

Care in Time

Celebrating longer lives in England and Wales



'The gift of life, for all the effort and pain it involves, is too beautiful and precious for us ever to grow tired of it.'

Pope St John Paul II, Letter to the Elderly, 1999.

Mercy from age to age

And I, who now was nearing Him who is
the end of all desires, as I ought,
lifted my longing to its ardent limit.

Dante, The Divine Comedy, Paradiso 33:46-48

Christian belief in the God who is - '*perpetuum nunc*'¹ – holding past, present, future and everything together, leads us to believe in an assurance of a divine care that holds us in being. The God who is love creates time and wills each person into being, for God's loving purpose, and because God wants us to enter life in full. Human care from another expands our recognition of this purpose, engaging the senses alongside what reason can deduce about an interconnected world ('mother nature'). Wholesome care for others in Scripture is direct, vivifying and relational, for example to honour father and mother (Ex. 20:12), to wash each other's feet (Jn. 13:14 and 1 Tim. 5:10),² to make provision for widows (Acts 6:1, Is. 1:17, 1 Tim. 5:3).

Each person is called in specific, responsible ways to share a journey of unknowing false securities.³ For people with faith, this journey is never alone but towards a point of closer encounter with Reality, in a temple not made by hands (Ps. 43:2-4). Christian hymns often end with some variation on the words, 'while endless ages run'. For example, they are sung when invoking the movement of the Holy Spirit, written beautifully in *Veni Creator Spiritus*, in the doxologies of the Eucharistic Prayers, and in repeating the words of Simeon, a Jew, in the canticle *Nunc dimittis*. The person who, like King Solomon, cares to seek holy wisdom (cf. Prov. 1:7), in time learns to recognise all as gift, in the eternal Being in which that person is eternally remembered, and to await, like Anna in the Temple, that final unending encounter with the Lord and resurrection of the body (Rev. 5:13). These themes in care – watching, patient waiting, of journeying in wisdom, of gift and attending to reality – all underpin the title of this work and our intentions for the work ahead.

...but my desire and will were moved already -
like a wheel revolving uniformly - by
the Love that moves the sun and the other stars.

Dante, The Divine Comedy, Paradiso 33:143-45

1. 'Always/eternal/continuous now'. Aquinas, *Summa Theologiae*, 1a.10.4, ad. 2. The Latin rendering is richer than English alternatives.

2. Cf. Old Testament references to providing water for people to wash their own feet.

3. Through ageing and major events in life, this can be experienced as a stripping of physical and mental functions, and markers of identity (Phil. 2:7; Matt. 26:36-46, 27:28-30). It can also be a journey of unknowing false ways of relating to God, and of relying on things other than Providence to save us. Cf. the 'globalization of indifference', a recurring theme in addresses by Pope Francis. CSAN has explored this a little further in a housing context in *Abide in Me*, 2018, p32-6, www.csan.org.uk/policy/a-catholic-approach-to-housing-in-england-and-wales/.

The Visitation of the Blessed Virgin Mary to Elizabeth

(Luke 1:39-56)



'...the younger woman goes to meet the older one, seeking her roots, while the older woman is reborn and prophetically foretells the future of the younger one. Here, young and old meet, embrace and awaken the best of each. It is a miracle brought about by the culture of encounter, where no one is discarded or pigeonholed, but all are sought out, because all are needed to reveal the Lord's face. They are not afraid to walk together, and when this happens, God appears and works wonders in his people. The Holy Spirit impels us to go out from ourselves, from all that hems us in, from the things to which we cling.'

From the homily of Pope Francis for the Feast of the Visitation of the Blessed Virgin Mary, 31 May 2019.

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Letter from a carer

December 2016

Cuts to social care and plight of carers

I am a Roman Catholic married mum of four and have been a long-term carer for my parents. My mum died of dementia in 2014, after I looked after her and my father for 5 years, and two years later, I support my 89-year-old dad. Up to about a month ago he was in good health, but is now failing, and I can foresee taking on a carer's role again.

I know that I have been hanging on by my fingertips at times these past years but, thank God, have managed to keep my parents out of residential care. I don't know if I can sustain this in the future, in view of my mental, emotional and physical health needs and financial needs and the needs of my family, but I am praying that I can [...]

I am asking you please to thunder out about this and somehow get the position of the Catholic Church in the news and media. This is not a party-political point, but please, can we do more to make the public stance of the Catholic Church about this out there and to be a leading voice for people who have nobody to speak for them. I have lots to do with people who have no faith, and the perception out there of Catholicism is awful. We are seen to be obsessed with abortion and sex, and whilst I know this is not the case, I find it hard when I don't see representatives of the Catholic Church out there being a divine nuisance and embarrassment. I worry we are doing lots of skilful diplomacy and negotiation behind the scenes so as not to upset people, when this signals to the rest of the world that we don't care.

Please can this be something that we yell about, that we become a boring nuisance about - please may we be prophets, not diplomats, because carers are at the end of their tethers and elderly people are abused and neglected in full view of us all because of cuts to council budgets reflecting totally unchristian priorities.

I am praying for our church and for its prophetic mission.

Please can we start being more of an embarrassment for Christ. And please can you mobilise all the Catholics in the media you know to speak out about this, and for Catholics in the pews, from across the political spectrum, to be urged to speak out.

The author has given permission to quote this unsolicited letter offering a personal perspective. Her father has since died.

Care in Time was launched publicly in December 2019. Details of registered care provision offered by charities with links to the Catholic Church in England and Wales have been published on the websites of the Care Quality Commission (for England) and the Care Inspectorate Wales. Caritas Social Action Network (CSAN) publishes resources for local action and undertakes national advocacy and education within its resources, as an agency of the Catholic Bishops' Conference of England and Wales.

Purpose

Care in Time is primarily for senior leaders in Catholic organisations, CSAN's national counterparts in other denominations and ecumenical bodies, and charity funders. It offers new theological reflection on ageing in the context of what many call a 'social care crisis', and research on how 'Catholic care' in later life is understood and could be extended today. Alongside this report, CSAN is publishing new online guidance (www.csan.org.uk). First, *Reaching Out* offers parishes ways to build confidence in forming activities with older people, based on the results of three years' grant-funded practice development in parishes and deaneries, facilitated by Caritas Salford, Catholic Care (Diocese of Leeds) and Father Hudson's Care. CSAN has also added to its website some further signposts to other practical action for individuals and groups. *Care in Time*, and the linked practical resources online, aim to:

- Help Catholics and professional care providers understand, describe and prepare for Catholic care in later life, beyond arranging access to the sacraments.
- Increase parishes' confidence in reaching out to older people beyond the church's walls.
- Encourage parishes and Catholic care providers to deepen mutual support, so that Catholic care – especially residential care – is recognised, promoted and supported as a shared enterprise, and embraced within parish activities.
- Highlight pressing challenges for Catholic care that affect the quality and financing of current provision and planning by dioceses, religious orders and Catholic households.
- Garner support for national dialogue between Christian and public agencies in England and Wales that leads to more strategic action, relevant advocacy and education.

Executive Summary

The populations of England and Wales overall, and of Catholics as a subset, are both ageing rapidly and living longer. But the typical age and concept of 'retirement' has changed little in its treatment both by society and church. While older people mostly have low needs for specialist support and prefer to be cared for at home, isolation of the elderly has increased and taken new forms, and pressures on carers and services are acute in all settings. Many professional care providers, including Catholic organisations, have closed services for older people in the last decade. Some currently refuse to take on punitive domiciliary and residential care contracts from over-stretched public funding bodies. Rapid increases in longevity, confusion on the roles of the government and wider society in care, and the operation of some aspects of the care market, have all contributed to paralyses in developing care and the 'warehousing' of older people.

Catholic organisations have long attended to pastoral care for older people, especially through the works of religious sisters and many other women. Catholic care has distinctive, vital features that need maintenance and development, but its historic organisational forms may no longer be sustainable. Future Catholic care needs to address changing patterns in household formation and participation in parish and religious life, and the distribution of Catholics – in fewer parishes, and in care homes outside Catholic control. New research for this report indicates, first, some distance between how working age Catholics think of care and the often highly regarded work of proximate (Catholic) care providers. Secondly it reiterates a lack of confidence in parishes, described in earlier research, to take greater responsibility for creating the kind of care they want to see.

Reflecting the novelty of widespread longevity, little Catholic teaching has been dedicated to ageing so far. Recent papal statements have addressed the fears of ageing, frailty, and death; contributions of older people to the common good and Christian mission, and realising intergenerational solidarity in practice. Catholic social thought offers a way to expand a positive vision in which all humans recognise their share in the same frailty, each person has a vocational responsibility to expand into life with others, and older Catholics are recognised as 'spiritual pioneers'.

Advocacy, education, successful commercial marketing of self-care products and services, and Catholic charity appeals, demonstrate that co-ordinated communications can inform more positive public choices for the common good. Recent collaboration between Catholic charities to support parish-led work on increasing social opportunities for older people has proved successful. Co-ordination among more Catholic organisations is needed urgently, to address with other Christian and public agencies the opportunities offered by increased longevity for Christian mission, spirituality and plural communities, and the threats of new, dehumanising approaches to older people and care practice. The Catholic Church in England and Wales needs to counter negative portrayals of older people. Silence could be read as approval for further reductions in social care, paving the way to neglect of the aged poor, and may add momentum to calls for assisted dying.

Key Messages for Senior Leaders in Catholic Organisations

1. Despite the significant ongoing rise in the number of older Catholics in an ageing society, justifying increased pastoral concern, available long-term Catholic care options and expertise are disappearing, silently and permanently, in much of England and Wales. Some providers have had to withdraw from what they see as an unstable, under-valued system that diminishes dignified, relational care.
2. Dioceses, parishes and many working age Catholics are not prepared for the struggle needed to secure the future of relational care over longer lives.
3. Catholic pro-life communications should actively exemplify positive public portrayals of ageing and care. We must counter, including in pastoral provision, the notions that care of the aged amounts to making a slow death comfortable, and that a quick death would be preferable to an experience of residential care.
4. Dioceses and Catholic specialist charities should invest together in local and national capacity, to advocate for care of the aged poor and carers, and to extend Catholic care for those who want to live it out together. This is a vital step in a market that tends to favour large commercial providers. Additional capacity should also extend to providing Catholics with a steer, information and support to take more ownership of creating new forms of 'Catholic care' together, and for new partnerships to develop Catholic care and long-term co-housing/land trusts.
5. The actions in 3. and 4. above should be accelerated and steered by new national co-ordination, possibly between Caritas Social Action Network (CSAN), the Conference of Religious (COREW), the Diocesan Financial Secretaries, and the Catholic Trust for England and Wales (CaTEW). Partnership development in this context requires dedicated facilitation and skilled project management that may be most effective as a nationally organised service delivering locally; it would need to be funded by local and national Catholic organisations on an 'invest to save' basis.

Terms used in this report

CAFOD	Catholic Agency for Overseas Development
Catholic care	A process in which organisations embrace and realise a Catholic understanding of the person and the common good, including provision for spiritual, human and moral formation, and religious practice, throughout the care system. For a fuller definition see p13-14, and 46-7.
CES	Catholic Education Service
CSAN	Caritas Social Action Network
Embrace	An initiative in 2017-19 of CSAN, Caritas Diocese of Salford, Catholic Care (Diocese of Leeds) and Father Hudson's Care, to develop parish capacity to form new and renewed social activities with older people.
NJPN	National Justice and Peace Network

Scope

Individual Catholics, dioceses, religious orders and other Catholic groups serve older people in many ways, through caring for relatives and neighbours, befriending, organised community activities, domiciliary and residential care, including support for people with long-term conditions such as dementia. Many Catholic carers are older people themselves and more likely to be women than men. The Church does not routinely collect data on existing provision.

In discussing care provision, *Care in Time* focuses on long-term residential care and community-led support, and less on domiciliary and palliative care. Catholic charities participating in the research have fewer care facilities than large care chains. At the time of writing we had received oral evidence from one Catholic-run hospice.

Detailed treatment of the following matters is beyond the scope of this report:

- Economics affecting the affordability of social care funding. We note the arguments that a more just care system is affordable, as advanced over several years for example by Sir Andrew Dilnot on efficiency grounds, and by the House of Lords Economic Affairs Committee in *Social Care Funding in England* (July 2019).

- Differences between generations in holding and using wealth.⁴ For example, generations have been affected differently by reductions in public spending from 2010, by different levels of protection applied to state benefits through welfare reforms, and by a shift in welfare from education towards healthcare.⁵ Older people are more likely than the young to have benefited from sales of social housing and from occupational pension schemes that offered defined benefits.
- Options for public policy, including devolved policy, the frameworks for commissioning and inspection of regulated services, the integration of health and social care, and alternative funding models such as social insurance schemes.
- Needs and variations in outcomes arising from specific long-term conditions and disabilities, and associated with factors recognised in equality and human rights law.
- Perspectives from overseas on care for the elderly,⁶ though participants in at least one of the parish groups drew on their own experiences of family care for older relatives in other countries.
- Recruitment and flexibilities for older people and carers in the workforce, in excess of legal minimum standards. With the intense pressures on relatively small-scale care services, and in some cases subsidy from other activities, it is unsurprising that employers in the Caritas network did not identify additional measures they could sponsor.
- How those serving in the Church and linked charities are supported to prepare for later life, although there are indications that this needs more systematic attention, perhaps as early as the point at which a candidate is accepted through recruitment and selection processes.

4. See, for example, work by the Resolution Foundation (www.resolutionfoundation.org/publications/an-inter-generational-audit-for-the-uk/, last checked 7 October 2019).

5. Public spending varies between years. Analysis by Christopher Chantrill (www.ukpublicspending.co.uk/, last checked 18 October 2019) indicates that education spending fell from a peak of 6.5% of UK GDP in 1975 to 4.5% in 2016, while health spending increased from 2% when the NHS was set up in 1948, to a peak of 7.65% in 2010. Budgets for 2020 have been forecast to equate to 4% of GDP for education and 7.1% for health.

6. The Catholic Church managed around 16,000 care homes for the elderly around the world in c.2013, according to figures cited by Robert Calderisi, *Earthly Mission - The Catholic Church and World Development*, Yale, 2013.

Background

Our society is ageing, and ageing Catholics – laity, consecrated religious and priests – form an increasing share of practising Catholics in many parts of England and Wales. The wonderful sign of progress that people are living longer in our country has long been apparent. Global Catholic thought has been equally clear for at least 20 years that Catholics need to get to grips with the opportunities offered by increased longevity for Christian mission and plural communities, and the threats of new, dehumanising approaches to care practice.

Catholic organisations in England and Wales highlighted the need for actions to safeguard and nurture Catholic care, in 2002, 2007 and 2009. Recommendations made then for co-ordination and voice have progressed very slowly if at all. Rather, on financial grounds, many providers have ceased operating care homes and community projects. Catholic and allied organisations now face rising pastoral and financial strain in caring for ageing members. These points resonate with the wider public environment for social care.

