Hartrigg Oaks

The Early Development of a Continuing Care Retirement Community

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NOTE: Hartrigg Oaks was developed under the aegis of the Joseph Rowntree Housing Trust (JRHT), a housing association which became a separate entity from the Joseph Rowntree organisation in the 1960s. The JRHT owns and manages an extensive portfolio of properties in North Yorkshire. The research on which this report is based was commissioned by the Joseph Rowntree Foundation (JRF), one aim of which is social policy research and development. Until 1990, the JRF was known as the Joseph Rowntree Memorial Trust (JRMT), and may be referred to as such in this report when discussing historical developments.

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Introduction

Continuing care retirement communities (CCRCs) have been a common option for housing and caring for older people in the US and Germany since the 1950s. In the early 1980s around 600 such communities were in operation in Germany, and in the US - where growth of these developments has been substantial over the last decade - there was an estimated population of 220,000 CCRC residents in 1995 (Hearnden, 1983; Humble, 1998). In terms of basic definition, CCRCs have been described as 'a planned, purpose-built living arrangement which aims to meet the housing, personal and health care needs of older people on one site' (Hearnden, 1983: p1). Most CCRCs comprise a small village-type settlement with independent housing units - either in flats or bungalows - and community buildings that include a centre with nursing and residential care facilities. As a means of catering for the needs of elderly people, the CCRC unites both traditional and modern characteristics of the UK's provision for older people: the community has a centre providing respite, residential and nursing care; and at the same time independent living is promoted by delivering home care to residents should they need it.

The unique characteristics of CCRCs make them more distinctive than simply being the combination of independent housing and residential care on one site. First, the CCRC features continuity of care: residents generally enter one of the independent accommodation units at the age of around 70-75 when they may still be very active, and remain in the CCRC for the remainder of their lives. Intensifying care needs will be dealt with within the CCRC - either in the residents' homes or in the care home. Traditional sheltered accommodation tends not to be geared towards the provision of long-term care: as needs intensify, the move away to a residential home is expected. Second, CCRCs operate with a unique type of funding mechanism. Residents or 'members' of the CCRC pay a one-off entrance charge and a monthly maintenance fee. On payment of these charges, the CCRC guarantees to cover the housing and a specified level of care needs of the residents until the end of their life. Third, CCRCs offer community living, and have a remit of making old age a fulfilling and stimulating period, providing facilities for the residents to enjoy a range of recreational activities.

Although the provision of CCRCs could become profitable, most of the CCRCs operating in the United States and Germany are voluntary sector, 'not for profit' concerns. In the United States, CCRCs are often attached to religious denominations; in Germany, it is more likely that sponsorship comes from large organisations and charitable trusts such as the Social Democratic Party and the Red Cross. These organisations provide the initial capital outlay for the communities, which over time become self-funding as the entrance fees are used to defray start-up debts, and monthly payments are used to cover revenue expenditure.

Interest in CCRCs has been marked in the UK since the early 1980s. In 1982, Robin Huws-Jones, in a paper published by the *Policy Studies Journal*, concluded that for some people, the CCRC 'may be the best alternative yet known' (Huws-Jones, 1982). A further, detailed evaluation of the US and German schemes was published in 1983 and concluded that despite the different care frameworks, similar communities could be viable in the UK given a sufficiently large community and 'realistic' entry and maintenance fees (Hearnden, 1983). Both these reports were produced in the context of anticipated increases in the proportion of the UK population over the age of 65. For example, it has been estimated that between 2001-

31, the proportion of 65-84 year olds will rise from 14 per cent to 20 per cent (reported in Sturge, 1998). Need amongst this growing group has remained a consistent theme for much of the discussion of CCRCs.

However, very early on in discussions of CCRCs in this country, it was acknowledged that they have one principal limitation: that they would only be able to cater for the small proportion of elderly people with sufficient savings or housing equity to cover the initial entrance fee. Hearnden calculated this sub-group as being 25 per cent of the older population (Hearnden, 1983). It has been acknowledged that care resources for capital-rich older people are often overlooked, since they tend to be reliant on care which they themselves purchase: means testing precludes them from social services provision that is free at the point of delivery. Indeed, in her 1990 review of new directions in housing and care provision for elderly people, Oldman noted that more attention should be paid to programmes that responded to the needs of a significant group of older people who are 'not rich, not poor' (Oldman, 1990: p136). Given the requirement to acknowledge need amongst this group, it has generally been considered that CCRCs could be a viable and useful addition to the care resources available to older people in the higher income brackets.

The setting up of the first major CCRC in the UK by the Joseph Rowntree Housing Trust (JRHT) constitutes an organic continuation of its long-standing commitment to the delivery of high-quality and innovative care models. The JRHT has been providing care homes for older people since the 1950s, and has been at the forefront of the development of new patterns of housing provision with a care component. For example, the JRHT operates a sheltered housing scheme of 48 flats with mixed tenure: residents can either fully purchase or part-purchase/part-rent their homes from the JRHT and can over time if required release capital by paying a higher proportion of their housing costs as rent. The JRHT has also participated in schemes - such as the Lifetime Homes Initiative - that have increased the possibility of older people being able to stay in their homes for longer, by completing adaptations such as alterations to the bathroom. Thus the JRHT had already shown interest in many of the principles encapsulated by CCRCs, including flexible financial arrangements and promoting independence in the home.

In the broader policy context, the delivery of care services to elderly people has seen a number of changes in the last few years. In 1990, the National Health Service and Community Care Act underlined the existing shift to caring for elderly people in their own homes, but also promoted greater use of private and voluntary sector care providers by statutory authorities. More recently, the Royal Commission on Long Term Care for the Elderly was established with a remit of exploring care provision both in the home and in other settings, with special regard given to the way in which costs should be apportioned between the State and the individual. The recent White Paper - 'Modernising Social Services' - confirms the Government's commitment to community care and stresses the important role to be played by independent care providers.

Given this background, the notion of establishing a CCRC was particularly attractive to the JRHT, especially since there were a number of key concerns that the CCRC could address relating to the anxieties felt by elderly people with respect to their final years:

Care and housing

- entry into the community would remove the fears of elderly people about being a burden to their families;
- respite, nursing and residential care could be provided at one location so removing worries about the need to move, and the consequent upheaval, as support needs became greater;
- care would be available as and when required, so there would be no need to worry about

having to make arrangements should need suddenly arise;

- where one partner in a couple needs to move into the care centre - temporarily or permanently - they would be in close proximity to their partner living in an independent unit;

- the community could provide different types of accommodation with flexible delivery of support, so meeting a wide range of housing and care needs of elderly people;

Financial security

- care and housing could be delivered under a variety of financial packages, so catering for people who may be either income rich/capital poor or vice versa;

- there would be a removal of financial insecurity, since some packages feature no increase in fees as care needs intensify;

- there would be no requirement to set money aside to cover the costs of home maintenance;

Personal security and isolation

- the community would grant a degree of personal security, in offering 24-hour alarm cover inside the units, with security provision covering the whole site; and

- the community would provide a stimulating environment, that would ease worries older people may have with respect to isolation, boredom and loneliness in their last years, especially if they have no family.

