and growth for housing projects; and
- contact for similar Quaker-supported projects.

QHT's 12 trustees are all Quakers with wide experience in diverse housing organisations.

QHT helps the 30 Quaker-run accommodation schemes for older people maintain an informal network for mutual support.

Contact Paula Harvey, secretary, QHT, Friends House, 173-177 Euston Road, London NW1 2BJ. Tel: 0207 633 1036. www.qht.org.uk

St John of God Care Services

Part of the international Hospitaller Order of St John of God, which works in more than 50 countries and provides more than 500 services, St John of God Care Services was formed in 2005 to take on the 50 projects developed by the Hospitaller Order in Great Britain. These include residential care and nursing care for people with a learning disability and mental health problems (as well as services for them in their own homes); supported living; a community centre; services for the homeless; and a horticultural project, run as a commercial garden centre, for vulnerable people.

In 2005 a consultancy, St John of God Management Services was also created to offer advice on management; evaluation and strategy support; training and recruitment advice; mentoring; and work on policies and procedures. The management services division works with 23 religious orders. It also runs six residential homes on behalf of religious orders from whom it receives a fee. Most of these homes are for elderly religious (and so are excluded from the Care Standards Act), but one includes provision for lay older people. Management Services is currently in negotiation with another religious order to take over its home for older people.

Although the charity's work is mostly not in the area of residential care for older people (but many of the people with learning disabilities and mental illness with whom it primarily works also happen to be elderly), it has moved its services from large, institutional care to modern small homes and community-based services. It has funded this in some instances by selling off land surplus to use, although it has also built new services funded by commercial borrowing. These services have been developed to resettle people from institutional care. Most people with whom it works are funded by local authorities or health trusts and the specialist nature of much of its work means that it can attract far higher fees than is possible for older people in residential care.

St John of God Care Services is currently looking at whether to embark on a continuing care project.

Contact Anne Rowlands, assistant chief executive (operations), St John of God Care Services, Saint Bede's House, Morton Park Way, Darlington, County Durham DL1 4XZ. Tel 01325 373700 www.stogcareservices.org.uk

Four ENDS

Conclusion

Backward glance or forward march?

Backward glance or forward march?

It is a reasonable assumption that the challenges to residential care for older people run by religious orders and may be for other Church agencies, too, have, if anything, become more acute since *On the Homes Front* was published in 2003. The financing of many homes remains very often precarious. The number of people entering the religious life continues to abate, while those who remain grow older and, in many cases, themselves become dependent on the Church for accommodation and care.

It is true that with the closure of some homes and some orders' withdrawal from the sector, there are opportunities for some new forms of ministry but this is not an opportunity that the orders' members desire. However, there are homes which, through planning and other means, are able to stay open or be replaced and flourish. There are also some agencies and orders who have the opportunity to embark on new forms of residential care.

Sheltered housing for rent or for sale, as well as care villages are only two ways that the Church could develop new services. How could this be done? Where are resources to come from? Some residential homes are in buildings large enough to convert to apartments. These could either be sold to private owners and the proceeds invested in a new nursing home or the converted building could serve as sheltered accommodation for sale or rent. Alternatively, the land could be sold and a care village, new nursing home or sheltered housing built elsewhere.

Such developments demand the employment of specialist property and financial advisers. They may involve partnerships with private developers; alternatively orders could act as developer or the Church itself could set up its own development company. (1)

However, the strong impression of vertical rather than horizontal communication, of isolation rather than sharing experiences and practice means that too many agencies struggle for want of knowing where to turn and what to do. There is no need for this, as this report has sought to show. All that is required, to start to seek solutions at least, is some imagination.

The examples of good practice detailed in this report are not comprehensive but they are an indication of the expertise, ideas, help and information that exists both within the Church and outside of it to provide professionally run and financially viable residential homes and other kinds of residential care. But, importantly, these examples are not simply good practice which can be found in a thousand and one places up and down the country. As important as financial viability, professional service, and good social, mental and physical care is something which is the hallmark of Catholic homes, although also to be found outside the Church. This is a deep concern for the spiritual and sacramental life of the residents and the opportunities for them to practice their faith however they choose – in conventional worship, through bible classes and small groups, with the aid of chaplains, lay and ordained.