We have completed a three-year formal collaboration (2017-19) on developing parish outreach – the Embrace Project – with Caritas Diocese of Salford, Catholic Care (Diocese of Leeds) and Father Hudson’s Care. These charities supported eleven parishes in four dioceses to create more of the social connections older people wanted. Over 1,000 people within and outside the Catholic community engaged in new and extended social activities. We have distilled learning from Embrace into new guidance for Catholic parishes, on engaging older people and relevant organisations in their neighbourhoods, at low cost and with good impact. We know there are already dioceses and parishes keen to use it. CSAN is publishing the guidance, *Reaching Out: Older People and Catholic parishes – making memories together*, on its website.⁷

Building on Embrace, in 2019 CSAN has again focused on opportunities for Catholic action and voice on care for older people in England and Wales. In preparing Part 1 of *Care in Time*, CSAN has drawn on input from directors of diocesan Caritas organisations collectively; several religious orders; professional Catholic charities delivering domiciliary care, residential care, and community-led projects. It includes some assessment of the impact of pastoral changes in dioceses on community activities organised from parishes, evidenced for example in the Embrace Project. Part 1 also draws on Parts 2 and 3. In Part 2, Professor Peter Kevern offers new theological reflection on care in our national context, and in the light of increased frequency of statements on ageing from the most recent three popes. In Part 3, Dr Kathryn Hodges presents the main findings of her new research on experiences of Catholic residential care for older people, and Catholic parishioners’ awareness and aspirations. The researchers have visited, and listened carefully to the experiences of, senior leaders, parish development workers, care home residents, parish focus groups of working age adults, and religious sisters involved in care. Each part of the report offers contextualised conclusions – the views expressed are those of the authors.

7. www.csan.org.uk/embrace

This work has been supported by a one-off project grant from an independent trust, and in-kind help from charities in the Caritas network, participating parishes and religious communities. In all CSAN has assembled a large quantity of learning, over and above what we have been able to include in this report: for Catholic pastoral organisation and practice, public policy and the strategies of Catholic funders. One challenge for the whole Church remains unchanged from CSAN's reports in 2002, 2007 and 2009: to work out among Catholic organisations how to co-operate, locally and nationally, to ensure there is 'Catholic care' for everyone who wants it. A further challenge, which has become clearer from successful work in the Embrace Project and in other contexts recently, is to provide animating support for parish development – more than a toolkit – where parishioners wish to commence action themselves.

Part 1:

Responding in faith, hope and love



‘The wisdom of the Catholic tradition is to recognise the complementary responsibilities of individuals, families, religious communities, the private sector, and government to work together to overcome poverty and advance human dignity.’⁸

The need for action now

The ‘Message from a carer’ at the beginning of this report powerfully sets out some challenges in an ageing Church and society. These and other challenges, foreseen in three earlier reports on Catholic services for older people between 2002 and 2009,⁹ have intensified over the subsequent decade.

This part of the report sketches an agenda for engaging Catholics in England and Wales – both lay and ordained – on why it is important and urgent to:

- Portray ageing and older people positively.
- Support each other in enabling elderly relatives and neighbours to have social connections they would like and to continue contributing to communities.
- Become informed about the realities of care, and – particularly for those now in middle age – how to reduce the potential need for specialist care in later life.
- Support Catholic charities and carers in diversifying and developing the care they want to see.
- Press Parliament and the Welsh Assembly for a more just and stable safety net of publicly funded care, insuring the whole population for specialist levels of care need, on a par with the National Health Service.

The content draws on workshops involving around 70 people in total, deeper one-to-one interviews with senior – mostly lay – leaders in dioceses, Catholic charities and other organisations, and external horizon scanning, over 18 months. It complements the conclusions of independent researchers Professor Kevern and Dr Hodges in Parts 2 and 3 respectively.

Reason 1: Parts of the care system are a ‘national scandal’

In England and Wales, there is still a need to counter negative characterisations of ageing¹⁰ and social care that damage older people’s dignity and participation, and that reduce the agency of households, communities, churches and public agencies in contributing to care. These stereotypes, which stoke the fear of ageing, have made it convenient to push the planning and organisation of care so far into the long grass, and down the list of priorities for support,¹¹ that loneliness among older people is now commonplace. Age UK has forecast that by 2026, without additional action, two million people aged over 50 in England will often feel lonely¹². Our society accepts reliance on low-paid workers, many of whom are from overseas, to come and care for neighbours who have given lifetimes of service to families and their local communities.

Social care accounts for 6-7% of UK employment. There are more paid workers in social care than the NHS. In addition, unpaid carers provide care estimated as worth more annually than the cost of the NHS. A survey by the NHS of over 50,000 adult informal carers in England found that two thirds had been providing support and care for

8. Mich, Marvin L. K., *A Spirituality for Rich and Poor: Contemporary Catholic Ideals for Economic Justice*, in ed. Kollar and Shafiq, *Poverty and Wealth in Judaism, Christianity, and Islam*, Palgrave Macmillan, 2016, p.236.

9. CSAN and Terry Philpot, *On the Homes Front, 2002, and Length of Days, 2007; National Mapping of Older People’s Services provided by the Catholic Community*, Social Policy Research Centre, Middlesex University, 2009. These are available on CSAN’s website: www.csan.org.uk/about-csan/publications/

10. Vasil, L., and Wass, H., *Portrayal of the Elderly in the Media: A Literature Review and Implications for Educational Gerontologists*, 1993; Age Concern, *How Ageist is Britain*, 2005; Royal Society for Public Health, *That Age Old Question*, 2018.

11. For example, households responding to consultations on council budget priorities have tended to put bin collections, schools and road maintenance ahead of support for their most vulnerable neighbours. However, recent research (by the Health Foundation, King’s Fund and others) indicates that where efforts are made to explain social care to voters, there is a swing towards recognising the need for improved budget settlements.

12. Age UK, ‘All the Lonely People: Loneliness in Later Life’, September 2018.

over five years, and 21.4% for over 20 years; 36% provided more than 100 hours' care per week¹³. In 2018, the King's Fund reported¹⁴ that:

- In England, fewer people were eligible for publicly funded social care in 2018/19 than in 2010/11, and fewer people were receiving local authority services.
- Adult social care spending in the UK fell by 9.9% between 2009/10 and 2016/2017.
- There was a 6.6% vacancy rate for the adult social care sector in 2016/17 in England, with particularly high turnover rates for care workers.

Over the last twenty years, there have been twelve Green and White Papers on social care, and five independent commissions, leading to little reform in the care system. In July 2019, the House of Lords Economic Affairs Committee described successive governments' abandonment of adult social care to a market that could not safeguard the ageing population, and failure to address the urgent need for radical funding reform, as a 'national scandal'.¹⁵ The Committee considered that substantial state intervention at national level is necessary, to create a social care safety net akin to the National Health Service, funded by general taxation to level out risks to local authorities.¹⁶ Other reports have found that the means testing mechanism for local authority care is profoundly unjust,¹⁷ encouraging immoral gaming in the

system by those who have the resources to do so.¹⁸

Charities in the Caritas network have seen and heard first-hand how policies that over-rely on a care marketplace have sanctioned and inadvertently added to isolation, let down many older citizens and carers, and contributed to ongoing losses of Catholic care provision. The Local Government Association has noted that widespread cuts in support for community provision may well be contributing to unnecessary early deaths and higher costs in health services.¹⁹

People of working age often first think about care when facing its challenges, either for themselves or with a relative. Commonly, many assume that someone else – mostly 'the Government' – should or will provide care. In the meantime, the public is spending much on 'looking good' and some are saving ('building barns'²⁰) for worst-case care scenarios. For most people this is likely to be a false economy.²¹ By participating in society more fully today, a more certain and beautiful route to 'being good' is achievable,²² from which vital gains may well be prevention of the need for more expensive care later and of early deaths.

Deferring planning for care can seem attractive because of the pace of technological and medical advances. However, as no-one can predict what kinds of health conditions may yet emerge in longer lives, or the costs of caring for these,

13. NHS Digital (2017), Personal social services survey of adult carers in England, 2016/17: Time Series Annex.

14. King's Fund, *The NHS at 70: What's the problem with social care, and why do we need to do better?* June 2018.

15. House of Lords Economic Affairs Committee, *Social care funding in England inquiry*, July 2019.

16. *Ibid.*, sections 151-160.

17. Cf. Commission on the Future of Health and Social Care in England (Barker Commission), 2014; Independent Age, *A pledge to fix our broken social care system*, 23 July 2019

18. Cf. House of Commons Library, *Funding social care: Key issues for the 2010 Parliament*, and *Social Care: paying for care home places and domiciliary care (England)*, July 2019; National Assembly for Wales, *Paying for adult social care in Wales: Debate and Reform*, May 2017.

19. Cf. Social Care Institute for Excellence and Contact the Elderly, 'At a glance 60: Preventing loneliness and social isolation among older people', 2012; Local Government Association, 'Loneliness initiatives cutting emergency hospital admissions by 20 per cent', 9 June 2018 (source, last checked 14 August 2019).

20. Cf. the parable of a rich man, Lk 12:16-21.

21. There is a difference between taking care of bodies as temples of the Holy Spirit (1 Cor. 6:19, or cf. Juvenal - *mens sana in corpore sano* - a healthy mind in a healthy body) and vanity; even for people of no faith, these can be navigated with humility and healthy realism, nurtured by observation of fleeting nature as well as by cultivating virtue (Eccl. 2:21, 4:45:10; Prov. 31:30; Ps. 39; 1 Tim. 4:8).

22. Cf. Anderson, James F., *St Augustine and Being: A Metaphysical Essay*, Springer Netherlands, 1965, ch. 7.

commercial funders (the market) alone cannot carry all the risks of investing in later life care. These factors present systemic challenges for providers in recruiting and training staff for the long-term, and for capital investments.

Reason 2: Catholic care needs to be better understood and communicated

What is Catholic care?

Despite their reflection of divine mercy in steadfast loyalty and bodily concern, historic lists of the corporal works of mercy within mainstream Catholic tradition are silent on what many carers (mostly women) do every day.²³ At the start of the Year of Mercy in 2015-16, Pope Francis published 'The Name of God is Mercy'.²⁴ He recounted the Visitation of the Virgin Mary to her elderly cousin Elizabeth²⁵ as a model of intergenerational, generous care, and argued that a measure of society's success would be how well it cares (shows mercy).

As a *corporate* work of mercy, 'Catholic care' may include more than 'good care practice'²⁶ in several ways. The following text box proposes a definition in principle and has not been measured in practice in England and Wales. It draws on feedback to CSAN from leaders in Catholic charities, and Parts 2 and 3 of this report.

Other writers in various international contexts have sought to understand Catholic charity identities, and explored relationships between the institutional church and care management. This work has often focused on health care, and triggered when transferring care provision from religious orders to new governance arrangements.²⁷

Features of Catholic care

Catholic care is both a vocational responsibility worked out in faith and human relationships, and an evaluable body of capital and intellectual assets that require specific maintenance and development. Its contribution in realising an authentic vision of human development makes it an indispensable part of assuring a humane society and the common good. Within Catholic charities, many of which engage volunteers as well as staff, it can offer a cohesive guiding narrative to overcome avaricious and technocratic approaches to care, the more it is understood and lived out in practice. It thus complements, and exists in creative tension with, the necessary state provision for all citizens. In organised care settings, the key features include:

- Kindness – 'tenderness' (Pope Francis, see quote on p20); the 'mercy ethos', a 'generous gift of self' (Pope Benedict);
- Physical resources, such as a chapel or prayer room, fittings and consumables;
- Substantive provision for religious and spiritual growth in community, such as liturgies, other celebrations, and pastoral support/chaplaincy;
- The time to sit alongside people during the last weeks of their earthly life, and to pray with them and their relatives before and after death;
- A wholesome approach to individual human

23. While this is more a universal observation on Catholic tradition, the initiative has to start somewhere – it is right for Catholics in this country to generate fresh perspectives and contributions to Catholic social thought. The addition of five Mysteries of Light to the Rosary after many centuries indicates how historic formulae can unfold further with integrity and no faddishness.

24. Drawing for example on Ex. 34:6.

25. Lk. 1:39-56.

26. As described in CQC's Key Lines of Inquiry for inspections, published 13 June 2018, last checked 27 August 2019).

27. For example, see Jones, Patricia, *Discovering the Common Good in Practice: The Catholicity of Catholic Charities*, Durham theses, Durham University, 2019; *Dolentium Hominum* N. 42, No. 3, 1999, p66-67, 69, 74-76; Christopher J Kauffmann, *Ministry & Meaning: A Religious History of Catholic Care in the United States*, Herder and Herder, 1995; Br J Gros FSC, *A Healing Church in an Era of Dialogue*; the Association of Ministerial Public Juridic Persons in Australia.

development²⁸ that shapes and runs throughout care provision and monitoring systems;²⁹

- Conditions that enable staff and carers to progress in their family life, employment, formation and reflective practice, plus
- The education, financial and in-kind support of the local Catholic community, funders and decision-makers, to ensure these features continue to thrive.

These features appear to be diminishing in our collective Catholic attention (i.e. understanding, practice and resource allocation to residential care and community settings), with increasing frequency down the list, over time.³⁰

Can you find it anywhere?

Catholic care is a work in progress. It remains a real process and aspiration in places. Catholic religious orders, specialist charities and community groups, distributed unevenly round the country and often with significant self-sacrifice, labour hard to maintain sacramental and pastoral support, frequently with older priests and religious who live in care homes. These stories are worthy to be heard beyond care home walls

and inspection reports. At national level, CSAN is taking the opportunity of the launch of *Care in Time* to bring some of these stories into the setting of the UK Parliament, with coverage to follow online.

Over the last 12-15 years, since CSAN last undertook significant research around Catholic care services for older people, many care providers, including those linked to the Catholic Church, have closed services. Yet our research has found that the lives of religious orders still offer a strong counter-cultural witness of embracing the older person in her/his entirety, however absurd and imperfect this may all seem in drives for efficiency. Many providers are struggling on margins that are unsustainable for further development. Reasons for closing include inadequate income (compared to the charities' values in care), and the impact of changes in regulation. Catholic providers, which remain small and localised with little co-ordinated national influence, consider that larger, more commercial providers are more successful in influencing policy their way, further disadvantaging smaller providers.

Is it worth supporting?

To answer this, we should look first at some alternative visions of a person's worth.³¹ For example, policy makers and businesses encourage take-up of products and services that might help to make us physically healthier

28. In other words, attending to people's physical, spiritual, intellectual, emotional, and social development, and to the formation of care settings as communities at least as well 'connected' (e.g. opportunities for participation) as the wider neighbourhoods in which they are located. One organisation seeking to integrate care practice with Catholic faith is the US-based Catholic Social Workers' National Association. The Catholic Social Workers' Guild in England and Wales has ceased to operate. Considerable resources have been invested in safeguarding at national and local levels. Relational care contributes to a person's becoming 'free to (become more human)' as well as 'free from (e.g. abuse)'.

29. Examples of support for Catholic health care professions and systems tend to be easier to locate, for example from the Catholic Health Association of the United States which runs some formation programmes and an organisational self-assessment process (the Ministry Identity Assessment).

30. A contrasting performance culture focuses on individuals, what can be measured, centralised power, and rights-based world views. CQC asks providers to show how those working in regulated care settings have 'the right qualifications, skills, knowledge and experience'. Effective care of spiritual and religious needs appears to focus most explicitly on nutrition, hydration, and older people's preferences for end of life care. A central inspection concept of 'person-centred' care is geared towards having 'as much choice and control as possible'. Providers are invited to evidence 'strong links with communities' through feedback from commissioners, Health-watch, community organisations and other professionals.'