The JRHT's active interest in the establishment of a CCRC can be dated from 1983 when representatives from the JRHT attended the launch of the Hearnden report, and initial enquiries were made for further information from a number of housing organisations. The notion of the JRHT itself establishing a CCRC was first mooted in February 1984, although some reservations were expressed. It was considered that the CCRC might amount to a 'ghettoisation' of elderly people, who should be 'integrated with the society' (JRMT, 1.2.84). It was concluded at that time that the piloting of a scheme should not be a JRHT priority.

However, material continued to be collected, particularly with respect to CCRCs in the US. In November 1986, JRHT representatives made a formal fact-finding visit to CCRCs in and around Philadelphia. The visit included trips to Kendall-Crosslands, Pennswood Village, Medford Leas and the Philadelphia Geriatric Centre. Following consideration of a report based on the visits, it was decided that the JRHT should support the development of a CCRC in the UK. By February 1987, a project manager was being considered for appointment to oversee the early stages of the community's development, and an area of land owned by the JRHT had been earmarked on Haxby Road to the north of New Earswick on the outskirts of York. From this early stage, it was recognised that there would need to be involvement and input from organisations outwith the JRHT, and a Steering Committee was established. Further discussion of plans for the CCRC took place in a meeting with representatives from local social services, housing and health agencies, who gave support to the development. By 1988, the actuarial side of the scheme was being given detailed consideration, and plans were being made to market test the idea amongst prospective residents, in a series of focus group discussions. At this stage, the community was being called 'Beechlands', and some financial and care parameters had already been established.

At the same time, the relevant district councils were approached for planning permission. It was at this point that the CCRC's development ran into its first serious problem, in the refusal to grant planning permission. In July of 1987, an appeal was lodged by the JRHT, challenging the planning decision. The Secretary of State decided to judge the case himself, since the appeal related to 'proposals which appear to raise important or novel issues of development control'. The decision was taken against the JRHT. Although it was acknowledged that the CCRC comprised an important innovation with the JRHT well placed to establish a pilot scheme, it was considered to be premature to give permission since green-belt planning for the area was in the process of being revised. The reapplication for planning permission and a further appeal delayed the development of the CCRC for some years, and only in 1994 was it certain that plans at the New Earswick site could proceed. Development finally took place on 20 acres on the west side of Haxby Road.

The first meeting of the Project Management Group took place in May 1994. The Group had responsibility for key decisions on the development of the community. By the end of 1994, it had been decided that the CCRC would comprise 152 bungalows and a care centre with 41 beds. Around the same time, it was concluded that the early development of the CCRC - renamed 'Hartrigg Oaks'- would benefit from the formation of a users' group. The group - named the Hartrigg Oaks Committee - was consulted on all major decisions relating to the development. Other specialist subcommittees were formed, to consider care delivery and some of the more complex funding and legislative issues. Residents finally began to move into the complex in Spring 1998.

Given the innovative nature of Hartrigg Oaks, the Joseph Rowntree Foundation decided in 1998 to commission this study of its early development. This resulting report is addressed to people with an interest in new developments in care for older people, and highlights the distinctive nature of the CCRC. The production of the report also underlines another key aim in the development of Hartrigg Oaks: that the CCRC should act as a 'pilot' community, with a view to understanding which elements might be replicable in the development of care facilities for older people.

The report is in two sections. The first considers some major decisions made in the process of setting up Hartrigg Oaks, and includes discussion of its structure and design, the actuarial/legal framework, marketing, and organising the process of moving in residents. The second section addresses the delivery of some of the key concepts that underlie the JRHT's commitment to the CCRC, and examines its flexible payment packages, continuity of care, the creation of a balanced and stimulating community, and security. The report's conclusion addresses some of the issues that have to be included in any discussion of how far Hartrigg Oaks might be replicated by other organisations.

The report has been based on examination of archival material dating from the very first inception of the community, to the point at which residents began to move into their homes in the Spring/Summer of 1998. The archive also includes information on the CCRCs in the United States visited by the JRHT in the course of the development of Hartrigg Oaks, and this material is used for comparative purposes. Interviews also took place in the summer and autumn of 1998 with JRHT personnel involved with the planning and setting up of Hartrigg Oaks. A focus group discussion also took place with residents, along with face-to-face interviews with two resident couples and two single residents. Material from the interviews features in the second half of the report, and supports discussion of the delivery of underlying concepts. It should be noted that the interview sample was essentially self-selecting: respondents were chosen from a list of residents who had expressed a willingness to be involved. For this reason, the interview material has been used in an illustrative fashion: the data is not representative.

Section One:
Setting up the CCRC

There are a number of CCRC models operating in the US and in Germany. Establishing a CCRC in the UK entailed a series of decisions as to which practices and features would most fulfil the JRHT's objectives with respect to meeting the housing and care concerns of elderly people, whilst being viable in financial terms. This section outlines some of the key development stages of the community, and discusses the structure of the settlement and its design, financial characteristics, some legal issues, the marketing of the CCRC, and the process of moving in residents.

Structure and design

Hartrigg Oaks is one of a range of possible CCRC models. Well over 1,000 continuing care communities have been established, and a number of different patterns have emerged with respect to both the housing arrangement and the delivery of care aspects of CCRC development. For example, in some instances the whole community is housed in a single multi-storeyed building: residents may have self-contained flats to which care may be delivered, whilst the communal facilities and care centre are based on the ground floor. Alternatively, the independent units might be dispersed on a 'split campus' basis with residents, associated with a central nursing/residential home, living in a handful of clustered units located within the broader community. Both these models have advantages and disadvantages. Having care and housing provision within a single building means easier access both of residents to facilities and of care staff to residents, and reduced expenditure on land costs. By contrast, the dispersed model entails greater expenditure on staffing with respect to the delivery of care, but could use existing housing units and would ensure that the older people continued to be integrated into the broader community.

However, neither of these models were considered appropriate by the JRHT. It was very quickly decided that multi-storey facilities or apartment-style complexes were not desirable. During a JRHT tour of CCRCs in and around Philadelphia in September 1994, a couple of visits were made to single-building communities, and there was some criticism that despite their good quality, there remained an 'institutional' feel to the buildings. The single-site, campus-style community was thought to be best suited to the aims of the JRHT, and description of the US campus-style CCRCs confirms that these in particular were deeply influential. For example, the Kendal community was described as a 50-acre campus on a rolling landscape with mature trees, with a single point of access from the Pennsylvania highway system. All the independent living units were single-storeyed. The Kendal Centre, at the heart of the campus, comprised a mall with dining facilities, a library/chapel, an auditorium, sitting rooms, and coffee shops as well as nursing facilities and the complex's offices (McNeil, 1994). JRHT staff were particularly impressed by the atmosphere engendered on this and other campus-style communities, of both peaceful relaxation and high levels of interest in the arrangement by residents themselves of a broad spectrum of activities often based at the central building.