That this is important is self-evident but that importance is underlined by the age of those in residential care (80 years and older is now typically the age of admission generally). These are people who may have had a denominational attachment throughout their lives but for whom physical incapacity may now make attendance at a church impossible. They wish to live in an atmosphere which has sustained them from childhood and that has an even greater importance given the emphasis now placed, in the heath and social services, on end of life care. (2)

While many religious orders employ lay staff in their homes (and this is probably even more so with homes run by diocesan agencies) there remains some feeling that to have

1 Zarraga, A (2006), Personal communication. I am grateful for to Andrew Zarraga for several ideas in this report.

2 For a useful discussion of end of life care in relation to residential homes see Help the Aged (2006), *My Home Life. Quality of Care in Care Homes.* London: Help the Aged.

to do so is, in some sense, a failure, as if the drying up of vocations, which sustained staffing levels for so long, is some affront to the calling of this life, some letting down of those for whom they care, some failure on the part of those responsible for the home. This is simply not so. The future of the religious life is beyond the scope of this book but no one believes that a Catholic school or a Catholic children's home is any the less because it is no longer wholly staffed by nuns and brothers; indeed, there may be none on the staff in some cases. Take Catholic schools. They have the highest of reputations partly because they have an explicit Catholic ethos, they offer the chance for children to learn about and practise their faith, and this comes about partly due to the attitudes and commitment of the lay teaching staff but also because, in some places some ordained and professed people still work in the classroom or are associated with the school. All Catholic schools draw on the ministrations of a chaplain or members of an associated convent, monastery or church.

Catholic homes, in recognising what they can no longer do by way of providing a steady flow of religious for the staff, would do well to look to other Catholic institutions, like schools, to see that a Catholic life and ethos can continue to flourish in a world which is increasingly secular and when the Church, at least in the UK, can no longer rely on vocations to sustain its work.

Catholic schools are a very good example of Catholic institutions which are part and parcel of the life of a local parish, a place to which parishioners feel a loyalty which is often expressed in visible ways through, say, volunteering and fund raising. This is not so with the Catholic home which can be isolated from the parish in any meaningful, day to day sense.

Homes, then, need to forge relationships with parishes so they are seen as part of the local Catholic mission and presence, as well as becoming a focus for volunteering and fundraising. But, in other ways, working with others must be a part of any strategy to sustain homes and help them to look to new initiatives. Half the congregations interviewed in *On the Homes Front* saw partnerships as a way forward for Catholic care. Those who had found partners were the most successful.

Apart from the few examples offered in this report, there are other positive changes taking place within Catholic residential care. For example, the Nazareth Sisters have taken an interesting step. They have 39 care homes in the UK and in six regions around the world. They offer both nursing care and short-term respite care. They have now formed a new charity, the Victoire Larmenier Foundation, and have appointed a "lay clerk" to the general council. This somewhat archaic title appears, in fact, to be the chief executive and one of that person's first jobs will be to oversee the care village being built in Ealing by the sisters in association with a private developer.

Changes elsewhere are afoot from which the Church can learn. For example, Abbeyfield provides 80 care homes and 700 sheltered housing units for 7,500 residents. It has a federated structure of 300 societies and in last 18 months has been creating Abbeyfield UK with local Abbeyfields investing assets in the new body.

The Church's residential care work for older people remains extensive. We know that this mission has problems which are, to an extent, talked about, although not as much as are many other issues with which the Church is concerned. However, the assumption appears to be that someone else will do something about them. It is not a state we would ever contemplate with regard to children and young people when it comes to, say, Catholic education. If Catholic schools were closing up and down the country, there would be an outcry in the Church, headlines in both the Catholic and secular press, outrage in parishes, which, one can be sure, would be reflected in questions raised in the House of Commons and with the Department for Schools, Children and Families. Bishops would be seen going in and out of 10 Downing Street. Or, in terms of action taken for an actual problem, look at the example of the child abuse scandals in England and Wales. Quite rightly and very quickly the Church set up the independent Nolan commission in 2000. This reported in 2001 and the bishops then accepted all of its recommendations almost immediately and set about putting the recommendations into effect, one of which was the creation of the Catholic Office for the Protection of Children and Adults. Five years later the Bishops of England and Wales commissioned an independent review into how its child protection policies had fared. This reported in 2007.

One cannot be struck by the irony of where the Church might look for partners. The government emphasises, with ever more forcefulness, the need for a great role for the voluntary sector in the provision of health and social care. More specifically, it refers to faith-based schools, as well as more faith-based care generally. The White Paper, *Our Health, Our Care, Our Say* [3] foresaw a greater role for the

3 Department of Health (2006), *Our Health, Our Care, Our Say. A New Direction for Community Services*. London: The Stationery Office

voluntary sector in NHS services for older people. And yet Catholic faith-based residential care for older people is left to the whims of the market.