31. See also the stories recounted to Dr Hodges by religious sisters about bidding processes to 'win' new care home residents funded by local authorities.

individuals, or at least to 'look good' and appear well, however briefly. These messages are effective. In 2017 the estimated annual value of the UK fitness industry, with over 6,700 facilities (compared to around 2,000 Catholic parishes) was £4.7bn.³² Many fitness and community facilities offer popular activities tailored for older people's health. The UK beauty industry was valued at around £14bn.³³ As well as celebrating good health, we should ask to what extent a focus on 'looking good' is rooted in a pride that deals out intolerance towards ageing and ailments, thus making it harder to put the case for care and the dignity of the infirm and elderly.

Catholic care is not a luxurious pampering or emotional prop, but embraces the whole person in community, body and soul. It is a sacramental sign of what is truly beautiful and good. Where commissioners and providers present a vision of care that makes it look and sound like just another consumer product, people may understandably be drawn into a more transactional relationship to care providers.³⁴ There is even a significant national market in care home marketing. This presents relatively small Catholic providers with additional challenges that emphasise the importance of nurturing a strong, shared identity as well as local roots: a very difficult task to achieve within current resources and awareness in Catholic 'feeder' communities. Charities in the Caritas network know that no amount of marketing can disguise the quality of relational care. Many would welcome more support within the wider church to build and sustain the 'real assets' described above.

Is anyone celebrating it?

Professor Kevern's articles draw together recent papal comments about the importance of care for the elderly, on shared responsibilities to invent a good future for care, and to discover the benefits arising from more people living longer, for them, for society and in the Church.

At local level, care and older people are being celebrated in myriad ways – in befriending and community projects, care services, in end of life care, funerals and commemorations. Even so, some parishioners in the focus groups facilitated by Dr Hodges appear to have absorbed ideas in general circulation: that care is foremost a (business) cost, the work is in some sense unworthy, and the need for it a disaster that may befall households. Priests tend to be clear that priestly ministry is not social work.³⁵ It is vital that parishes, as 'the family of God, a fellowship afire with a unifying spirit,' a 'familial and welcoming home', and "the 'community of the faithful'",³⁶ hear and proclaim social care as part of the common good of our society, and pray for vocations to social care.

In the middle (e.g. national) level between papal statements and local action, care of the aged poor and Catholic care need far more confident institutional advocacy within the Church and in public policy. First, there is a need for more joint communication of Catholic care by providers. Secondly there is a need for dioceses and care providers to work together, to improve understanding of, and commitment to it, in the wider Catholic community, relative to investment in other issues. These processes are in addition to, and underpin, confident Catholic engagement in a plural society.

32. LeisureDB, State of the UK Fitness Industry Report 2017.

33. Statista, Market value of beauty and personal care in the UK, 2015-20.

34. The logical conclusion of this thinking would extend to choosing Catholic pastors, though in practice the pastor holds much of the legal power to make choices on behalf of parishioners, who often have no choice except to attend or not.

35. Cf. Catholic World News report on address of Pope Benedict XVI to priests, 'Priests are not social workers', March 12, 2010 (source). Charities in the Caritas network have indicated how this plays out in some parishes where priests choose to charge Catholic charities full commercial rates for facilitating community activities for older people in parish halls.

36. *Christifideles Laici*, 26.

Reason 3: Care of the aged poor, and access to Catholic care, are pastoral concerns for the Church in England and Wales; the future of this provision relies on better engaging support from Catholics, and developing partnerships

‘Courtesy costs nothing’, but Catholic care is not a free ride. Public funding does not fully fund, and public inspection is barely concerned with, what we see as ‘Catholic care’. Fragmentation among Catholic providers, including a number of religious orders running one or two care homes, has made it difficult to assemble discussion in the wider Catholic community and institutions, and to enlighten public policy, about contribution, value³⁷ and innovation. This stands in marked contrast to the deliberate approaches taken by Methodist Homes, the Salvation Army and Pilgrims’ Friend Society, of ensuring end-to-end spiritual care in their residential settings, supported by effective national infrastructure support.

There is evidence that many Catholics are unaware Government funding and policies tend towards (often short-term) transactional relationships, and do not cover spiritual and religious care in social care settings. Catholic care providers and families have suffered long-term reductions in public funding and eligibility for publicly funded care. More strategic co-operation among dioceses and religious orders is needed, on realising new forms of mission from the lived experience of an older population, both alongside and as part of work with young people and families. Without a step change in co-operation, much of the surviving Catholic care will be

overstretched, and the end of life care (particularly from religious sisters), described in the research by Dr Hodges, could disappear. Much of the residential provision is already beyond the poorest members of local communities.³⁸ It has become largely restricted to private fee-payers, and even with their support, providers tend to operate on tight margins.

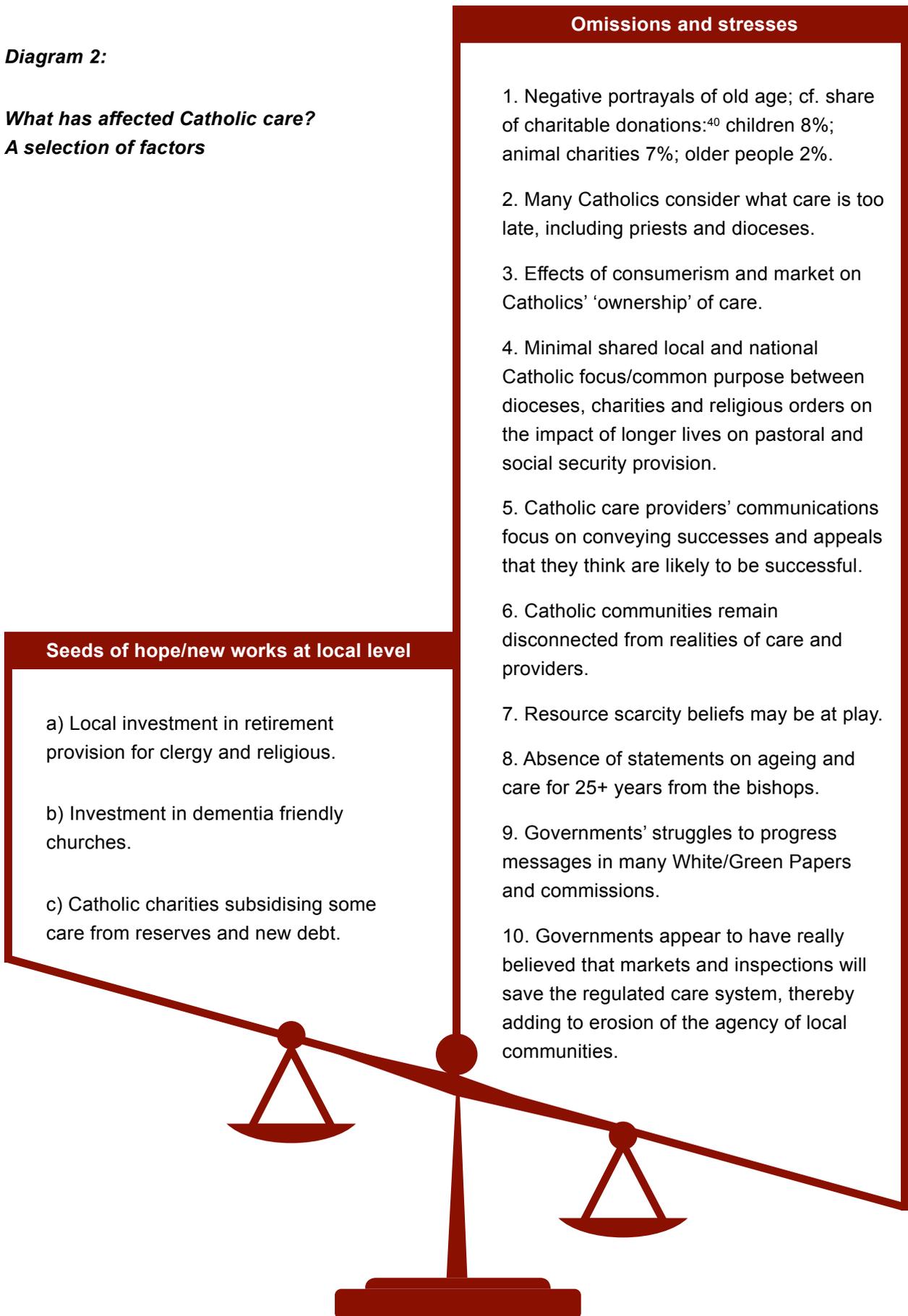
Organised Catholic care provision has historically relied on very localised philanthropy and is small scale relative to commercial chains. A revived – and more collaborative – focus on this is needed alongside a focus on contracts and inspections. The challenge goes beyond good communication, towards integrating the design and lives of care settings in neighbourhoods, rather than to treat the former as places of confinement and decay that should be visited occasionally. Architects, urbanists and landscape designers, artists, gardeners, pastors, social care leaders and educators all have special roles in this process.³⁹ This should help to counterbalance a sense of resignation from the mission field caused by fewer vocations, diminishing financial returns and lack of education and ownership among Catholics. The distance travelled, since CSAN’s earlier reports, illustrates a pattern of managed decline among some religious orders and professional charity leaders. We heard of few instances of substantive support for providers by diocesan trustees (who had occasionally blocked strategic development), and – with exceptions – little proactive discussion by providers with parishioners and clergy who may require care in future.

Diagram 2 (overleaf) summarises some of the key current responses and challenges for informing Catholics and developing partnerships.

37. In *A Very Modern Ministry: Chaplaincy in the UK* (Theos, 2015), Ben Ryan explores the impact of multi-faith chaplains in varied contexts, and how it is measured.

38. Local authority fees paid to care homes tend to fall short of the full costs of care. One estimate of the shortfall, on residential care for older people without dementia, in modest accommodation in converted premises, was £68 per week in 2017/18, rising to £171 per week for people with dementia in new, purpose-built accommodation. Source: LaingBuisson, Care Cost Benchmarks Toolkit.

39. Examples of purpose-built intentional communities include the College of St Barnabas in Lingfield, and Older Women’s Co-Housing in Barnet. These are unusual in England, but more common abroad, with around 250 schemes in Denmark for example (Pederson, M., *Senior Co-housing Communities in Denmark*, Journal of Housing for the Elderly, 26 June 2015, p126-145).

Diagram 2:**What has affected Catholic care?
A selection of factors**

40. Charities Aid Foundation, *UK Giving 2017*, April 2017, p13 – figures based on a survey of 2,903 adults' donations over 4 weeks in 2016.

What can be done?

Practical steps for individuals and local groups

Alongside this report and the new Reaching Out guidance for parishes from the Embrace Project, CSAN has extended the range of signposts for individuals and local groups, with examples on its website (www.csan.org.uk).

National co-ordination

English and Welsh debates on care have increasingly recognised a need for better insuring citizens against meeting the full costs of complex care in later life, through a national system. Similarly, the challenges described above for Catholic organisations, and for older Catholics who live in areas with no Catholic residential care facilities, suggest a need to consider what national co-ordination might be helpful.

In 2019 the Department for Social Justice endorsed CSAN's proposal for national action and voice on Catholic social care. This report and the Embrace Project were funded by a one-off grant from a philanthropic trust. With the publication of *Care in Time* and *Reaching Out*, CSAN's national team has taken the work as far as possible within its resources, for the foreseeable future.

Co-ordination of practical support among a range of organisations is now needed – including dioceses, religious orders, and specialist charities in the Caritas network – to prioritise and realise new ways of winning support for and resourcing Catholic care in future.

a) Federation of professional care providers

Providers need capacity to build awareness of the possibilities for, and training in, religious and spiritual care. Being a local well of good practice might be great for a regulatory inspection but falls short of engagement by the wider church. We need to build reservoirs capable of irrigating a national grid of Catholic care. Some Directors of Catholic social services consider the engagement on this - particularly the lack of a dedicated, joint statement from the bishops - as a serious failure in pastoral leadership in the Church for the Catholic population as it is now, and as it ages further.

To nurture the identity of Catholic care, and to ensure the contribution of Catholic care is heard in public policy making, providers should consider developing a federation of Catholic care homes, with collective representation through CSAN, and in dialogue with other major Christian providers:

Provider in England and Wales	No. of care homes	National development and formation of care provision	Member of National Care Forum
MHA (Methodist Homes)	90	Yes	Yes
Salvation Army	12	Yes	Yes
At least 43 charities linked to the Catholic Church, of which 7 are in the Caritas network	153+	No	No

A federation may also open up opportunities for some professional services to be shared, to release resources for strategic development.

b) Catholic community ownership and support

In some of the interviews with senior Catholic leaders, three potential areas of focus for future national collaboration to enhance Catholic care were considered briefly:

1. *Improve the **quality** of existing care, including its Catholicity in relevant delivery contexts.* Regulatory and inspection frameworks were considered very powerful influences to focus on standards, but were also seen by some leaders to have disadvantaged small, local providers. We found no case to advocate for a Catholic inspection framework akin to the statutory arrangements for Catholic schools.
2. *Increase the **supply** of Catholic care.* In practice the Caritas network in England and Wales partly adopted this approach through the Embrace Project in 2017-18, to stimulate parish-led initiatives addressing loneliness and isolation. National Catholic effort to increase (by direct resourcing) the supply of high-quality home care and affordable residential provision is not realistic at scale, but might be achieved on a local footing through asset management in dioceses.
3. *Encourage a greater sense of **ownership** of Catholic care by the Catholic community.* Our research for Care in Time, together with the Embrace Project, has shown the need to raise awareness among priests and parishioners of the realities of care, to promote 'relational care', and how all can help nurture a more stable future for Catholic community-based, domiciliary and residential care.

While all three areas are important, the third appears to be the most viable route to make sustainable progress on the preceding two points. We need the good practice in relational care – the tenderness described in the Catholic care settings visited by Dr Hodges and the Catholic social thought elaborated by Professor Kevern – to be translated into parish and community settings:

'Tenderness means to give joyfully and, in turn, to stir in another person the joy of feeling loved. Tenderness is expressed in a particular way in looking at another's limitations in a loving way, especially when they clearly stand out. Dealing with delicacy and respect means attending to wounds and restoring hope in such a way as to revitalize trust in the other. Tenderness in family relationships is the virtue which helps people overcome the everyday conflicts within a person and in relations with others. In this regard, Pope Francis invites everyone to reflect on his words: "Do we have the courage to welcome with tenderness the difficulties and problems of those who are near to us, or do we prefer impersonal solutions, perhaps effective but devoid of the warmth of the Gospel? How much the world needs tenderness today! The patience of God, the closeness of God, the tenderness of God."

The Vocation and Mission of the Family in the Church and the Contemporary World, Synod of Bishops, XIV Ordinary General Assembly, 2015, 70, quoting Pope Francis, Homily for Midnight Mass on the Solemnity of Christmas, 24 December 2014.

Learning from both the Embrace Project and the research by Dr Hodges highlights needs for parishes to have access to support that will build confidence to act.

In the Embrace Project, a grant-funded paid development worker provided parishes with support for two years on (re-)forming community activities. The choice and success of community activities depended on volunteers, many of whom were themselves older people. The paid worker brought community-building skills, playing a significant role in 'awakening' and connecting latent talents, and informal coaching of volunteer co-ordinators in parishes. However, the newly emerging roles of development workers and Caritas leaders, in contrast with pastoral assistants and parish fundraisers for programmes outside parishes, are unclear in the mission and ecclesiology of the Church in England and Wales, and there is no common evaluation of their practice and collective impact.⁴¹ Parishes' successful use of the guidance produced from the Embrace Project, *Reaching Out*, does not depend on recruiting a paid worker.