Having decided to pursue the ideal of a campus-style site, it was clear that the community would have to be based at a single location. The ability to use land owned by the Joseph Rowntree Foundation to the north of New Earswick created the opportunity to attach the community to existing infrastructure, whilst at the same time introducing possibilities for the residents to become integrated into an existing well-established

settlement. The decision brought constraint along with convenience, however. The site was split by a main road and the half which was used comprised a 20-acre tract, so restricting the number of independent living units that could be accommodated. Furthermore, the assumed amenability of New Earswick residents to the development came into question: in fact they represented a consistent dissenting voice to the planning authorities. There were concerns that a retirement community would unbalance the village, and it was argued that the sudden influx of retired people would create a situation whereby more than 50 per cent New Earswick residents would be over the age of 65 (*Yorkshire Post*, 29.8.89). Ongoing negotiations with the residents of New Earswick remained and remains a continuing thread in the development of Hartrigg Oaks, and indicates that future CCRCs may not always be well received initially by the communities in which they are developed.

A further and more welcome constraint was the operation of planning regulations that prescribed the aesthetic of the new community. Hartrigg Oaks was built to reflect the architectural features of New Earwick. For example, initial plans to institute formal, geometric patterning with quite intensive clustering of housing units (see illustration #1) gave way to a more fluid design that reflected the curved and organic structure of New Earwsick (see illustration #2). In addition, the use of red pantiles deliberately echoed the village aesthetic. Initially, a further stage in encouraging integration was planned, in the construction of a walkway from the village right through to the care centre, but permission was not granted for the necessary demolition of a single property on Rowan Avenue to make this development possible. An alternative strategy to assist integration was the establishment in the care centre of creche facilities - 'Little Acorns' - which is open to use by anyone in the village or beyond.

The principle of having a 'non-institutional' feel was carried through in a number of decisions made with respect to the bungalows and the lay-out of the site. As early as 1987, it was being recommended that the site should have 'no regimentation', and be 'human in scale' (Fraser, 1987). The site has been laid out so that it is easy to relate every point back to the care centre, and all the closes have slight differences in design so countering the possibility of residents or visitors becoming lost. Both spaciousness and choice were considered to be important features. In terms of site layout, up until quite late in the design stage it was considered to be a good idea for the site to include a number of covered walkways. However, these plans were suspended, since to make these walkways truly protective they would need to be shuttered in bad weather, which would in essence create a number of enclosed corridors that would counteract the open feel of the site. As plans were further developed, the number of living units was reduced, so further adding to feelings of space. In addition, the 1994 JRHT visit to the US in particular revised notions of the size of the bungalows themselves. Bedroom and living room spaces were extended, and bungalow plans were changed to enable the roof spaces in some of the properties to be remodelled into an additional room. Residents were encouraged to feel that they 'owned' the site and their properties, by having a degree of choice in the features of their bungalow: for example, they could decide the layout of the kitchens.

The principle of non-institutionality was also pursued within the care centre, named 'The Oaks'. Again, following the trip to the US, an increased space allocation was given to recreation and craft activities at the centre, with use made of the roof space to house both a library and a music room. In addition, the building was designed to allow open access at all times to all residents. One admired feature of one of the US CCRCs was that residents were allowed unimpeded access to the building and its facilities. In design terms, this meant that necessary storage and utility rooms at the care centre have tended to be grouped together: many are in the basement.

The decision to establish a non-institutional feel to the CCRC was judicious. As residents moved in, it became clear that this particular aspect of the development was important: in fact, staff reported that residents wanted the care features of Hartrigg Oaks to be as hidden as possible. Perhaps one of the less successful decisions taken by the JRHT was the installation in the bungalows of bathing facilities that were

specifically designed for elderly people with restricted mobility. Some residents have expressed dissatisfaction with this type of special facility, as being something that they do not need, and which marks them as 'different' from any other householder. In addition, complaints were made about the reference to 'continuing care' on the sign initially erected at the entrance of the site, and the wording has been appropriately amended to remove the reference to care. Even at this early stage, with the planting not yet mature, the site has the feel of a well-designed housing complex suitable for any type of resident, with many of the bungalows south-facing, and each with a self-contained garden and car-parking provision. Indeed, the ability to park almost directly outside the front door was deemed to be an important consideration by many prospective residents, and was reflected in a shift away from the initial intention to restrict cars to the periphery of the site.

Thus in structure and design terms, although Hartrigg Oaks is to some degree self-contained, decisions relating to its design have aimed to integrate the residents with the broader community. In addition, many of the features of the community represent a step away from more traditional and sometimes restrictive institutional care environments in offering to residents both space and choice.

Financial considerations

Perhaps the most distinguishing characteristic of the CCRC is its funding mechanism: that expenditure is met by residents contributing both an initial capital payment or residence fee, and the monthly payment of a maintenance or community fee (see Appendix one for worked example). These payments cover an individual or couple's housing costs, and care costs up to a specified level. The CCRC provider must ensure that the payments balance against capital outlay, current, and anticipated future expenditure - particularly on care costs - to the degree that the community remains self-sustaining in financial terms. With Hartrigg Oaks - as with all CCRCs - a series of decisions had to be made with respect to issues such as capital outlay; the level of the residence fee and the community fee and what these charges cover; and estimates of care needs and mortality rates. Decisions under each of these headings, leading to the setting of charges and fees, feed into an actuarial assessment of a community's viability. Indeed in the US, actuarial reports are expected and guidelines for their production have been published. This section considers the way in which the JRHT addressed each of these factors, and concludes with a discussion of the way in which the decisions were drawn together to structure Hartrigg Oaks' financial packaging.

Initial development: capital and size

For most agencies, issues relating to the capital outlay required to set up a CCRC would be central to its structure and design. For example, the desire to restrict initial outlay could lead to a provider concluding that it is more feasible to have a dispersed community. There would be no need to purchase an extensive tract of land, and it could be possible for residents to live in existing properties. It may also be possible to modify an existing building to use as a care centre, and there would be no expenditure on the development of necessary infrastructure. Furthermore, ongoing costs would be reduced with respect to maintenance of the built and planted features of a campus site. Hearnden does not give comparative costs with respect to the dispersed model compared to a single campus site, but indicates that the latter might cost up to £8-9m to develop (1983 prices). This calculation was based on expenditure relating to the development of a 28 acre site with 200 one and two-bedroomed flats and bungalows in Guildford (Hearnden, 1983). However, the need to raise funds to meet capital expenditure does not generally appear to be problematic. Although the schemes are required to pre-sell at least 50 per cent of their units and provide an independent actuarial report, most of the CCRCs in the US operate as not-for-profit concerns and are backed by large organisations and charities willing to make the initial loan. The JRHT visit to the US in 1986 found that few communities had difficulty in dealing with the requirement to service initial debts following

establishment. Indeed, most had completed full repayment within 15 years (Sturge, 1986).