The future of care homes run by religious orders is not a healthy one. The problems are mostly hidden, even within the Church itself: not much talked about, certainly not acted upon in any concerted way. And yet the revolution wrought in Catholic residential care offers the opportunity for the Church to think about what it means to be Catholic and elderly, what such a person's spiritual needs are, and how they may be met, and what kinds of provision will be needed by future generations.

The facts show that we are an ageing society. What is the challenge? More than 125 years ago the Church summoned up its resources to meet a glaring need at the other end of the age range – that of children. The children's societies, which were founded, were set up not only to offer homes, shelter and a better life but also to help protect children in their faith.

Catholic agencies and the other bodies, like Barnardo's, NCH and the Children's Society founded at about the same time, have continued to grow and to prosper. They have moved with the times, away from institutional care in orphanages, to specialist kinds of residential provision; to work in the community with children and families; and offer fostering and adoption and much other kinds of specialist work.

We take pride in, and are rightly very possessive about Catholic schools and children's services but where is our general concern for what we do – and could do – for older people? Where is our concern not only that they receive good health and social care but that they should have the chance to practise their faith and live in the spiritual ethos which they have always known? Are there, then, not parallels today for the Church in its mission for older Catholics – for good care, physical, social and spiritual – in the same way that it rose to meet the needs of Catholic children in the latter part of the 19th century?

When we think seriously about the answer to those questions, when we consider what the Church *could* do, then we will be asking about the value we place on *all* aspects of old age in our society.

Conclusion ENDS

Recommendations

1 The Church has a continuing responsibility for the social and physical welfare and spiritual well being of older people. This is analogous to its mission to children 125 years ago.

2 Religious orders and others within the Church who run homes should seek partners, advice, information and examples of good practice from those within and outside the Church to sustain those homes.

3 Some congregations would benefit from entering into partnerships with other congregations in the provision of residential homes when they find difficulties in sustaining them on their own. To do this they need to take professional advice.

4 While residential homes will remain an important part of the care of older people, the Church should also see care villages and sheltered housing for sale and for rent as new developments to meet the varying needs of older people.

5 Where homes prove to be financially unviable, investigations should be carried out to see whether the use of the buildings and/or land lend themselves to developing other forms of residential care or building new homes.

6 Parishes should regard residential homes within their boundaries as integral to its life as they do the local Catholic school. Homes and parishes should be more active in making contact with one another.

7 Modern social care and the fall in vocations mean that more professional staff and managers need to be employed in religious-based residential care.

8 The Church should consider whether it is feasible to create its own property development company to work in partnership with orders and diocesan agencies running homes or wishing to develop new forms of residential care.

9 The Church should consider setting up a Catholic Housing Trust, an agency equivalent to the Quaker Housing Trust which would offer, among other things, advice and funding to homes and the chance for feasibility studies of new ideas.

10 The Church should create a standing advisory body, either within the Catholic Housing Trust (as outlined above) or as a division of Caritas Social Action Network. This would draw on professionals involved in all aspects of residential development – social and health care, personnel, legal, architecture, finance, development – from within and outside the Church to act as an advisory body. This body, in association with the Catholic Housing Trust could also comment on or advise the bishops in their submissions and reactions to any government proposals, new standards, or legislation within its remit.

Author biography

Terry Philpot is a journalist and writer and a contributor to *The Tablet, The Guardian, THES* and other publications. He has written and edited more than a dozen books, the latest of which are (with Anthony Douglas) *Adoption: Changing Families, Changing Times* (2002); (with Julia Feast) *Searching Questions. Identity, Origins and Adoption* (2003); (with Clive Sellick and June Thoburn) *What Works in Foster Care and Adoption?* (2004); and (with Richard Rose), *The Child's Own Story. Life Story Work with Traumatized Children* (2004); (with Janie Rymaszewska), *Reaching the Vulnerable Child. Therapy with Traumatized Children* (2006); and (with Billy Pughe), *Living Alongside a Child's Recovery. Therapeutic Parenting with Traumatized Children* (2007). *The Child's Journey to Recovery* (with Patrick Tomlinson) will be published later this year. He is currently writing a book on the partners of sex offenders. He has also published reports on private fostering, kinship care, and was author of Caritas Social Action Network's first report on residential care for older people, *On The Homes Front* (2003). He is a trustee of the Social Care Institute for Excellence and the Michael Sieff Foundation and was formerly a trustee of the Centre for Policy on Ageing and Rainer. He has won several awards for journalism.