The research by Dr Hodges points to a need beyond Embrace for a network of support that expands the lives of parishes, carers and care homes together. This would address even more creatively the possibilities highlighted by Professor Kevern's review of Catholic social thought, for example what it means for a care home to be a 'lung of humanity'.

c) Capacity for communications, evaluation, strategic investment and institutional advocacy

Unlike in hospital contexts, no-one at national level – in public policy and Catholic contexts – appears to accept responsibility for promoting spiritual and religious care or safeguarding its future in the care system. Within the Catholic context this is in part because of capacity and priority allocated in national Catholic fora; more broadly it may be symptomatic of public attitudes to the worth of older people, and of changing patterns of faith literacy in the UK.

To promote awareness and ownership in the Catholic community, and to develop a right relationship between Catholic care and advocacy, some communications may best be formed nationally and delivered locally, drawing on the approaches exemplified by CAFOD and the Catholic Education Service to address parallel major challenges in our society. Greater balance is needed in Catholic national communications, to attend to pastoral realities throughout England and Wales, the lives of carers in our society who are mostly women, and the effects of austerity in most dioceses, alongside an ever-increasing and complex international agenda.

41. The Church Urban Fund, Theos and Church of England are collaborating on a three-year research project (GRA:CE) to explore the relationship between parish social action and church growth. See www.cuf.org.uk/research-policy/grace (last checked 7 October 2019).

From the many contributors to *Care in Time*, CSAN has identified needs for more structured dialogue with the following ten audiences:

- The public
- ‘Older people’
- Carers
- Policy makers and commissioners
- The Care Quality Commission (CQC) in England and Care Inspectorate Wales
- Care home managers
- Investors and funders
- Catholic groups in England and Wales
- Institutional Church in England and Wales (e.g. parishes, dioceses, religious orders and trusts)
- Dicastery for Integral Human Development

This work will need national coordination to bring experts together, develop communications and to be based on the participation of carers and older people. CSAN could fulfil this role but the work will need investment in proportion to the significant size of the older population and other programmes.

A first step would be to bring into closer relationship the process of discerning priorities and investments of dioceses, other charities in the Caritas network, and religious orders, through a new strategic forum alongside the national peer support groups that already exist for each form of Catholic organisation in England and Wales. The Embrace Project has successfully illustrated that a mission-based approach to convening organisations for social change can create teamwork to achieve more than was possible in historic patterns of Catholic charitable organisation. Some dioceses with the highest levels of need have few professional Catholic care services. At least some dioceses appear to welcome support to avoid reinventing processes for domestic social action many times over, that would be best developed together with national support, in order to maximise dioceses’ capacity to form relationships that can best be built locally.

Part 2:

Expanding into Life

Our Catholic Mission and Witness in a society that fears old age
Peter Kevern, Professor of Values in Social Care, Staffordshire University



Although the care of older people has always been considered part of the pastoral mission of the Church, the 'classic' foundational documents of modern Catholic Social Teaching say very little about ageing and older people as a distinct theme. Similarly, there appear to have been no dedicated statements from the Bishops in England and Wales on our ageing society.⁴² This reflects the fact that, until the latter half of the twentieth century, relatively few people could expect to live into old age; and in societies made up of large extended families it was both natural and sensible to leave the care of older people to their own family members. For both the Church and society at large, there seemed to be more pressing issues demanding attention.

In recent decades, the needs and contribution of older people have gained significantly more public attention and moved up the agenda of governments and care providers. This is particularly true in the industrialised nations such as England and Wales, where one of the surprising phenomena is the way in which older people have come to be seen as a threat to society. The rapid rise in the numbers and needs of older people constitutes, we are told, a 'grey tsunami' that will overwhelm our social care system, and plunge the nation into poverty.⁴³ In addition, older generations are singled out for unjust accusations of hoarding money and housing that should be passed on to younger, socially-useful members of society,⁴⁴ condemning these to relative penury. The Catholic Church

should be concerned about this portrayal of older people and of their role in society, for two reasons. In the first place, the Church has a pastoral responsibility to protect the old and the needy: the portrayal of older people as dependent and greedy can be used to justify woefully inadequate levels of social care amounting to a 'national scandal'.⁴⁵ These attitudes therefore pave the way to a neglect of the poor and needy in the land.

There is a second reason to resist this portrayal, in the strong suggestion that the public attitudes and imagery that we adopt in relation to old age may be providing momentum to the movement for introducing euthanasia or assisted dying in the UK. For example, Megan-Jane Johnstone has demonstrated how fear of dementia, intensified by strong images and metaphors of its onslaught, has been frequently deployed in Australian debate as a justification for legalisation of assisted dying and euthanasia.⁴⁶ Similarly, and notoriously, the distinguished ethicist Baroness Mary Warnock stated that some people might choose to die to spare their family expense,⁴⁷ and that people with dementia may have a 'duty to die'.⁴⁸ Finally, in a well-publicised 2015 case, a former nurse sought assisted suicide in Switzerland on the grounds that old age is 'awful'.⁴⁹ If the Church is to successfully resist the introduction of Assisted Dying in the UK, it will need to identify and challenge the underlying message that old age is a time of unremitting and purposeless decline and dependence, imposing a 'burden' on society. If the notion of a 'grey tsunami' is accepted uncritically

42. Although the Australian Catholic Social Justice Council produced 'A Place at the Table: Social Justice in an Ageing Society' in 2016.

43. Gordon, M (2014) 'Gray Tsunami: A Dangerous Metaphor in Aging Discourse?'

44. Phillipson, C (1998) *Reconstructing Old Age: new agendas in social theory and practice* London: Sage; Carozzi, F (2016) Carozzi, F. (2015). Credit constraints and the composition of housing sales. Farewell to first-time buyers?. *Journal of the European Economic Association*.

45. House of Lords Economic Affairs Committee (2019) *Social Care Funding: time to end a national scandal* London: Houses of Parliament.

46. Johnstone, Megan-Jane (2013). "Metaphors, stigma and the 'Alzheimerization' of the euthanasia debate." *Dementia* 12: 4, 377-393. Johnstone, Megan-Jane (2016). *Alzheimer's disease, media representations and the politics of euthanasia: constructing risk and selling death in an ageing society*. New York: Routledge.

47. See <https://www.independent.co.uk/life-style/health-and-families/health-news/right-to-die-speakers-at-the-house-of-lords-assisted-dying-debate-explain-their-views-9610708.html>

48. See <https://www.telegraph.co.uk/news/uknews/2983652/Baroness-Warnock-Dementia-sufferers-may-have-a-duty-to-die.html>

49. See <https://www.telegraph.co.uk/news/health/11778859/Healthy-retired-nurse-ends-her-life-because-old-age-is-awful.html>

as the truth about ageing, the prospect of Assisted Dying may appear to many as a more attractive option.

An opportunity to influence the public debate about ageing is presenting itself this year, as the funding of Adult Social Care is dominating the government policy agenda. A Green Paper leading to a consultation on Funding Adult Social Care (England), has been repeatedly delayed, and was planned for release “at the first opportunity in 2019”.⁵⁰ This has been overtaken by the release of a report from the House of Lords Economic Affairs Committee, calling for “a White Paper, not a Green Paper, with clear and plausible proposals for sustainable adult social care funding.”⁵¹ Consequently, if the bishops wish to shape the future of elderly social care at national level, this is the moment in which to speak clearly and with a distinctive voice.

The social context and the changing significance of older people

In order to understand current fears of a ‘grey tsunami’ and the attitudes underlying them, it is first necessary to look at the origins of those fears in the shifting social context of the last twenty years or so. During this period, there have been significant changes to the population structure, social attitudes to old age and our understanding of ‘good’ elderly care:

1. The demographic challenge

One of the most striking changes in the demography of England and Wales in the last generation has been the way the number of older people has continued to increase compared to the number of younger people. Thus, the number of people in England and Wales over 90 years of age increased by 50% over the fifteen years to 2017,⁵² with virtually no change in the working age population.⁵³ In England, older people are not needing significantly more care than they used to,⁵⁴ but because more people are living into old age the overall costs have risen sharply. Behind the talk of a ‘grey tsunami’ lie fears that there will simply not be enough money, time or carers.⁵⁵

2. Two types of old age

People are living significantly longer, but the typical age at retirement has hardly changed. This means that a man retiring at 65 today can expect to live more than three years longer than one retiring in 1998.⁵⁶ Over a generation, both the wealth available to people in retirement and the period of time they may expect to spend in good health have rapidly expanded, and this has led to a new category of ‘young-old’ or ‘healthy-retired’ people who have successfully resisted the traditional social role of an old person.⁵⁷ These people make up the ‘Third Age’: active learners and consumers who consider themselves to be free of need for social care and who distinguish themselves from the frail elderly care-recipients who constitute the ‘Fourth Age’. The danger is that this distinction will further

50. House of Commons Library (2018) *Social care: forthcoming Green Paper (England)* Briefing Paper Number 8002.

51. House of Lords Economic Affairs Committee (2019) *Social Care Funding: time to end a national scandal* London: Houses of Parliament p.3.

52. In 2002: 350,700. In 2017: 525,000 (last figures available) from the Office of National Statistics (2017) *Mid-year Population estimates of the very old including centenarians in England and Wales*.

53. 2002: Working age population in England and Wales: 61.7%. In 2017: 60.0%. From the Office of National Statistics, *Population Estimates* [accessed through Nomis July 2019].

54. Public Health England (2017) *Health Profile for England* Chapter 1.

55. King's Fund (2018) *A Fork in the Road: next steps for social care funding reform*.

56. Office for National Statistics (2017) *National life tables, UK: 2014 to 2016*

57. Gilleard, C., & Higgs, P. (2014). *Cultures of ageing: Self, citizen and the body*. Cambridge: Routledge p.71.

marginalise older people who are in genuine need. It does not question the assumption that activism and consumption are social goods or that old age is a problem: it merely pushes the inevitability of dependence and human frailty further into the future and out of sight.⁵⁸

3. Frailty and individual choice

The delivery of care for older people has undergone significant changes over the last twenty years, with an increasing proportion receiving home care rather than being admitted to residential care homes.⁵⁹ A number of factors are at play here, including a shift in emphasis from provision of passively-received care to active choice (most older people would prefer to be at home); the introduction of personalised welfare payments; and the wider use of assistive technology (such as chair lifts and monitoring systems). This shift has significant implications for care providers. For those providing residential care, although the numbers have hardly changed, the residents' average age and need for specialist nursing care have both increased markedly. As people are able to assert their independence for longer, social isolation is overtaking material poverty as the primary pastoral need: 2 million over-75s in 2018 live alone and in England more than a million older people say they go for over a month without speaking to a friend, neighbour or family member.⁶⁰

4. Family and community support

The reported loneliness of older people raises the question of how family members and communities may be struggling to hold together. A key study concludes that the amount of care being offered in family contexts is not falling, as

is frequently assumed. However, many couples are having children later in life at a time when their own parents are themselves in need of care, leading to a 'squeezed middle' generation with caregiving responsibilities for two other generations. Furthermore, since the number of older people needing care has increased, the proportion of care provided by the recipients' children has decreased. Finally, throughout the 1990s the provision of informal support by non-relatives (mainly friends and neighbours) declined markedly.

But as the proportion of care offered by children has decreased, some of the shortfall has been made up by increased care from spouses and partners. As the gap between the life expectancy of men and women has closed, so more couples are living together into very old age and can care for each other. Although a recent study concludes that "there are limits to the extent to which care by spouses or other older people can compensate for a shortfall in the supply of care by children",⁶¹ the experience of old age and the care needs that accompany it will clearly be different for those living in a stable relationship of care. So the support offered to carers may need to be increasingly geared in the future to people who are themselves in need of care: the assumptions we make about who provides care within a family, and how they may be most appropriately encouraged and supported, need to reflect the changing reality in England and Wales.

The value of unpaid care from families and communities, for disabled, seriously ill and older people has been estimated as £132bn a year, close to the annual cost of the National Health Service.⁶² In recent years, while statutory funding for community-based services has declined and many day centres have closed, some new

58. Higgs, P., & Gilleard, C. (2015). *Rethinking old age: Theorising the fourth age*. London: Macmillan.

59. So, for example, in the 10 years from 2001-2011, the population of over-65s grew by 11%, but numbers in care homes hardly changed: people are delaying the decision to enter residential care as long as possible. See Office for National Statistics (2014), *Changes in the Older Resident Care Home Population between 2001 and 2011*

60. NHS (2018) *Loneliness in older people*

61. Centre for Policy on Ageing (2014) *Changing family structures and their impact on the care of older people* pp.15-16.

62. Carers UK and University of Sheffield, *Valuing Carers*, 2015.

community-led provision has opened at national (e.g. The Silver Line, established in 2013) and local (e.g. Linking Lives and Anna Chaplaincy) levels. These should be seen in the context of a 19% increase in the over-65s from 2009/10 to 2017/18, to 10m people, and real terms reduction in public spending on all-age adult social care of 3% over the same period.⁶³ The Catholic Church in England and Wales does not collect or share information at national level on how local Catholic communities are working through these changes.

The social changes outlined above clearly raise questions for the pastoral mission of the Church in England and Wales, and the response to them needs to be informed by insights from the Church's Social Teaching. For example, the changes raise questions about the way groups of people are described, scapegoated and marginalised in our society. At a deeper level, they raise questions about what we value and how we understand the purpose and destiny of our culture. If our society cannot see value in the frail and needy, it has gone astray and needs a new vision.

Older people in the Church's thought and pastoral mission

The purpose of this section is to analyse the existing teaching of the Church on the needs of the elderly and to consider how it addresses the social and policy challenges in England and Wales described above. This will then lead to the concluding section, sketching a vision of the role and purpose of older people as described in Catholic Social Teaching. This vision will yield some proposals for how the Church in England and Wales may respond constructively to the

'signs of the times'.

The first phase in the development of a specific teaching on old age emerges during the pontificate of John Paul II, arising from his concern for the role of the family in the Church's mission. Although this had been the traditional context for all concern for the elderly, families are buckling under the pressures of industrial society: "In this kind of context, the elderly, often enough, finish by becoming an encumbrance".⁶⁴ So "The pastoral activity of the Church must help everyone to discover and to make good use of the role of the elderly within the civil and ecclesial community, in particular within the family . . ." ⁶⁵

This broad framework is developed into a programme of exhortation and action for the Church in the Pontifical Council for the Laity's document, *The Dignity of Older People* (1998). It calls the Church to be a countercultural witness at a time when the needs and contributions of older people are being neglected. It concludes, "New forms and methods [of pastoral care], more consonant with the needs and spiritual aspirations of older people, need to be sought; new pastoral plans . . . need to be formulated. These are essential conditions for encouraging older people to make their own contribution to the mission of the Church and helping them to derive particular spiritual enrichment from their active participation in the life of the ecclesial community".⁶⁶

The Dignity of Older People is a groundbreaking document in a number of ways. It confronts the destructive stereotype of old age as a process of unremitting decline and identifies distinctive charisms of old age. It proceeds to explore how these charisms issue in a distinctive contribution to the life of the Church; and only then raises the

63. Institute for Government, Performance Tracker 2018

64. "The problems of the elderly today differ considerably from those with which they had to contend in the past. There is, firstly, the fact that the numbers of old people have been steadily increasing . . . Then there are certain factors proper to the modern industrial society, the principal being the alteration in the pattern of the family . . . Further, it is often isolated and unstable, sometimes even broken up. . . and to these may be added in our times the (sometimes immoderate) search for comforts and tendency towards consumerism. In this kind of context, the elderly, often enough, finish by becoming an encumbrance." (Pope John Paul II, Message for the 16th World Communications Day, 10th May 1982).