With respect to Hartrigg Oaks, the initial costs of the development have been covered internally. The JRHT has provided a loan of £6.1m, which includes the notional value of the land, and is intended to cover expenditure on the communal buildings. Repayment of this loan will be made from any suprluses accrued by the CCRC. The Joseph Rowntree Foundation has made an additional loan of £11.6m, to cover the cost of building the bungalows. This loan will be repaid through initial membership fees (Humble, 1998). The development has essentially been underwritten by the Joseph Rowntree organisation. It should be noted, however, that the CCRC finances have been ring-fenced, with no anticipation of either a long-term subsidy or surpluses accruing to the organisation.

Focussing on the development of a single-campus community, size will evidently have an impact both on initial outlay and on actuarial calculations relating to entrance and monthly fees. Hearnden concluded that although economies of scale were possible, savings became less substantial in communities of over 500 residents. However, it was considered that larger communities would lose the 'community feel' and make the social aspects of the site more difficult to orchestrate. Also larger sites would incur a greater capital outlay, producing debt which would have to be reduced over a longer period. Hearnden considered that a community of 350-400 was perhaps the most viable both in financial and social terms. Most of the communities visit by JRHT staff in 1986 had 350-400 residents, although one had around 500. Because of decisions taken not to overcrowd a limited site with buildings, Hartrigg Oaks remains by contrast a small development, having fewer than a total of 300 residents in bungalows and the care centre.

Further decisions also have to be made with respect to the balance of independent housing units and nursing beds in the care centre. Hearnden calculated that 300 residents would require a 60-bed residential facility - around one bed for every 5-6 residents (Hearnden, 1983). The care centre at Hartrigg Oaks has 41 beds, and the bungalows can accommodate a maximum of 247 residents. However, some single residents have chosen to live in two-person accommodation, as was anticipated: initial calculations were based on the assumption that 50 per cent of the two-bed units would be taken by a single person.

Residence fee

Residents move into CCRCs on payment of an entrance or residence fee. This is a substantial payment: for example, at Kendal Crosslands in the US, it can vary between $78,000-$92,500 for a small one-bedroomed apartment, to $156,500-$170,500 for a two-bedroomed unit (Kendal Corporation, 1998b). At Hartrigg Oaks, taking occupation of a two-bedroomed bungalow can cost between £50,138-£86,000 (see Appendix one). The range demonstrates the number of different payment options relating to the fee; the JRHT's concern to create as much flexibility as possible in this regard is discussed in Section Two. This section covers decisions made about the nature of the residence fee. This is perhaps the least familiar aspect of CCRCs, and one which has been difficult to explain to prospective residents. In the US, the entry fee is sometimes represented as a 'gift' that the resident makes to the community, which is earned over time and with any level of refund similarly reducing over time. With respect to Hartrigg Oaks, the residence fee is represented in terms of a payment to cover costs of occupation, with entitlement to care. The payment also includes temporary or permanent residence in the care centre, should that prove to be necessary. Perhaps the most unusual feature of the payment is that it gathers no equity: residents are purchasing a 99 year lease on the bungalow, with the stipulation that they can only sell the lease back to the JRHT. Furthermore, some cases also include the possibility of a full refund of the original payment.

It was noted early in discussion of the financial organisation of the CCRC that prospective UK CCRC residents may find it unacceptable for there to be capital expenditure on a property where ownership was

retained by the JRHT, and where there was no repayment either to a resident on leaving the community, or to their estate in the event of their death. Offering a selection of payment packages that includes refundable options and the possibility of annualised payments assists in countering any concerns that may be expressed by residents about the control of and access to their capital. It should perhaps be noted that from the JRHT's perspective, there is complete neutrality concerning which packages are chosen by the resident, and penalties or incentives do not operate to 'encourage' residents to opt for a particular package.

The level of the entry fee rests to some degree on the payment option taken by the resident, but other factors are also taken into account and these include the age of the resident and the market value of the bungalow in the period immediately before the resident moves in. With respect to age, older residents pay lower entry fees. For example, fees for a single person on the non-refundable package can range between around £28,000-£39,000 for someone who is 85, compared to around £47,000-£65,000 for someone who is 65. The differential is based on the expectation that an older person may be in residence for a shorter period. The payment also reflects the market value of the bungalow, with a higher charge being made for the larger, two-person property.

Community fee

In addition to the entry fee, residents pay a monthly charge or community fee. The standard community fee ranges from around £3,700-£5,500 a year. Again, different payment options are available, which will be discussed in Section Two. In the US, the level of the monthly charge varies according to the size of the property, and tends to cover a wide range of services, including surgery, prescriptions, meals, amenities, transport to town or shops, communal services, laundry, repairs and maintenance, and fixtures and fittings within the unit including carpets and curtains. Because the UK offers a different context for the CCRC, it was decided that Hartrigg Oaks' community fee would cover a more restrictive range. For example, access to the NHS means that UK CCRC residents would not need the community to provide medical facilities beyond basic care services. Furthermore, it was thought more likely that residents would want to cook for themselves, and so meals are not included in the fee although the care centre houses a restaurant and a café, both with subsidised prices.

At Hartrigg Oaks, the community fee includes the maintenance of the bungalow and other community buildings, and care support either in the bungalow or in the care centre. Essentially, the charge represents a 'pool' into which all residents pay no matter what their care needs. Where residents are fit and active, they will still pay into the pool, in the anticipation that they will draw on the pool during times in which they are in need of care. As with the residence fee, the community fee varies according to age, with the fee increasing as the resident gets older. For couples, the community fee is reduced by 12.5 per cent, as it is assumed that to some degree partners may be giving each other care and support that would otherwise have to be provided by the community. In the event of a partner dying, then the community fee of the surviving resident is increased to the standard charge. The charge does not vary according to the size of the property.

Demand, mortality and care estimates

Estimating the feasibility of establishing a CCRC in the UK to a large degree requires some calculation of demand for the facility; and establishing its fees and charges rests on mortality rates and the levels of care that are likely to be required. In 1995, the JRHT commissioned two reports that assessed the proportions of elderly people who could bear the financial costs of entry into and long-term residence in the CCRC being developed. Secondary data analysis took place of the 1993 Family Expenditure Survey and the 1991 English House Condition Survey (Hancock, 1995; Gibbs, 1995). The analysis assessed the proportion of pensioners in each survey that would be able to pay one of a series of five hypothetical options that included the capital-rich option of full payment of returnable residence fee and care costs on entry, through to the

more income-rich option of the up-front payment of a non-returnable residence fee and half the care costs, with the remaining costs covered by annual payments. The residence fee was set at £82,000 returnable or £39,000 non-returnable, with care costs at £56,000. The analysis differentiated between younger pensioners up to the age of 75, and pensioners over that age. On the basis of an assessment of income and housing wealth, the EHCS study concluded that 9.3 per cent of single older pensioners, and 15.9 per cent of older pensioner couples could afford all the options. For younger pensioners, the proportions increased to 13.8 per cent of single people and 27.4 per cent of couples. However, it was noted that these figures would be subject to substantial regional variation (Gibbs, 1995). Although this research could not indicate the proportions of elderly people likely to want to move into a CCRC, it did indicate that movement into such a community was financially viable, albeit for a minority of pensioners.