65. *Familiaris Consortio* (1981) 27.

66. *The Dignity of Older People*, 1998, page 8.

question of what sort of pastoral care should be extended to address the distinctive needs of older people. Its vision of the Church as a dynamic, countercultural community of diverse gifts rather than a simple provider of pastoral and social care to the needy elderly remains fresh and relevant as a provocation and a challenge to lift our eyes to God's purposes for the world.

However, more than twenty years have elapsed since *The Dignity of Older People*, a period of rapid change and social transformation in England and Wales. In addition, the document is aimed primarily at the Church and the fulfilment of its pastoral mission. The question therefore arises: how might the Church's social teaching be developed and extended to take account of these changes and the opportunities for advocacy offered by the forthcoming policy discussion on Adult Social Care?

Changes in the Church: the pastoral mission

The first step is to recognise that the traditional model of elderly care offered by the Catholic Church to its members may not be sustainable in the future. This model can be understood to have three tiers. First, and in accordance with the principle of subsidiarity, the primary responsibility for caring for the needs of an elderly person rests with their family. Second, where families proved unable or unwilling to offer the level of care required by their older relative, they have traditionally been able to call on lay pastoral societies such as the SVP as well as some secular institutes to support lonely older people at home. Finally, for those not blessed with caring relatives or with complex needs there was traditionally the prospect of care in a home run by a religious order or secular institute which, due to an abundance of unpaid staff, could offer a caring and devout second home for little or no cost.

This model was crystallised in the teaching of John Paul II, as outlined above. The family is a 'microcosm of the Church', and the organising centre for care for the elderly family members. If the burden becomes too much for the family, then the Church offers support out of its pastoral and material resources.⁶⁷

Each of these tiers of care is under pressures of its own. Family-based care has been subject to the same demographics in the Church as in society at large: families of fewer children, increasingly geographically dispersed and dependent on both spouses working are less able to care for elderly relatives. Although some children could undoubtedly offer more, the demographics of care impose their own logic. The extra 'burden' of care cannot necessarily be offset by the generous commitment of Catholic laity: most of these are themselves older, active-retired members who have the energy and time to share with those in need. Although this cohort of potential volunteers has held up relatively well in recent years and they tend to be more committed than younger Catholics, the reduction in Mass attendance in younger cohorts suggests their numbers may rapidly decline over the next decade.⁶⁸ Finally, the reduction in Mass attendance is paralleled by a reduction in the numbers of both priests and religious, and an increase in their average age. The rapid decline in vocations to the religious life has led to the curtailing of many orders' apostolate to the elderly. Of itself, this has not inevitably led to the closure of care homes, as in many cases the work formerly accomplished by Religious has been picked up by charities (often founded on their assets). Nevertheless, these independent charities, most of which are small providers offering a mix of home care, community projects and care homes, face many pressures including funding, recruitment and retention, and increased regulation of care homes.

67. See Kevern, P (2018). "It's Beautiful to be Old." In Search of Emergent Catholic Social Teaching on Old Age. *New Blackfriars* (in press).

68. The Faith Survey data for England and Wales shows a 40% reduction in Mass attendance from 1999 to 2015. In 2013 Catholics over 65 were nearly twice as likely as the other age groups to attend mass. These figures, possibly more pronounced after a further 6 years, indicate an ageing profile in which the supply of active younger people is likely to be drying up.

Changes in Spiritual Care: the new rights-based approach

In England and Wales, there has historically been little government recognition that the religious and spiritual needs of older people need to be addressed as part of social care. Paid and unpaid chaplaincy support has been offered in acute hospitals for historical reasons,⁶⁹ but in all other areas of health and social care religious and spiritual care has been left to individual providers or interest groups, without central direction or support.⁷⁰ Religious support has always been firmly embedded in hospice work and relies on voluntary funding. Some care homes and groups of care homes (in particular MHA) have chaplaincy programmes and a few GP practices even offer chaplaincy services to patients; but in each case these have been despite rather than because of central government guidance. 'Religion' has been treated as an interloper in policy and the provision of state-sponsored care.

This situation is starting to change as elements of the Equality Act 2010 are progressively translated into public policy. Since 'Religion or Belief' is a protected characteristic under the Act, neglect of these aspects of care can be understood as a form of passive discrimination. Thus, the Care Quality Commission in its *Care Quality Objectives* for 2019-21 notes "recent work to support CQC staff to think about good quality care for people with different faiths and beliefs", working with Skills for Care to build a workforce that is "confident with difference".⁷¹ This modest proposal represents a significant opportunity for the Church to extend its pastoral support and outreach to include the support of Catholics in care homes that are not under Catholic control, since under equality legislation they now have the right to the provision of religious and spiritual care. As the

proportion of social care that can be provided directly by Church organisations decreases and the traditional model becomes unsustainable with the decline in numbers of priests and religious, so a new model beckons: one of providing care to all Catholics across a diversity of care contexts as the situation demands.

Summary

Despite all the changes we have observed in society at large and within the Church, there is a temptation to follow the tried and tested ways of caring for the needs of older people through the ministry of clergy, religious, staff and volunteers in individuals' homes, community settings and care homes. While there is much to celebrate and cherish in this tradition of care, it no longer fully reflects the current reality. It does not address the needs of a society in which there is a discernible fear of growing old and dependent; and in which older people are increasingly autonomous, but also increasingly isolated. It does not reflect the reality of a Church community in which the number of priests and religious is declining, while the statutory requirements placed on residential and day care facilities make it increasingly difficult to run them on a diminishing pool of 'gifted amateurs'. And it does not respond to the opportunities being presented at the moment by the response to equality legislation and the forthcoming policy debate to contribute a Catholic perspective to the shaping of public policy and governance.

It appears therefore that the Church's pastoral engagement with older people may not be sustainable in its present form, but that new models of engagements and pastoral care may be emerging. These conclusions prompt two interrelated questions which return us to the

69. See Swift, C., (2016). *Hospital chaplaincy in the twenty-first century: The crisis of spiritual care on the NHS*. Cambridge: Routledge.

70. CQC states that, 'Assessments of people's care and treatment needs should include all their needs, including health, personal care, emotional, social, cultural, religious and spiritual needs.' Providers must have regard to this guidance, cf. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 9.

71. Care Quality Commission (2019) Equality Objectives 2019-2021 Summary for providers of health and social care. Obtainable from www.cqc.org.uk/sites/default/files/20190529_equalityobjectives-2019-21_providers.pdf

main purpose of this essay. First, What are the fundamental insights of Catholic Social Teaching on ageing that need to be retained or developed? And secondly, How might these insights guide or inform a more expansive vision of old age as not simply a process of decline, but a time of growth and flourishing in the midst of physical frailty?

Towards a Catholic response

In order to respond to this new reality, it is necessary to take a step back and to reflect upon what the Church understands old age to be; what older people need; and how the distinctive charisms of the Church fulfil these needs under the authority of Christ. While there is no distinct body of Catholic Social Teaching that deals specifically with the role and needs of older people, the last three Popes have each in turn given the subject some thought. In order to stimulate reflection here, we will begin with some words of Pope Francis:

1. Society “*carries with it the virus of death*”. Francis has observed that society’s failure to care for the elderly is linked to its denial of frailty, decline and death. This is clearly a problem for elderly people in need, but may also be understood as diminishing everyone in society.⁷² A society that cannot contemplate frailty is one that “carries with it the virus of death”, stunting everything creative that it tries to do. The paradox is that “life spans have increased, but society has not ‘expanded’ to life!”, as its fear diminishes it. This critique has something to say to people who try to relegate frailty and dependence to a ‘fourth age’ at the end of life, a time of terminal decline that should be put off for as long as possible. For at the heart of Catholic teaching

is the assertion that our ‘true identity’ as human beings does not depend upon what we are capable of achieving or our exercise of personal power, but our status as children of God. This cannot in any way be undermined by frailty or loss.

2. *The elder is not an alien*.⁷³ An aspect of this fear of death is that older people are seen as subsisting on the edge of oblivion, in a terrifying place. This is the fear driving the relegation of the frail elderly to a ‘fourth age’, insulated from the rest of humanity. But it is clear in Catholic teaching, and pre-eminently in the incarnation, that frailty and dependence fill our earliest days and shadow us throughout our lives: our existence is only possible with the grace of God and the help of other people, notwithstanding this illusory period of ‘healthy adulthood’ that we may think of as our birthright and our true identity. This may be why, when Pope Francis recalls the story of an elderly woman who was left unvisited by her children for 8 months, he calls their behaviour “a mortal sin”.⁷⁴ as well as breaking the fifth commandment, the children are failing to understand that the first principle of solidarity is a shared frailty.
3. *It is not yet time to ‘pull in the oars’*.⁷⁵ Reflecting on his own age and addressing other elderly people, Francis argues that ‘old age is a vocation’, with its own challenges and opportunities for discipleship. From the perspective of secular history, old age is the final phase of a life in decline, a life with no future.⁷⁶ From the perspective of the Christian faith, it is one stage in a human story that continues into eternity: there is no point in this life at which the Christian pilgrimage

72. Francis (2015) General Audience, St Peter’s Square, 4.3.15.

73. General Audience 4.3.15.

74. General Audience 4.3.15.

75. Francis (2015) General Audience, Saint Peter’s Square 11.3.15.

76. Gilleard, C., & Higgs, P. (2014). *Cultures of ageing* p.137: “Several writers have argued that the widespread negative attitudes towards old age evident in contemporary society lead to an internalization of those values by older people themselves. This internalized ageism erodes the self-confidence of older people, reducing expectations, leading to poorer physical and mental performance, which are then treated as ‘objective’ evidence of an age-related decline.”

ceases. Christ continues to call us to seek our own sanctity and the transformation of our societies for as long as we are able to respond: “The Lord tells us that our history is still open: it is open until the end; it is open with a mission. And he indicates our mission with these three imperatives: ‘Rise! Look! Hope!’”.⁷⁷ From this perspective, the Church can only welcome movements which seek to prevent older people from being ‘warehoused’ in aimless and unstimulating residential care facilities and promote instead autonomy, choice and self-determination among even the frailest older people. The Church will find many allies among care providers if it seeks ways to enable older people to continue to struggle living out their faith in their daily life in community, if this is understood as a way of fulfilling the CQC-driven mandate for care providers to recognise and value religious diversity.

4. “We . . . have to ‘invent it ourselves’”.⁷⁸ Since we believe that old age is one stage in a continuing existence in God, older people are for us forerunners leading us into the future rather than relics of a bygone past, living out their final days before extinction. This means that they are spiritual pioneers, and Francis points out that “Christian spirituality has also been caught somewhat by surprise, with regard to outlining a kind of spirituality of the elderly”. There has never before been a generation of Christians who could expect to live so long, and who are therefore discovering new challenges and insights with which to enrich the Church. Consequently, we must find new ways to support, communicate with and value older people within the Church for the sake of the whole community: we are all impoverished when, succumbing to the pressure of a culture of denial, we treat

the engagement and support of the oldest members as a problem to be solved rather than a treasure of the Church: “The prayer of grandparents and of the elderly” would be “a great injection of wisdom for the whole of human society: above all for one which is too busy, too taken, too distracted. . . Homes for the elderly should be the “lungs” of humanity in a country, in a neighbourhood, in a parish; “sanctuaries” of “humanity””.⁷⁹

5. *An integral ecology*...⁸⁰ is inseparable from the Common Good. Throughout the encyclical *Laudato si'*, an anthropocentric “throwaway culture” which exploits children and discards old people (123) is contrasted with a vision of a diverse and integral culture that thrives because it has space for all and is inseparable from social justice. From this perspective, topics such as care for the elderly and support for those who care for them can never be considered peripheral to the mission of the Church: on the contrary, they sit at the heart of the struggle between Christocentric and anthropocentric views of God’s created order. Conversely, the requirement of social justice precludes a hoarding of resources for a hedonistic old age: “Intergenerational solidarity is not optional, but rather a basic question of justice, since the world we have received also belongs to those who will follow us.” (159). A vision of the common good thus rests on a renewed relationship of gift-giving between the older and younger members of society.

77. Francis (2017) Homily, Pauline Chapel, Tuesday, 27.6.17.

78. Homily, 27.6.17.

79. Meeting of the Pope with the elderly. Address of Pope Francis, Saint Peter’s Square, Sunday, 28 September 2014.

80. *Laudato si'* 256.

Building a renewed vision of the place of older people in the Church and in society

Pope John Paul II, and consequently the document *The Dignity of Older People*, called us to a vision of the Church as a place in which older people have a distinctive charism and contribution to make: without them, the Church is impoverished and lacking in insight. The changes in society over the last twenty years have indicated that this is a message not just for the Church, but for our society as a whole: against the “virus of death”, the Church is called to challenge our society to “expand into life” in its understanding of and vision for old age, and in its approach to the care of its oldest members.

Negatively, this entails standing against the stigmatisation of old age and some of the language of denial that surrounds it. The elder is not an alien; the wellbeing of the state is not threatened by a ‘grey tsunami’ and being old is not in itself a ‘burden’ for society. Older people are not selfishly hoarding resources that should be given to younger generations; they are not swallowing up an increasing proportion of the social care budget;⁸¹ there is no discrete ‘fourth age’ of frailty and need whose members can only passively receive what is offered. Rather, we all have contributions to make and needs to be filled at each stage in our lives. Theologically, we all stand in need of divine grace and are called to a life of holiness and apostolic activity, and this is as true for the oldest members of the community as for the youngest.

Positively, the Church can hold out a vision of a rich and diverse “integral ecology” in which older people are recognised as “spiritual pioneers” with unique gifts to offer. Not just care homes but any community in which these gifts are nurtured and valued can become “lungs of humanity”, where explorers in the uncharted territory of increasing

old age provide new insights into our humanity and new opportunities for service of God and each other. The Catholic vision of the Common Good is of a society which is much greater than the sum of its parts: each member is enriched by the contribution of all of the others and the whole community is diminished if any are excluded or marginalised.

As we have seen, there are civil society and political movements to challenge the ghettoization of older people, to accord them greater choice and agency in shaping their own lives and new patterns of care and support within a rich community life. There is a movement to reject the division of society into the independent and the needy, and instead to see ‘wellness’ as a goal to be pursued by all across the lifespan, with whatever support is appropriate to the individual’s circumstances. It is appropriate and necessary for the Church to communicate with these movements on how they can understand and apply its vision of old age to the concerns of the present day.⁸²

Conclusions: “Expanding into Life” as a community of hope and love

The purpose of this essay has been to track the major social and ecclesial changes of the last twenty years that have affected the lived experience of older people; to probe beneath them to expose the deep assumptions distorting our views of old age; to challenge and correct these in the light of contemporary Catholic Social Teaching; and to apply this renewed perspective to some of the concerns driving the current policy debate on providing for elderly social care.

Underlying these specific goals is a coherent and distinctive Catholic vision of humans-in-community as exemplified in the Mass. The eucharistic Body

81. See The King’s Fund (2019) Social Care 360, which shows that in England, the proportion of older people accessing care is decreasing.

82. See *Gaudium et spes*, 63.

of Christ is only fully realised in a community of individuals who humbly acknowledge their frailty, excluding no individual or group; and this becomes the pattern for Catholic Social Teaching. It is a vision in which each has a contribution to make to the Common Good, so that the whole community is diminished by the exclusion or marginalisation of any. Thus, the 'preferential option' for marginalised and frail elderly people is not simply an act of charity; it is also a recognition that true community can only be built upon an act of solidarity with all its members. All are frail, we all stand in need of each other's help: there is no easy distinction between care-providers and care-receivers.

The Catholic vision stands in contradiction to a 'culture of death' that considers ageing as little more than a process of inexorable loss and decline into irrelevance as a precursor to an empty and meaningless end, inflicting a 'burden' of care on younger, fitter individuals who deserve to be released from it. The rational response to this burden in a 'throwaway culture' may well appear to be suicide, or a form of Assisted Dying. It is incumbent on the Church to offer a richer, more hopeful, more expansive vision in its spiritual and pastoral care, its policy contributions and its representations in the national debate.

Professor Peter Kevern has been working on issues raised in the dialogue between religion and dementia studies for over 10 years, most recently working on a range of projects which concern human spirituality, the interface between religion and health, ageing and/or death, with a particular interest in the potential role of religious communities in helping to deliver public health gains.

Professor Kevern has written a longer article in collaboration with CSAN, 'It's beautiful to be old - In search of emergent Catholic Social Teaching on Old Age', available at CSAN's website.

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Part 3: Exploring Care

Dr Kathryn Hodges, Independent Researcher



Introduction

The availability of Catholic social care in its previous guise of older people's homes, where care was predominately led and delivered by religious sisters, has diminished. It is essential to understand if there is something particular about 'Catholic care' and if it can be disseminated in future models of support, both in Catholic and secular provision. Many of us will experience the challenges of older age and/or caring for others. It is critical to understand how Catholics hope to experience care in the future and to explore their role in creating the environment of support they may want or need in their later years.

This research is based on interviews and focus groups in the first half of 2019, with 50 people in England who either receive, provide or may need care in the future. Participants were either resident in Catholic care homes, providing professional or pastoral care in a Catholic care home, or working age Catholic parishioners. A full copy of the research report can be accessed on CSAN's website.

Summary of findings

1. It was striking that when asked about what they understood care to be, or what they thought it looked like, all of the three working-age adult focus groups moved directly to a conversation about the cost of care and care as a business, and what they saw as value for money in terms of the care they had witnessed. There seemed little awareness or discussion about how little local authorities paid for those needing residential or nursing care, the actual cost, or the difficulty of providing care at that level. Whereas those providing care set out the stark realities of funding, the implications for care, and some of the current commissioning practices where homes are left bidding against others to provide individuals with care.
2. Those receiving care noticed how staff paid attention to the detail, describing what they experienced as caring as being kind and pleasant, putting people at ease and not talking down to people. Both recipients and providers of care emphasised the importance of sustained relationships in caring, and the environment that enables carers to take time and be present with residents.
3. Observing the care others received had an impact on individuals' understanding of the care they were receiving, and how they might be treated if their circumstances changed. The most powerful experience of observing care was seeing how other residents were cared for at the end of their lives.
4. All groups of participants involved in the study mentioned end of life care. There were concerns amongst working age adults that the process of dying may involve being dependent on the care of others whilst in much pain. Religious sisters talked about the power of being present with a person at the end of their life, as something they felt was an important part of their work. This delicate act of being present, providing support for residents and their family, clearly comes from extensive experience, which is in part embedded in their faith. Residents observed this end of life care as they understood how they would be cared for, and it had an impact on their confidence about how they might experience dying.
5. Care home residents often talked about the on-site chapel and how they were able to attend Mass every day. For many this provides the opportunity to continue practising their faith as they have done throughout their life, as an essential part of their identity.
6. Faith underpins the care provided by religious sisters. Values of the orders were shared with staff at care homes with a view to ensure the way they offered care reflected these values as the number of sisters providing direct care diminishes. Arguably this is more effective where there is a stable and consistent staff team.

7. Caring for others can be enjoyable and rewarding, however for those who had experience of caring for relatives it was often described as tough, frightening and horrible.
8. For those providing care, there is a significant challenge in finding staff that care and will stay with the organisation longer than six months. This was frequently attributed to the low wages available, with staff moving once they had gained experience to other providers, such as hospitals, which offered better rates of pay and benefits.
9. There is frequently a failure in wider society to recognise and value the work of paid carers. Supporting staff development, and empowering care staff to challenge and take action, were seen as essential in affecting how care is delivered and received.
10. It is crucial that organisations care for their carers - among whom many will have complex challenges in their own lives, which will also be present with them at work. Providing effective support and a listening ear helps create a stable staff team, enabling an environment where relational care can be delivered.
11. Participants in the research recalled poor care they had experienced during the course of their lives, not necessarily relating to their current circumstances. These ranged from a failure of carers to pay attention to the detail of the individual's preferences and needs, to reports of previous care homes where one participant was assaulted, and another was unable to leave the confines of a bedroom. In all these examples it seemed that concerns, needs and preferences had not been heard or responded to.
12. Participants talked about coming into residential care after a particular event or crisis. When talking about this time, it was notable that there was little discussion about exercising choice, planning their care, or autonomy in decision-making.
13. Those working age adults who had cared for relatives were deeply affected by this experience, and they were clear that they did not want their children to go through a similar experience so would plan future care to avoid this. Whereas those who had not had this experience assumed that they would stay in their own homes, and/or their children would care for them. For many, this was the first time they had been asked to think about how they might manage any future care needs and they were unsure how to answer.
14. Discussions around the delivery and funding of care were focused on the need for government to take action, but also individuals questioning their own role, and that of the (institutional) Church in challenging current provision. There were concerns that the complexity of needing and receiving care is not considered until too late.
15. Participants of focus groups explored their role as a 'church family' going beyond the walls of the church and creating some kind of support for older adults and their carers. In other groups participants felt 'paralysed': they wanted to do something but did not know where to start.
16. There are silences in the research process, and it is essential to pay attention to the things that are not said or discussed as they also have meaning and value. There are times when participants struggled to put things into words, where they were unable to answer, or glossed over subjects. There were also 'silences' on particular topics, or the things that are not talked about. In the focus groups this related to gender and caring, the expectation of family to care in the future, and for those who had not been exposed to the realities of caring for others in later years, their understanding of what this might look like for themselves.

Context

Caritas Social Action Network (CSAN) commissioned this research; it commenced in January 2019 and was completed in June 2019. CSAN has previously commissioned three research projects that have reported on the services provided to older people by the Catholic community in England and Wales (Ryan et al., 2009;⁸³ Philpot, 2007,⁸⁴ 2002⁸⁵). These studies have mapped Catholic social care provision, explored the impact of diminishing vocations on residential care, and explored the support available via parish communities. These reports made recommendations on how the Catholic Church in England and Wales could respond to the challenges of home closures and associated impact of social policy and related market, fewer vocations to priesthood and religious life, and the increasing population of older people needing help and support.

Additionally, throughout the research, there were recommendations to connect local churches with the older people in their community. In particular Philpot (2007) noted how well churches and Catholic schools had maintained close links and partnerships, and how this could be replicated for social care provision. In his forward to the report by Ryan et al. (2009), Rt Rev Terence Brain commented that it was hoped that those who read the report “begin to see how you and others can engage in the mission of the Church to enable older people to continue their journey in the things of God, and for us also to provide opportunities for older people to teach us from their journey in the things of God”.

Much of the research identifies gaps in and the nature of provision and brings attention to the future social care of older people. The previous CSAN reports comment on the value of ‘Catholic care’. Whilst there is discussion about the nature of faith and spirituality in care (especially

health care), it is clearly difficult to define what ‘Catholic care’ looks and feels like, for those receiving and providing it, beyond sacramental participation. However, there is also a view that there is something particular about ‘Catholic care’, although descriptions on what this looks like, how it is delivered, and how it is experienced are limited. There is also much commentary on the need to engage the Church (at various levels) with provision of care for those in need of support in the local community.

If we are losing Catholic social care in its previous guise of older people’s homes, where care was predominately led and delivered by religious sisters, then it essential to understand if there is something particular about ‘Catholic care’ and if it can be disseminated in future support, in provision managed by both Catholic and non-Catholic organisations. In addition, since anyone may need care, and most older people do not need care of the most complex kinds, it is critical to understand how members of the church community hope to experience care in the future, and to explore their role in creating the environment of support that they may want or need in their later years.

To explore these two broad areas, this research addressed the following questions:

- What are the different understandings of ‘care’?
- What do older people consider to be important aspects of the care they have received?
- How do working age adults/church congregations think about the ways they want to be cared for?
- What are the narratives of religious sisters/ other carers involved in the care for older people?
- Is there a model of ‘care’ that can be developed and understood?

83. Ryan, L., D’Angelo, A., Tilki, M. and Castro-Ayala, A., 2009. National mapping of services to older people provided by the Catholic community. Available at: www.csan.org.uk/wp-content/uploads/2016/10/Mapping-OP-services-fullreport.pdf [Accessed 8 Jan. 2018].

84. Philpot, T., 2007. Length of Days, p26. Available at: www.csan.org.uk/wp-content/uploads/2016/10/length-of-days.pdf [Accessed 8 Jan. 2018].

85. Philpot, T., 2002. On the homes front: the Catholic church and residential care for older people. Caritas Social Action Network, p.5.

Care: A relationship, a crisis, and future plans

Care: a relationship

The concept of 'care' is a "complex and evolving social phenomenon and has an enduring moral value" (Rummery and Fine, 2012, p.323). There are broadly three distinct facets of care.⁸⁶ The first attends to the feelings and emotions involved in care, often appearing as empathy, concern and a degree of responsibility for another's wellbeing. The second facet, where care is a form of labour, has a focus on competency and the impact of caring on the workforce, such as workload, financial recompense, physical and mental wellbeing. The third explores the social relationships of care, where it is not just caregivers who can dominate or exert power, but that the caregiver can be dominated in these relationships through the sacrifices made to provide care (Rummery and Fine, 2012).

In her work exploring kindness and its role in social policy, Unwin (2018)⁸⁷ observes that care has always been provided and seen as something done by one part of society to another. She brings attention to the two lexicons that are used in public policy:

...there is the language of metrics, and value added, of growth and resource allocation, of regulation and of impact. And there is the language of kindness and grief, of loneliness, love and friendship, of the ties that bind, our sense of identify and of belonging (Unwin, 2018, p.9).

Both languages have their strengths, but on their own are 'dangerous', and there has been pressure on the value of kindness in public policy in part due to reductions in public expenditure, digital analytic capability, and digital communication (Unwin, 2018). Changes which have provided a higher level of predictability and an associated focus on impact, have played a key role in developing a transactional, rather than relational approach, eroding the ability to "respond to individuals, to recognise their differences and to engage with the complexity of individuals and their community" (Unwin, 2018, p.11).

Elsewhere in the literature and policy, attention has returned to relationship-based practice (Munro, 2011;⁸⁸ Folgheraiter, 2007;⁸⁹ Ruch, 2005;⁹⁰ Trevithick, 2003⁹¹). All social care is undertaken within and through relationships, and the medium of relationships is the "primary means of intervention" (Ruch, 2005, p.113). Relationship-based practice, "explores not only the 'how and what', but also the 'why' of practice", with practitioners developing a holistic understanding engaging with all aspects of an individual's behaviours, recognising that "individuals are complex, multifaceted and more than the sum of their parts" (Ruch, 2005, p.113).

The concept of being 'met as a person' develops and progresses relational models from general guidance for service approach and delivery, into the details of one-to-one interactions between care-seekers and professional caregivers; "a framework for thinking about the way we interact with one another".⁹² This framework also demonstrates the relational complexity of giving

86. Rummery, K. and Fine, M., 2012. Care: A Critical Review of Theory, Policy and Practice: Care: A Critical Review of Theory, Policy and Practice. *Social Policy & Administration*, 46(3), pp.321–343; Daly, M. and Lewis, J., 2000. The concept of social care and the analysis of contemporary welfare states. *The British journal of sociology*, 51(2), pp.281–298.

87. Unwin, J., 2018. Kindness, emotions and human relationships: The blind spot in public policy. [online] CarnegieUK. Available at: https://d1ssu070pg2v9i.cloudfront.net/pex/carnegie_uk_trust/2018/11/13152200/LOW-RES-3729-Kindness-Public-Policy3.pdf.

88. Munro, E., 2011. The Munro review of child protection: final report : a child-centred system. Norwich: TSO.

89. Folgheraiter, F., 2007. Relational Social Work: Principles and Practices. *Social Policy and Society*, 6(02), p.265.

90. Ruch, G., 2005. Relationship-based practice and reflective practice: holistic approaches to contemporary child care social work. *Child and Family Social Work*, 10(2), pp.111–123.

91. Trevithick, P., 2003. Effective relationship-based practice: a theoretical exploration. *Journal of Social Work Practice*, 17(2), pp.163–176.

92. McCluskey, U., 2005. To be met as a person: The dynamics of attachment in professional encounters. London: Karnac, p3.

and receiving care. Ultimately a failure to be met as a person occurs when professional caregivers do not consider the individuals' needs when seeking help and support, a large part of which includes previous experiences of seeking support and receiving care.

Care: a crisis

There are significant challenges continuing to affect overall provision of social care for older people in this country, including the potential of Brexit to affect the availability of care assistants,⁹³ alongside the on-going austerity conditions in which care is being delivered.⁹⁴ The nature of the ageing population and increasingly complex support needs, mainly of those over 85, has been reported extensively.⁹⁵ Alongside these challenges are the intersecting and complicating experiences of older age, family support, isolation and loneliness, grief and loss, pensions and housing, and physical and mental wellbeing.

The proportion of the population who are retired will rise to about 24% in 2050 from the 12% recorded in 2012, and there will be around eight million adults aged over eighty years old, three times more than there are currently (RSA Action and Research Centre, 2012; CSJ, 2011). Forecasts suggest that by 2040 there will be double the number of older people needing social care support, of whom 1.4 million would be diagnosed with dementia (RSA Action and

Research Centre, 2012; CSJ, 2011).

Social care throughout the life course is “widely recognised to be in crisis” (Land and Quilter, 2018, p.1).⁹⁶ Additionally, since 2009/10, it is estimated that there has been a “25% reduction in the number of older people accessing publicly funded care” as a result of tightening in eligibility criteria during this time.⁹⁷ According to Age UK (2018), there are more than 1.2 million adults in England aged over 65 years who do not receive the comprehensive care and support they need to support them with essential aspects of daily living, an increase of 48% since 2010 (Land and Quilter, 2018).

It is thought that there are six million informal carers in the UK providing unpaid care and support to older people. Age UK (2018) estimate that 2 million informal carers are aged over 65 years, with more than 400,000 of this number over 80 years old. The majority of paid and unpaid carers are women, and women are most likely to need support in their older age (Land and Quilter, 2018). Previous research has found that spouses are likely to care for each other. However, outside of this relationship, female relatives are more likely to provide necessary unpaid care and support.⁹⁸ Further information about the cost of caring to the individual and to the state can be found at the Carers UK website.⁹⁹

The paid care sector is facing a “recruitment

93. Department of Health, 2017. Evidence on EEA nationals working within the health and care system, focusing on England. Available at: www.assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/693468/Department_of_Health.pdf.