Perhaps of more importance actuarially was the need to make some assessment of likely mortality rates and care needs amongst residents. The importance of taking mortality rates into account was underlined by Humble, who noted that in the 1970s some US CCRCs had entered into the business with inaccurate estimates. In essence, these organisations had not anticipated that residents of CCRCs, because of their relative wealth in being able to afford this sort of provision, were much likely to be from the healthier proportion of the elderly population, and so less likely to die as younger pensioners. In addition, it may be possible that the enhanced quality of life in CCRCs extends the life expectancy (Humble, 1998). Although it is possible to note generalised trends in morbidity, anticipating future changes over the long term is a problematic task: for example, neither medical advances nor the increased virulence of certain diseases can be anticipated. Similarly, the anticipation of care needs is also difficult, especially given the relatively small size of a CCRC. An actuarial report submitted on Hartrigg Oaks in 1996 included the caveat of a lack of information on care needs amongst the group likely to want to move into a CCRC.

Achieving financial viability

An initial assessment of the financial viability of the community was completed early in its development, in 1988. This exercise defined some of the parameters being used to define the financial organisation of the CCRC, and gave an early indication of possible charges. A further financial report was prepared in 1996, when the level of residence fees had become more firmly established and it was possible to analyse potential income against a more accurate estimate of costs. The principles underlining these assessments were discussed by Humble in 1998, who concluded that Hartrigg Oaks' financial arrangements 'do not aim for a close matching of assets and liabilities or of income and outgo'. He considered that the setting of residence and community fees have been less a reflection of outgoings and estimated future costs, than illustrative of an attempt to provide a package that will prove to be attractive to potential residents without undue risk to the Housing Trust (Humble, 1998: 6). According to JRHT staff, the pioneering nature of the scheme, the financial standing of the JRHT and its long experience in care delivery mean that to some degree exacting calculations of risk are neither feasible nor strictly necessary. This approach is not unusual. It has already been noted that in the US, most CCRCs are non-profit concerns operating for the benefit of members, and with directors that are generally reluctant to raise fees. There is some debate as to whether it is indeed possible to charge residence and communities fees at a sufficiently high level to achieve profitable, commercial viability (Humble, 1998).

In any case, the achievement of financial viability will be driven by different principles at different stages of a CCRC: obviously the setting-up period of a CCRC will carry different financial imperatives compared to a CCRC operating in a more mature 'steady' state. Perhaps a key area in this regard is the varying use that will be made of the care centre by bungalow residents. Humble estimated that the first wave of high demand for the care facility from bungalow residents to be in around year 14 of the lifespan of the CCRC. Given this possibility, the marketing of the Oaks as a care centre for non-CCRC residents therefore becomes imperative. These residents have not been required to pay an entry fee, but make a regular

payment as they would in any other residential establishment. The process of filling beds in the Oaks was given a considerable fillip by the decision to transfer residents from a nearby JRHT home, so filling over 20 of the 41 bed spaces.

In its 'steady state', and as time progresses, a more accurate assessment of mortality rates and care needs will be made possible through monitoring residents. The JRHT is currently supporting the development of a standard care assessment model - Resident Assessment Instruments - which will ease the process of anticipating future care needs. It has been suggested that regular actuarial analysis should take place every three years, and feed into possible changes to the residence and community fees for new residents. Some degree of control might be exercised over the care and age profile of the CCRC through setting particular criteria for new residents. In the US, it has been noted that CCRC populations tend to become older over time, and consequently tend to attract older prospective residents since younger pensioners are dissuaded by the image of a more 'elderly' CCRC. It is uncertain how far this scenario will operate at Hartrigg Oaks, since the JRHT has always had a good reputation for the delivery of care to elderly people, and strong interest in its facilities is consistently expressed amongst all age groups of older people.

Legal considerations

Because of their long standing in the US, and because of difficulties associated with poorly planned schemes in the 1970s, there is state regulation of CCRCs in that country. In addition, the American Association of Homes for the Aged sponsors a Continuing Care Accreditation Commission, although CCRC registration with the Commission is voluntary. No similar legislation pertains in the UK, and at present the CCRC sits between a number of bodies of legislation without fitting any in an exact way. For example, although financial aspects of the scheme do have the potential to be interpreted as insurance packages, it was decided that it would not be in the interests of the CCRC to be classified as needing regulation under that heading. A further problem was defining the residence and community fees with respect to VAT. The tax does not apply to rent but does apply to certain services - such as help with cleaning - that may or may not be defined as care depending on the needs of the client. In both instances, legal advice had to be taken, and individual contracts with residents are worded accordingly.

Other legal considerations included deciding the degree of obligation that should be enshrined in the contract between the CCRC and the individual resident. In the US, because of the charitable status of most of the CCRCs, it is anticipated that no resident will be asked to leave if their financial circumstances change: support funds would be made available. Indeed, many CCRCs receive donations which can be applied to this purpose. At Hartrigg Oaks the JRHT has pump-primed a fund which will be available to residents should they fall into a situation whereby - through unforseen circumstances - they will be unable to meet fees. Outwith this proviso, however, the contract between Hartrigg Oaks and residents operates in a similar fashion to a tenancy agreement, outlining the residents financial obligations and defining the care arrangements. Should a resident fall in breach of their contract, they will be asked to leave. All the residents were advised to pursue independent legal advice on receipt of their contracts.

Care provision

A number of issues relate to the delivery of care in a CCRC, and include the way in which the care is delivered, the way in which residents pay for that care, staffing, and relationships with statutory agencies responsible for care and health services.

Delivering the care

Care delivery in a CCRC can follow a range of models. In Germany, it was more common for care to continue to be provided in the home with a final move to the care centre as the resident becomes more frail. Some disadvantages were perceived to attach to this approach, since it increased care costs (because most residents were living in clusters out in the community) although the residents could be integrated into the community for longer. In the US, use of a multi-level care facility means that residents could more readily be moved into the care centre, and in some instances no care at all is delivered to the residents' home. At Hartrigg Oaks, the main principle is to keep people at home for as long as possible, and the close proximity of the bungalows to the care centre reduces staff costs. There is continual monitoring of the residents' care needs, and plans are underway for individual supervisors to take over the management of care in 'clusters' of bungalows.