94. ADASS (Directors of Adult Social Services) Budget Survey 2019: Human cost of failing to address the crisis in adult social care. [online] Available at www.adass.org.uk/media/7275/adass-budget-survey-report-2019_sans-embargo.pdf. Accessed 28 Jun. 2019.

95. CSJ, 2011. Age of Opportunity: Transforming the Lives of Older People in the UK. London: Centre for Social Justice; RSA Action and Research Centre, 2012. Improving decision-making in the care of older people: Exploring the decision ecology. Joseph Rowntree Foundation.

96. Land, H. and Quilter, I., 2018. Social Care: A system in crisis. [online] London: Women's Budget Group. Available at: www.wbg.org.uk/wp-content/uploads/2018/10/Social-Care-October-2018-w-cover.pdf [Accessed 31 May 2019].

97. Age UK, 2018, 'Why call it care when nobody cares?' An Age UK campaign report about how older people and their families experience the crisis in social care. [online] London: Age UK. Available at: www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/care-support/RB_mar18_social_care_campaignreport.pdf

98. Arber, S. and Ginn, J., 1990. The Meaning of Informal Care: Gender and the Contribution of Elderly People. *Ageing and Society*, 10(4), pp.429–454; Carers UK, 2018. 10 facts about women and caring in the UK on International Women's Day - Carers UK. [online] Available at: www.carersuk.org/news-and-campaigns/features/10-facts-about-women-and-caring-in-the-uk-on-international-women-s-day [Accessed 24 Jun. 2019].

99. www.carersuk.org

and retention crisis due to poor pay and working conditions” (Land and Quilter, 2018, p.1). Brexit poses additional challenges that are likely to affect recruitment and retention, with European Economic Area (EEA) staff making up approximately 7% of the adult social care workforce in England, the majority of which (around 69,000) are employed in relatively low-paid direct care roles (Department of Health (DoH), 2017). If demand for social care staff is not met, and “if we fail to meet social care needs adequately we are likely to see a decrease in labour market participation levels, especially among women, as greater numbers undertake informal care’ (DoH, 2017, p.3).

Care: to plan for (or not)

In their comprehensive scoping review of literature around how we plan for later life, Preston et al¹⁰⁰ write that “there is a widespread and common-sense-based perception, backed to some extent by evidence, that planning and preparing for later life is associated with increased wellbeing in older age”. However, their review found that many in mid-life have not yet planned for their later years (Preston et al., 2018). Whilst there is a much greater evidence base which considered pension planning and the timing of retirement, there was less literature which explored some of the other key decisions, such as potential home moves or developing support networks (Preston

et al., 2018). They found characteristics shared amongst those less likely to plan for the future, including, “having a lower income or fewer assets, living in rented accommodation, having lower educational attainment, being in poor health and working part-time or in the private sector”¹⁰¹ (Centre for Ageing Better, 2018, p.3). Elsewhere, women were more likely to have considered and participated in preventative health care, and have thought about end of life care, whereas men were more likely to have focused on particular tasks such as making a will or putting in place power of attorney (Preston et al., 2018).

Overleaf is a table from the review illustrating the range of barriers and enablers to adults planning and preparing for their later life.

100. Preston, C., Drydakis, N., Forwood, S., Ellen-Hughes, S. and Burch, S., 2018. Planning and preparing for later life. [online] London: Centre for Ageing Better, p11. Available at: www.ageing-better.org.uk/sites/default/files/2018-09/Planning-and-preparing-for-later-life-research-report.pdf [Accessed 15 May 2019].

101. Centre for Ageing Better, 2018. Planning and preparing for later life: Summary of research findings. [online] London: Centre for Ageing Better. Available at: www.ageing-better.org.uk/sites/default/files/2018-09/Planning-and-preparing-for-later-life.pdf

Enablers and barriers to planning

Enablers		Barriers
Awareness/salience	Wanting to attain something in future	Issue seems a long way off
	Wanting to avoid a perceived risk	
	Wanting to escape a current aspect of life	
	Wanting to preserve an aspect of life	
Choice and control	Feel that they can exercise choice and control over future	Experience of life as unpredictable
	Positive life-course experience of planning	Fatalistic attitude about survival into old age
	Sufficient financial resources to plan	Socio-economic constraints
Knowledge and skills	Sufficient knowledge and skills	Inadequate understanding of and familiarity with planning products and services
		Difficulty in predicting probable future timeline and understanding risk
Instrumental and informational support	Sufficient support from employers	Inadequate support from employers, industry, regulators and landlords
		Inadequate infrastructure
Social influence	Social networks promote planning	Peers' views undermine planning behaviour
		Gendered role beliefs undermine planning
	Positive age stereotypes	Negative perceptions and terminology of ageing

(Preston et al., 2018, p.5)

Exploring Care

Research Strategy

Data was generated from semi-structured interviews and focus groups involving fifty individuals. Three Catholic residential care homes were visited, with residents from each of these homes involved in the study. These residential homes were in three different geographical locations across England. In two of the homes religious sisters lived nearby or on site, providing either direct care, management of care, or pastoral support. A number of the sisters at these two sites were involved in the study. Focus groups of working age adults were organised at parish churches in the vicinity of the residential homes. Those who attended the focus groups were Catholic parishioners.

The interviews explored residents' experiences of needing care, and thoughts about the care they receive. Additionally, those providing care talked about what led to and informed the care they provide, their understanding of how care should be delivered, and challenges in this work. In the focus groups there were discussions about what 'care' was, with observations about care being provided and what receiving care in the future might be like.

For further information about the analysis of data and detailed findings, please read the full report is available which is available at CSAN's website. The main findings of this research are presented below.

The different understandings of 'care'

There were dissonances between the different groups and their understanding of care. This, in part, is understandable, as each person's direct interaction and involvement in care giving and receiving varied. However, these tensions seemingly result from different interactions

and involvement with different facets of care (Rummary and Fine, 2012).

Cost of care

When asked what they understood care to be, all three groups of working age adults responded with long discussions about the cost of care. This broadly fell into discussions around the spiralling costs that they had heard others experience, and their thoughts on the value and quality of care in comparison to its cost. Additionally, there were comments relating to documentaries that had paid witness to carers behaving badly to those they were paid to support. This view reflected an understanding of care (Rummary and Fine, 2012) as the work, its related physical activity and carers' competency. The issue of cost was one groups returned to throughout the discussions. At times some of the ideas shared seemed to lack all the factual details about why care was expensive, or the limited funds that local authorities used to pay for care and the impact this had more broadly.

It is not surprising that those who are not directly involved in caring for others or supporting relatives who need care, moved straight to the issue of the cost of care, when this is frequently how we hear care discussed in the press and by politicians. The comment Philpot (2002, p.5) made seventeen years ago, feels very current, where he notes that the "biggest source of friction between the independent sector, government and local authorities has been the level of the fees which local authorities pay, which, the independent sector claims, fall seriously short of the money needed to provide high standards of care for each resident as well as allowing private homes to be profitable". Since Philpot wrote this summary in 2002, the situation has not just remained unchanged, it is arguably worse. For example, care home providers are reportedly increasing the prices for those residents that self-fund, with fees in 2015/16 for self-funders 41% higher on average than for local authority-funded beds in the same care homes – equivalent to an extra £235 per

week.¹⁰² The 2019 ADASS Survey (2019, p.35) firmly sets out the impact of the ongoing funding crisis, bringing attention to the “very real and damaging effect on the day to day lives of people who need and provide care”. The realities of these financial challenges were heard in the interviews with those providing care, particularly where Sr. Nancy recounted how individuals’ care packages were being put out for care homes to bid for; she questioned where in this a person’s wishes and feelings were considered, particularly their spiritual care. Sr. Nancy commented, “It’s very different from when our founders started, and everything has changed and there have been so many changes over the years, and it is very difficult to accept them and look at what’s happened...there’s not an awful lot you can do about it if you want to continue in the care field”.

As a responsibility, frequently frightening

Focus group participants, who had been involved in the care of a parent suffering ill-health in later years, saw care as a responsibility which was frequently frightening. This understanding of care was also evident in their thoughts of how they might want to be cared for in the future: they did not want their children to go through a similar experience. Echoing the findings of Rummery and Fine (2012, p.323), who comment that where care is “understood as a feeling or emotion involving a disposition towards others” it can often be a form of “stressful and emotional labour”. One of the participants who had cared for a parent had also been a nurse. She noted the difference between the experience of caring for someone outside her family and caring for her parent; she had expected herself to manage the latter as she had so much caring experience - but found it very hard.

A relational act

It is essential to recognise that caring is not just something that is done to another, but rather that the care giver, alongside the care recipient, can feel as if they are losing their autonomy as they

accept responsibility and associated sacrifices in their life (Rummery and Fine, 2012). Whereas, for those participants whose pastoral or paid role was to provide care, care was a relational act, it was a joy and privilege. One of the participants said that caring was ‘part of who she was’. Also amongst the focus group participants were those who volunteered and cared for others (varying ages) in the community, who commented on the powerful experience of caring for others and wished that more people could have this direct experience. Caring for others (not relatives) was considered as something enjoyable and rewarding.

Those receiving care talked about both care as the physical work that they observed, and how they experienced care as a “social relationship” (Rummery and Fine, 2012, p.324). The majority of those receiving care, when asked about the care they received, first responded by talking about the food, the personal care, help to move around, and access to services such as the hairdresser or chiropodist. However, they also talked about the relationships they had with carers, the way that particular carers talked to them, or they observed carers talking to others.

One of the most repeated observations expressed by all groups involved in the study was of some treating caring as ‘just a job’, comparing a person who just did the tasks required of them compared to those that went beyond their job description. This difference appeared to reflect the relational acts, demonstrated through listening, having conversations, taking time to think about the detail of an individual’s particular needs. In the working age adults’ groups, the term ‘just a job’ seemed to reflect their understanding of someone who didn’t care or provide care that would fit understandings of the importance of the relational aspects of ‘meeting people’ (McCluskey, 2005) and the attachments made. This distinction of care, as something which is done or something which individuals intuitively undertake, was also present in the narratives of those providing care,

102. Competition and Markets Authority, Care homes market study, 2016, full report p14. www.gov.uk/cma-cases/care-homes-market-study

as one participant commented that they wished they could find more staff that “care, but with a little more warmth.”

Receiving care: Important aspects of care

Those receiving care talked in the main about the social relationship of care, particularly as they explained most important aspects of the care they received.

The detail

For those receiving care, they noticed when carers paid attention to the detail, and when they didn't. This detail would range from knowing that someone would struggle to unfold a towel, to the way they were anxious about being handled when being washed, or the way that a cleaner paid close attention to dusting a resident's personal effects. Whilst often on the surface this can seem like small practical actions, the relational aspect of the interaction matters: getting to know someone, understanding what is important to them, and paying attention to this when you meet them. Elizabeth talked about her experience of how a carer paid attention when helping her wash, and this should also be read in comparisons to when she was less happy about the way personal care had been provided. She thought this carer was “very good” because he “took the trouble to wait and ask someone to check” something that was causing her discomfort. This was a person she went on to trust and she preferred it when he helped her wash. This trust was also developed from the dignity and respect that she felt some carers afforded her; she noted another carer who did not do this and how this made her feel.

Caring for others, being involved

In social care more broadly, the relationships that care givers and care receivers make are the “primary means of intervention” (Ruch, 2005, p.113), rather than the transactional approach that has developed over the years (Unwin, 2018). As noted earlier, caring is not a one way street, where something is being done to another, and

this was voiced by a member of the focus group who wished more people could volunteer to support individuals who were homeless, because ‘the relationship is a win-win, people get what they didn't know they were going to get...it's very rewarding’, reflecting Unwin's (2018) comment that there is a human need for kindness. This human need for kindness and relationships was evident as those receiving care talked about how caring for others and being involved in the life of the home was important to them. For some this was a continuation of a previous life of service to others, particularly for the religious sister receiving care. If caring for others has been something which has brought you ‘joy’ and is ‘hugely rewarding’, comments voiced by those who provide care, then it is not surprising that caring for others and being involved in the life of a home is an essential aspect of individual's lives.

Faith

For many people living in care, faith remained of vital importance. Some of the religious sisters and priests had been active in their communities until the day they entered the residential home. Many were grateful for being able to attend Mass every day. For some of the resident priests this meant that their ministry as a priest was ‘satisfied’. However, for some it was evident that they wanted more, such as further opportunity to pray with others or for there to be more religious iconography. It is worth noting that there are potential silences here, in how the interviewer captured the detail of a faith experience and participants being careful how they talked about what they felt was lacking.

End of life care

As clearly iterated in the findings, those receiving care observed the care that others received. Their witness to this care told them much about how they could expect to be treated if they needed further help and support. This was particularly evident in the way that some observed others receive end of life care. One of the religious sisters (Mary) who was a resident in the home, but had also involved herself in caring for others,

talked about being with other residents in the final days and hours of their life. During this time, she witnessed the medical and pastoral care, and commented how this made her worry less about when “it came to my time”, as she knew she would be looked after. Georgina made similar comments that, having observed excellent care at the end of people’s lives, she knew how she would be treated, noting the level of devotion she witnessed. It is important to note here that Georgina would not identify herself as someone of Catholic or any other faith, but she was deeply moved by the pastoral care that she observed when others were dying.

Care in the future

As noted earlier the cost of care was a central narrative to the working age adults’ focus groups, but so were the silences on whether and how they had planned for any care they may need in the future. Participants found it difficult to respond to the question of what they hoped care would look like if they needed support in later life.

Not to be a burden

The majority of those that had thought about any care they may need in the future, had been involved in providing care to their relatives. They were clear that they didn’t want their children to care for them, reflecting on their experiences of the responsibility and frightening aspects of providing care. This echoes the finding of Preston et al., (2018, p.8) that an enabler to planning future care was “wanting to avoid a perceived risk”, whereas a barrier to planning was found in low personal exposure to the issue or risk. One focus group was in a more affluent area, and whilst they talked about the cost of care, they also talked about buying the care they needed to remain in their own homes.

My family will care

Some of the participants saw life continuing as it was, and expected any future care to enable this, whether living in their homes or retaining their independence. For some who had not had the

experience of caring for relatives, they thought that their family would care for them. There was an expectation that their family would step up and intervene when needed. Across the groups there was an expectation of choice and autonomy in decision making about care, that homes would be adapted, and care arranged to support their lifestyle. However, when reading the narratives of the journeys that individuals had into care, for many their arrival in residential care arose out of a health crisis, such as a fall or a stroke, something that they had not planned for. There was an interchange in one of the groups that highlights this -

FCM: think we’d all like to go in our sleep, wouldn’t we?

MCM: I think I’d certainly want a quiet exit. The last thing I would want to be is hanging on for years in a residential home.

However, a participant of a different focus group commented, “I think we’re assuming that we’re going to be in a position to make those choices. If we suddenly get a stroke or a heart attack, then we don’t have that freedom to simply look at all the choices and make a decision...very often... it’s going to be circumstances that’s going to force their hand”. It is of course very difficult and unsettling to think about the potential of a life-changing event and consider planning for it.