Within the 21 hours of care a week that may be delivered to the home as part of the standard community fee package, some negotiation has to take place with the resident to distinguish the sort of care that might be deemed essential to their wellbeing, and the support services that might just be desirable. Chiropody services are one example: some residents might need regular foot care to ensure that they remain ambulatory, whilst others might simply like to see a chiropodist regularly, for routine treatments that could be self-administered. It is also the case that some residents might require quite high levels of care, but resist any support that is given, thinking that they can cope: again, the principle remains for the situation to be resolved through negotiation with the resident. Where care needs are regularly in excess of 21 hours a week, the expectation is that the resident moves into the care centre. Again, this process is subject to negotiation between the resident and the care manager.

Paying for care

As part of the *standard community package*, residents are entitled to receive unlimited care without incurring any additional expenditure. The level of care being delivered to the home can fluctuate at any level below a maximum of 21 hours, and is decided through negotiation between the resident and the care manager. Under a *fee for care* package, residents pay a basic component of the community fee - to cover such costs as buildings maintenance, for example - but pay for care as it is received. Residents on the fee for care package are at liberty to purchase services from other providers - for example, from the local authority or from private sector agencies. The competitive nature of the domiciliary care industry means that it might indeed be cheaper for residents to buy in care themselves on an individual basis. However, for many of the residents, cost is not always likely to be a deciding factor in choosing care: it is anticipated that the quality and convenience of receiving care services from Hartrigg Oaks will persuade most people not to use external providers.

Staffing

The JRHT has a strong interest in the development of training programmes for its care staff, and carers at Hartrigg Oaks are encouraged to train for the JRF Certificate in Care. The staffing of such a specialised community as Hartrigg Oaks has raised some issues with respect to the qualities needed by the staff employed. Residents are from a particular social class, with high expectations of the community and perhaps strong views on the way in which they should experience care delivery. Generally speaking, care staff are motivated by a degree of vocationalism, and are attracted to caring because they like the idea of helping people (Ford *et al.*, 1998). They also tend to be from a different social class, and may find residents intimidating, and the job unfulfilling because their desire to help may not be appreciated. Choosing staff therefore becomes a very careful process, and new carers are given probationary periods in which to discover whether they are able to cope with the particular demands that might be placed on them by residents. Staff support sessions also assist in this process.

Relationships with other agencies

The care delivered within Hartrigg Oaks takes place alongside the provision of statutory services for elderly people. From the early conception of the community, effort was made to forge relationships with existing care providers within York. Although initial responses were muted - largely because of the persistence of the notion of ghettoisation of older people - local health trusts and social services departments expressed interest and sent representatives to the appropriate development committees. However, a close relationship with the social services department does not comprise a central strategy on the care delivery side of the community: means testing precludes most residents from social service provision that is free at the point of delivery.

The provision of medical service does, however, become an issue since the CCRCs does not aim to provide acute or surgical services. Good relationships with the local health trust are therefore essential, and the JRHT quickly made links with local practices to sound out GPs about their views relating to the centre. There was also some concern about the use of community nursing resources being intensified in one area, and so putting pressure on a local service. There is a view that some nursing, chiropody, physiotherapy and dentistry services may be available to residents, but not necessarily based in the community itself. Hartrigg Oaks does have facilities for these types of practices to be established in the care centre, but as yet these have not been arranged. There has been some discussion of the principle of residents having to travel outside Hartrigg Oaks to receive some services, as a means of encouraging greater integration with the wider community.

Marketing

Initial marketing of the proposed CCRC was completed by the Research Institute for Consumer Affairs during the summer of 1988. At that time, the community was being referred to as 'Parkfields', and focus groups were being asked to consider information in a brief brochure that sketched the basic principles of the CCRC. Initial reports noted that responses to the concept were ambiguous. There was some difficulty in respondents visualising the whole concept: 'the nearest most people could get to it was a sort of geriatric Butlins with rows of little chalets' (Bailey, 1988). There were some reservations about such a large number of elderly people living together, and it was thought that the idea would only be appealing to older people who are frail, which would then lead to the creation of communities which younger and fitter residents would not find attractive. For the idea to work, it was thought to be important that prospective residents would see that the community would be mixed in terms of age and care needs. It was also noted that there were difficulties with some older people not wanting to face up to realities in considering the possible costs of care in their later years, and some objection was expressed to the high proposed monthly charges and the possibility that they might increase.

In response to the focus group findings, it was proposed that the marketing of the community should highlight the possibility of retirement being an enjoyable experience, although it was acknowledged that this is not a particularly British attitude. A revised brochure would stress that living in the community would promote independence amongst the residents, who should be encouraged to move in as soon as possible so to have a longer period in which to enjoy the facilities. Interest in the community was raised through advertising in magazines including *The Friend* - the Quaker periodical. People were invited to write in expressing interest, and a mailing list was developed. In June 1996, the first marketing presentation was given to a group of 30-40 prospective residents.

The entry process

The process of moving into Hartrigg Oaks has been subject to change since the CCRC was first mooted. During the period in which the CCRC was being marketed, a complex process of waiting lists and priority waiting lists was in place, with prospective residents paying a fee of £25 a year to be on a list and kept informed of developments. Since all the bungalows have been filled, expressions of interest are placed on a mailing list with no charge. It was felt that if people were paying to be on a waiting list, then there would be obligation to ensure that the bungalows that became available would be allocated on a first come, first served basis. Retaining the flexibility to make decisions about new residents presents a means of ensuring balance in the community.

A second aspect of the entry process that was subject to change was in the assessment procedure. Prospective residents are asked to submit both a financial statement and a GP assessment that indicates the level of their health and gives some indication of care needs. It was found early on in the process of people moving into Hartrigg Oaks that the GP assessments tended not to be a particularly accurate indication of the care needs of residents: some residents do not necessarily see their GPs on a regular basis. For this reason, it was decided that a member of the care staff should visit the resident before they move into a bungalow, to get a clearer idea of the degree of support they might need. Although the principle of making a visit has been established, the point at which the resident is visited remains flexible: an early assessment appears to be too pushy and impertinent, and a late assessment leaves too little time for planning. Having any sort of rigid timetable for assessment was considered as being contrary to the principle of creating an individual process in which the resident is assured that they have a voice.

Section Two:
Delivering the key concepts

In establishing Hartrigg Oaks, the Trust has signalled its intention to promote some of the key concepts underlining CCRCs including:

- instituting a flexible fee structure, to make access to the CCRC as open as possible;
- promoting continuity in care provision, so delivering a seamless service to residents even if their care needs might fluctuate;
- creating a stimulating and vibrant community, enhancing the experience of retirement; and
- fostering security and peace of mind in old age.

This final section underlines some of the policies that have been instituted directly to facilitate the delivery of these principles, and the consequent creation of a housing and care system that offers freedom from the anxieties that commonly attach to increasing frailty in old age. Material from interviews with Hartrigg Oaks residents reflects the degree to which the principles encapsulated by the community meet the concerns of its 'first generation'.
The section also indicates that delivery of the key concepts has not been unproblematic; thus, some discussion also takes place of ongoing difficulties.

Flexible fee structure

Early on in the development of the CCRC, it was mooted that entry should rest on a single financial package. This idea was very quickly abandoned, since it conflicted with one of the key requirements of the JRHT in establishing the CCRC: that as many older people as possible should be able to gain access to residency. It is for this reason that a number of financial packages are available, offering the resident the possibility of paying both the residence and the community fees in a number of different ways (see also Appendix one).

With respect to the residence fee, three payment options are possible:

A REFUNDABLE RESIDENCE FEE
The full sum is refunded either to the resident or, if they die in residence, their estate on their leaving Hartrigg Oaks permanently. Essentially, this payment represents an interest-free loan from the resident to the CCRC. This fee takes into account the market value of the bungalow selected, but not the age of the resident.

A NON-REFUNDABLE RESIDENCE FEE
No repayment of this fee is possible, aside from a partial repayment if the resident leaves within a limited time period on entering the community. This is a lower payment than the refundable fee, and takes into account the value of the bungalow and the age of the resident.

AN ANNUAL RESIDENCE FEE
No initial capital outlay is required; the resident makes a monthly payment, dependent on the market value of the bungalow.

Once residents began to move into Hartrigg Oaks, it was noted that some people were having difficulty selling their homes to finance the initial capital payments required. Further flexibility was therefore introduced, giving residents the ability to enter the community on an annualised fee, and then switch over to a refundable or non-refundable package when the house sale is completed. Another option gives the resident the ability to sign onto a refundable or non-refundable package, but to make a side agreement that for the first twelve months an annualised fee is paid. This fee does not have to be paid until the house sale is completed, and then is 'rolled up' and paid with the residence fee. In either case, the resident is still required to pay the monthly community fee.

Flexibility is also evident with respect to payment of the community fee. Again, three payment options are available:

STANDARD COMMUNITY FEE
Annual sum, paid monthly through standing order.

REDUCED COMMUNITY FEE
The payment of a lump sum on entry can reduce the monthly fee.

FEE FOR CARE
The payment of a lower standard community fee, with charges for care services as and when received.

The combination of residence and community fees in appropriate packages can accommodate those who are either asset rich/income poor or asset poor/income rich. The system also takes into account the variety in aspirations with regard to assets and income: for example, where there are no beneficiaries to receive a capital sum, elderly people might consider it more appropriate to pay the lower, non-refundable fee and use any extraneous capital to offset their community fee. Alternatively, residents might choose the more expensive refundable package, but be assured that a capital sum will be paid to their beneficiaries in the event of death. Residents can switch from the refundable to the non-refundable fee or to the annualised fee at any time, for example if they want to release capital. With respect to the community fee, some people might opt for a fee for care package because they have no support needs, and the options remain for them to be able to switch to a standard community fee before they reach the age of 70.

At present, the most popular options are the refundable residence fee combined with the standard community fee (see Table 1).

Table 1
Fee option take-up

	Percentage (n=191)
Residence fee	
Refundable	62
Non-refundable	25
Mixed refundable and non-refundable	7
Annualised	6
Community fee	
Standard	59
Reduced	10
Fee for care:	
under 70 years of age	8
over 70 years of age	10
health grounds	13

(Source: Hartrigg Oaks CCRC Presentation, 1998)

Table one shows that other options are also being utilised, which indicates that the CCRC is fulfilling its purpose in providing a necessary flexibility. There is some concern that in the delivery of a flexible housing and fee structure, there has been the creation of a whole range of options and financial decisions that can be daunting. However, there are plans to monitor the financial advice that people are seeking, and their degree of satisfaction with the packages they have chosen.

Continuity of care

Research completed in the US on CCRCs indicated assurances of nursing and personal care constituted a major reason why people moved in - 83 per cent of residents in a US survey noted this being the case (Hearnden, 1983). One of the key principles being promoted at Hartrigg Oaks is to provide a continuity in care. There are a number of policies in place to achieve this aim. Within the community, care is conceived as being ranged along a continuum, with the intention being that residents experience smooth transitions as they receive greater or less intensive service delivery according to fluctuation in their needs. Thus, residents are encouraged to receive low levels of support that can be increased very gradually over time, rather than be suddenly in receipt of a larger package of care. Giving support for perhaps one or two hours a week also enables the care staff to keep an eye on needs of the resident, and to indicate if and when care delivery should be modified. The system also acts as a preventive measure, and ensures that the resident does not place themselves under unnecessary stress in attempting to cope, so leading in the long run to more intensive care. Forging an early relationship with support staff also contributes to the impression of continuity, especially since staff are trained and managed so that they also work in the care centre: should residents have to move to the Oaks, they are likely to encounter familiar faces. Thus residents are made aware that staff visiting the bungalows to deliver low levels of support - for example, assistance with

cleaning - are also trained to give more personal care, so encouraging the forming of longer-term relationships.

Aiming to provide continuity of care does carry some problems. Financial imperatives are such that the Oaks has to operate as a residential home, with beds that are marketed to non-residents. To some degree, filling the beds with non-residents - especially the movement *en masse* from another residential home - has created some anxieties, with residents expressing worries that should they need a care bed then one will not be available. One resident clearly resented the influx into the Oaks, and said that before she moved in she had been told that the centre was '*a nursing home for us [ie bungalow residents] when we needed it*'. Residents have been given a promise that their care needs will be met at the Oaks or in their bungalow, although in extreme circumstances this might entail a move out of Hartrigg Oaks and into another JRHT residential property in York. This possibility runs counter to the notion of care continuity at Hartrigg Oaks, especially with respect to the continued proximity of their partner should a spouse have to move from their bungalow to the Oaks. There is, therefore, some tension between balancing the economic viability of the care centre, and allaying residents fears that intensive care needs will not be met within Hartrigg Oaks.

Creating a balanced and stimulating community

A third key feature of CCRCs in the US, and which appealed immediately to JRHT staff, was the fact that these organisations offered the chance for elderly people to enjoy an energetic and stimulating old age: 'It was pleasing to see all the residents taking part in one activity or another rather than sitting around looking at the wall' (Dennis, 1985). Much of the literature that was collected in the early stages of the development of Hartrigg Oaks relating to the US CCRCs noted the enhanced quality of life that can be offered by living in a retirement community. For example, the Samarkand community noted the desire to offer a 'spiritually and culturally uplifting environment'. In many of the US communities, an activity director was involved to assist residents in the organisation of events, and CCRCs had dozens of events/crafts/hobby committees that were set up and managed by the residents themselves.

Within Hartrigg Oaks, the aim to create a stimulating environment is supported by policies that empower residents to make their own decisions about the facilities that will flourish. Within the design stage of the care centre, for example, space was set aside for music, a library and craft activities, and residents have been encourage to manage these spaces themselves. Residents have made donations of musical instruments and books, and have established appropriate committees. Funds have been made available for fixtures and fittings in the craft areas, including work benches, lockers, and shelving. There has been a high degree of support given to residents in these early stages, but it is not intended for the Trust to employ an activity manager, as is the case in the US: rather, that residents will co-ordinate their own efforts.