The role of women

All of the groups talked about the how other communities and cultures were better at supporting older relatives, or that needing to find paid care for relatives was a relatively modern concept. However, there was seemingly a silence about the role of women in caring. Whilst, as noted earlier, spouses tend to care equally for each other, it is primarily women who take on the caring roles of relatives, (Arber and Ginn, 1990; Carers UK, 2018). Much is written about the double or triple burden facing women as carers for their own children, their parents, whilst having an active role in the labour market. This expectation of others to care, because of their personal

concern for the well-being of another, is often experienced as a stressful emotional labour, an experience voiced by participants who had cared for relatives. Where individuals lacked exposure to what caring for others looked like, it left many expecting family to accept what can often be a stressful and difficult experience.

The church family

When participants were asked to explore what role they thought they had, in ensuring care is available for those who need it now (and in the future), they struggled to answer. One group started to develop some ideas and saw their role as a 'church family' going beyond the walls of the church and creating some kind of helpline and associated support. In another group, a participant commented that they felt 'paralyzed'; they wanted to do something but did not know where to start. There were some stories of individuals and the things they did in their local community, such as holding coffee mornings, inviting neighbours for dinner, and taking people shopping. For many, there was a desire to do something, but lack of clarity on what and therefore how to proceed.

Care providers: narratives of religious sisters and other carers

In contrast with the experiences of those in the focus group who had cared for relatives, those who cared for others either in a pastoral or paid capacity commented that caring was a 'joy' and 'privilege'. They talked about how they personally benefited from the act of caring for others – whether it was the kind words they received, observing people's wellbeing improving, or knowing that individuals had found some calm.

Relational care

When describing what they thought was good care, those providing care only talked about the relational aspects of care. This was where they aimed to relate to the individual and respond to their need. Presence talked about knowing

a person and thinking about how they were feeling; she talked about dimming lights, or putting the television on, only "if they've been television people". Engaging fully in relational care is something that takes time, and as Sr. Sally commented this is often very difficult: we all tend to "hurry, hurry, hurry" and "if we're not careful we all do it". For Joy, creating a place of tranquillity and calm enabled this relational care. Creating an environment where there is time to get to know someone, understanding their likes, dislikes, wishes and feelings, and their life and experiences before entering a care home, may enable carers to better 'meet people' (McCluskey, 2005). This is of course a challenge when resources are limited. It also speaks to a question of how Catholics understand their roles in building places of welcome both as members of parish communities and as agents of hope in their own neighbourhoods.

Rarely are professional caregivers trained to understand the mechanics and dynamics of interactions, with the focus often on the skills of "listening, observing, clarifying, negotiating, empathy and goal setting", which fails to address the complex dynamics of careseeking and caregiving (McCluskey, 2005). However, by developing an understanding of interactions between caregivers and careseekers, caregivers can make sense of the emotions and feelings of those they support, and "achieve a compassionate and intelligent response" (McCluskey, 2005, p.2). If the goal of careseeking is 'effective caregiving' – and when this is unsuccessful those who seek help withdraw, become frustrated and upset - then attending to the ability of professional caregivers to understand these dynamics and be able to respond is essential.

Values of faith and presence at the end of life

It was evident how faith, and the values of their faith, underpinned the care provided by the sisters, not only in the values, but also in their prayer and presence with others. As Sr. Presence commented, "we've God's grace working in us and through us...I believe God is working through me". The descriptions of being present at the end

of life were powerful, particularly alongside the observations and experiences of those receiving care. As noted earlier, anxieties about how one would be cared for at the end of life were diminished having seen how others are cared for. A number of the sisters involved in this study provide pastoral care, enabling them to have the time and flexibility to stay with people for as long as needed. This is clearly a unique resource, but arguably an essential aspect of care, to offer a presence to those that are dying and support to their families. The sisters had much experience of being with people at the end of their lives, and this was something that they seemed to do intuitively, being able to respond according to the needs of the resident and their families. There is recognition that spirituality at the end of life may look and feel different for those of faith or otherwise, but however it is measured, those who witness this care notice the sense of calm and comfort.

Caring for carers

Amongst the sisters and manager of one of the homes, there was extensive commentary about how hard paid carers worked and how difficult their work was, but how they were undervalued by wider society, with their roles receiving limited recognition. Many wished that carers could be paid more, and the challenges of finding good staff that stayed with organisations was frequently mentioned. Joy was clear how important it was to care for the carers, so that they would be in a better position to support residents and continue working for the organisation. Consistency of staff was seen to be essential, particularly to enable relational care. Joy likened this to a family structure, with longstanding staff knowing the residents, confident in their roles and comfortable in accessing the management team when they needed to.

Joy talked at length about the investment the organisation and the carers made in their own development, recognising how this had a positive impact on staff wellbeing and value of self.

However, training is another cost competing with multiple demands on resources. A number of the participants, along with Joy, talked about the importance of caring for the carers. They wanted wider understanding that paid carers, who are primarily women, are often already caring for others in their lives outside of work and have other challenges that make life difficult at times. Listening, supporting and giving time to thinking about how carers come to work, what they leave behind, and what they bring with them is essential. It is vital for the caregiver to be attuned to the needs of recipients of care. McCluskey (2005, p.247) sets out nine unique forms of interaction that take place between careseekers and caregivers, resulting from the “verbal, non-verbal and emotive messages and their response to each other”. Caring for others is undertaken through relationships, and as Unwin (2018, p.19) comments (here she is talking about policy, but the point is useful), “to assume a clean and tidy approach to decision making ignores the messiness of human emotions”. The attuning and presence of those who are caring for others is essential. Caring for them at work and understanding that we all have difficulty in our lives at times is one way of helping with this.

Caring for staff also means caring for their leaders. Managing a care home is complex and difficult, as shown in this study and by Moriarty, Manthorpe and Harris,¹⁰³ in work on recruitment and retention in social care, where they comment that, “leadership is thought to influence organisational culture strongly”. They agreed on the need to pay greater attention to improving the “quality of leadership at all levels”. Sr. Lucy was clear about the value of good leaders, and talked about the care that was taken when appointing managers: “I think the appointment of staff is extremely important, particularly managers and senior carers...If you get a good manager you’re away with it”. It was clear that the religious community linked to this home were highly supportive and appreciative of the manager and

103. Moriarty, J., Manthorpe, J. and Harris, J., 2018. Recruitment and retention in adult social care services. [online] London: Kings College London. Available at: www.kcl.ac.uk/scwru/pubs/2018/reports/recruitment-and-retention-report.pdf.

her team. They talked extensively about how they witnessed her care and compassion of others, and how she met people.

Developing a model

From this study, there appear to be two areas of work that can be explored and developed. The first relates to the role of the church family in creating communities of care in its parishes and associated communities, and the second considers the particular aspects of care that are interconnected with Catholic faith and activities of Catholic organisations.

The role of the church family in creating communities of care

It was evident when hearing from the working age adults in the focus groups, that there was a want to help older people in the community. Some were already doing this under their own volition. However, in one of the groups there was much thought and debate about how they could develop a supportive network, providing a place for those in need to contact them. The group understood that it is sometimes difficult for people to ask for help, and there were challenges when trying to find those in need of support. This conversation went on for some time, with one member of the group commenting on how paralysed they felt and just not knowing where to start. There was, however, a desire to create a network of support that extended beyond the church walls.

After the planned release by CSAN, in December 2019, of new guidance for parishes on reaching out to older people, it will be helpful to explore further what if any extra support parishes need to self-organise, whether that be through providing facilitators to help develop ideas, training, suggested methods of working, connections with schemes that have worked well elsewhere, or bespoke support in response to individual parish development. CSAN should play a key role in raising awareness and readiness to share information between local churches and people co-ordinating activities (whether voluntary or paid). However, successful evaluation of what

is working well will stem from understanding the nature of the problem and the value of investing time in learning, often with limited data. Arguably, as time passes, greater exposure and involvement through a network of support will develop understanding. Caring for others can be a joy and a privilege and something that can enhance lives. Additionally, as one of the focus group participants commented, “The whole ethos is that you should exercise your lay ministry of care to each other, but that requires organisation and you’ve got to have sufficient support from the community, volunteers to look out for each other” (FCM). By creating a network of support now for the community, provides a network of support for the future selves of parishioners involved. This echoes and develops recommendations made by Philpot (2007) and Ryan et al (2009) on how parishes develop their networks with local provision.

Additionally, a supported network of parish churches would provide an important means to support informal caregivers, such as parishioners caring for parents and other close family or friends. This is a current concern for many; having a network of support that you know are present if you need it could help people feel less alone and provide practical, emotional and spiritual support.

‘Catholic care’

The number of Catholic care homes have diminished as a result of the dwindling numbers of vocations and the broader social care landscape, as has been recorded extensively in the previous studies of Ryan et al., Philpot (2007, 2002). Philpot (2007, p.11) noted that observers felt “Catholic homes offered a different ethos from other kinds of homes...Catholic homes offered a sacramental and spiritual life in a society that does not find it easy to accept spirituality generally, as well as seeing it as integral to good social care”. Philpot (2007) goes on to point out that there was no reason that the Catholic ethos could not continue as homes were run by lay staff, offering the example of Catholic schools having high reputations in part because they have an overt Catholic ethos.

Much of this change has already taken place, with many homes now in charitable trusts, some of which are overseen by orders, but staffing and management of the homes no longer involving many religious sisters. In a number of homes, sisters retain a presence, often in a pastoral capacity. This study has illustrated the impact of their presence, particularly in relation to end of life care, and to some extent providing pastoral support for staff. Whilst there is much written about end of life care, and different faiths will also have commitments to caring at end of life, this is unequivocally Catholic care embedded in the prayer and faith of the individuals providing it. There needs to be consideration about how

this care will be provided in the long-term as the number of vocations dwindle and older people become an even more dominant proportion of the Catholic population in many places.

Additionally, many of those receiving care who participated in this study talked about their faith, and whether or not they felt their spiritual needs were being met. Being Catholic was an essential part of their identity; for quite a few involved in this study it had been their life as a priest or religious sister. One can see that their needs are more likely to be understood by someone else who is Catholic and can broadly understand and empathise with their faith experience.

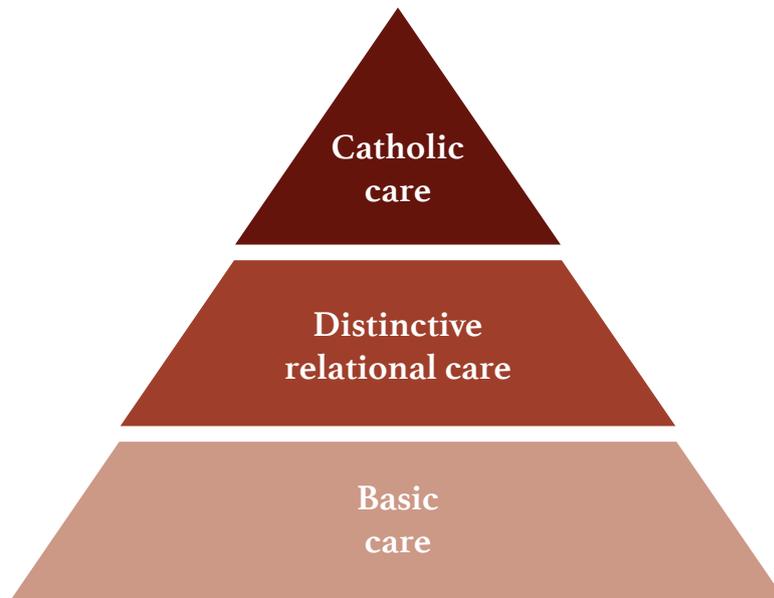


Diagram 1: Foundations of care

This diagram sets out the different types of care and where the things particular to Catholic care add to the foundations of basic care and distinctive relational care. At the foundations is everyone's need for basic care, such as personal care, help with mobility, health care and medication, that is the kind of needs that are often recorded on assessments and care packages are built around. Perhaps one could understand providing this level of care as "just doing a job", as it explains the tasks of care, the things that are done to another.

Building on basic care is distinctive care; it is the relational aspect of care, where care recipients

are 'met' by caregivers. There is an understanding that care is delivered through relationships that are two-way in nature. This care requires consistency in caring relationships, carers that are supported and cared for themselves, so they can be attuned to the needs and experiences of care receivers.

Catholic care then intersects and is in addition to distinctive care, providing spiritual support to both Catholics and those who are not Catholic. The particular aspects of this care rest in the spiritual experiences of those of faith, and the presence offered through end of life care.

Concluding comments

This study has drawn attention to the different understandings that people have of care, the way care is experienced by older adults in residential care, the narratives of religious sisters providing care, and thoughts of working age adults about potential future care.

A number of messages emerge from this study:

- The distinctive Catholic care that is offered at end of life is at risk of being lost with diminishing numbers of priests and religious in England and Wales, and their availability to be present with individuals in their last days and hours. Consideration and action are needed to ensure this powerful act of presence continues, and is encompassed in wider care standards.
- Supporting paid carers to provide relational care requires organisations to commit to providing an enabling environment and effective support. Catholic care providers should bring together their expertise and values to develop care practice that prioritises relational care. This will require a focus on how organisations care and value those they employ to care, and how this focus can be sustained among a shrinking group of small, independent Catholic care providers, by co-operation or more radical partnering.
- Caring for others can be rewarding and joyful. It is also a huge responsibility and a stressful emotional labour. Given the steep increase in ageing in the Catholic population of England and Wales, many parishioners and priests will be involved in caring for others, and there needs to be action taken both at a national and local level to value and support them in this role
- In conjunction with Catholic charities involved in care (where these exist), parishes need to find the support and confidence to self-organise and extend Catholic care to older adults in the community and their carers - additionally creating and providing reliable networks of pastoral care for those receiving residential and nursing care. The Church is well placed to provide this, but it is a significant undertaking requiring long-term resourced networks of support.
- Receiving care, providing care, and planning for future care, will affect all members of the Catholic community at different points in their lives, and in fulfilling their distinct vocational responsibilities. Additionally, Catholics have made a lot of investment in care, as individual donors of land and buildings, and by enabling Catholic charities to build expertise as care providers. Therefore, it is essential that the Catholic Church hears the experiences of care and brings its voice to the wider policy debate to champion care.

Dr Kathryn Hodges is an independent consultant and researcher. She is a registered social worker with over 20 years' experience in adult social care practice, management and higher education. Her work explores the decisions and choices individuals make when seeking help and support, the complexity of help seeking, and the relational aspects of care.

The full research report, 'Exploring Care', is available at CSAN's website.

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Care in Time aims to improve understanding of urgently needed improvements in our society's care for later and longer lives in England and Wales. How will increased longevity and use of resources affect being available 'here and now' for older people? How does our society's vision of 'care' in England and Wales appear to affirm or deny the purpose of the older one cared for, and carer(s)? We approach these questions through new Catholic social thought, the voices of people receiving and providing care in settings supported or managed by Catholic organisations, and of Catholics who may need care in future. The report presents a compelling case to accelerate bringing forward a just care system, including in public awareness, in organisational co-operation, and in increased community ownership of provision. This work needs to be progressed in the distinct contexts of public policy making, and of a step-change in Catholic support for carers and caring professions, as an intentional, tender response of a people of faith, hope and love.

Caritas Social Action Network (CSAN) is an agency of the Catholic Bishops of England and Wales, extending the depth and reach of Catholic charitable activities, and offering a coherent Catholic voice for the common good. We bring together over 40 Catholic charities and dioceses, to build up community life for everyone, with a special concern to address many kinds of destitution and misery, in England and Wales.

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