During the resident interviews, there was appreciation of the view that old age should be a more stimulating experience, and some of the interviewees had come to Hartrigg Oaks both to enjoy their retirement and to counter any possibility that they might become lonely as they got older and their friends began to die. There was appreciative comment on the social function of the café and restaurant, which have acted as focus point and meeting place. Some residents contrasted the activity available at Hartrigg Oaks with the residential homes they had visited, where older people simply sat and watched television all day. The Hartrigg Oaks residents evidently prided themselves in their responding to the challenge of setting up their own activities, and in taking over the organisation of the Residents' Committee and arranging residents' meetings, which were always heavily attended.

It is certain even at this early stage that sufficient activities are available for the community to be regarded as a stimulating place in which to live. Issues of balance and integration, however, remain problematic. For

example, residents in the Oaks are perhaps not as fully engaged as possible with social activities in the broader retirement community. Over time, and as bungalow residents begin to move into the Oaks, it is probable that any evident differential in terms of involvement will disappear. A further issue is achieving a good mix in the community in terms of ages. At present, the average age of the population is 75, with more than a quarter of initial residents under the age of 70. This is perhaps a better record than in the US: the average age of residents in Kendal Corporation properties is 80 (Kendal Corporation, 1998a, p21; see also Table 2).

Table 2
Hartrigg Oaks residents age profile (1998)

	Number		Percentage
60-65		23	12
66-70		31	16
71-75		54	28
76-80		37	19
81-85		34	18
86-90		11	6
Over 90	1	1	

(Source: Hartrigg Oaks CCRC Presentation, 1998)

The lower age range at Hartrigg Oaks reflects the encouragement that has been given for people to move into the CCRC whilst they are fit and healthy. However, it is inevitable that in the long term, the current 'first generation' of residents will grow older, and the average age of the community will rise. It is anticipated that as bungalows become available, so marketing for new residents will be targeted at people at the younger end of the retirement age group. High demand for places at JRHT properties will probably ensure that this policy is successful.

Balance also becomes an issue with respect to the class and professional status of residents. It has already been noted that it is evidently the case that only some sectors of the elderly population will be able to afford to move into Hartrigg Oaks. Following complaints from New Earswick residents that they would be unable to afford to move into Hartrigg Oaks, ten places have been made available on a bursary basis to people who have been in long-term residence in a Trust property. Fees are being paid by the Trust itself, at no cost to the CCRC. However, there has been some tension, with some residents not fully appreciating that their fees are not subsidising the bursary scheme. The ability of bursary people to be able to mix with other residents of the CCRC has already been questioned, since there are evidently class and consequently cultural differences.

An associated issue reflects the association of CCRCs in the US with particular religious denominations. During the Trust visit to the US in 1986 it was found that, in the CCRCs that were visited in and around Philadelphia, between 15 and 45 per cent of the residents were Quakers. Early discussion of the community had noted that 'that a strong Quaker nucleus in the community would be most valuable' (JRMT, 22.7.87). The Quaker philosophy is deeply influential in the Trust's dealings, and the decision was taken to target marketing of the CCRC amongst UK Quakers through *The Friend* periodical. It has yet to be seen how far non-Quaker residents will feel integrated into a community with a strong Quaker element. However, it

should be noted that the Quaker residents who were interviewed clearly felt a responsibility not to dominate the community; and non-Quaker interviewees considered the issue unproblematic, since Quaker philosophy is undogmatic and tends to be tolerant and conciliatory.

Security and peace of mind

Issues relating to security and peace of mind in old age have been promoted in a number of ways at Hartrigg Oaks. On the financial side, it has already been noted that under the standard community fee, no increases accrue to the resident should the care needs increase either temporarily or permanently. This particular package directly counters anxieties relating to the need to 'set money aside' to meet the possibility of increasing care costs. All the residents who were interviewed had opted for the standard community fee. Although many considered the cost to be high, it was common to view the fee as 'insurance' against the possibility of greater care needs. Some residents also mentioned the high cost of private residential care, which was - by comparison - of much poorer quality and offered little in the way of security or stimulation: '*you're paying a lot now for very little [care]; but when the time comes that you might need care then that fee you're paying now remains the same and it would be much less than a good residential nursing home would be*'. The ability to offset some of the community fee with an initial capital payment was appreciated by one couple, where the wife had more limited pension provision than her husband: he felt happier knowing that she would have less difficulty meeting the community fee if he died first.

It should be noted, however, that under the fee for care package, this degree of security is absent. Furthermore, it is the residents with the more substantial needs that are not being relieved of their anxieties. Residents with above-average care needs are only accepted into the community if they take the fee for care package. To some degree, this requirement undermines the principle of promoting security, since there have been concerns that some residents on the fee for care package are not paying for all the care they require because they are worried about running down their capital and having insufficient funds to meet future costs.

In general terms, the combination of housing and care at Hartrigg Oaks removes a number of fears that are often expressed about the onset of old age. In the interviews with residents, recurring themes included anxieties about being a burden to the family, or perhaps dying and leaving a spouse alone and without adequate care. Residents - or families they knew - had themselves taken care of an older relative, which had been an increasingly onerous responsibility that they did not want their children to experience. Some residents had also been provoked into thinking about a move because they had had unexpected illnesses that had suddenly increased their need for care. Catering for these eventualities was considered to be a sensible move, particularly at a time when they were young enough to be able to make the decision for themselves, and cope reasonably well with the consequent upheaval.

An associated fear related to home maintenance and security. Underlying the decision to move for some of the interviewees was the knowledge that they could not physically maintain a family-sized home indefinitely, and gardens - though deeply loved - would soon become unmanageable. Having a home with no responsibility for ongoing maintenance therefore constituted a release from a costly and stressful burden. Furthermore, residents also appreciated the fact that the site was well protected, and that staff were always available to respond to security emergencies.

Conclusion

In conclusion, it perhaps should be noted that very early in its decision to set up a CCRC, the JRHT expressed the aim for the community to act as a pilot model for other agencies seeking to expand services for elderly people. The community very clearly represents a valuable and valued addition to the services available for elderly people seeking to finance their own housing and care needs. However, the circumstances in which Hartrigg Oaks was established indicate some limitations to the ability to replicate this model. Unless an organisation is involved with similar financial standing as JRHT, then the risk of setting up a community would be difficult to bear. It has been suggested that the model might be more readily copied if three organisations were involved: a building company, to construct independent units and the care centre; a provider to manage operations and deliver care both to the bungalows and the centre; and an insurance company to underwrite the risks involved. Essentially, the care provider would collect community fees to cover care costs, which would include a component for insurance against the need for additional costs.

The popularity of Hartrigg Oaks reflects to a large degree the public confidence in the JRHT as a high quality care provider. Some residents expressed the view that they would have been unlikely to have considered a move to Hartrigg Oaks otherwise. For example, one couple commented that they had not taken detailed legal advice: '*It's a Rowntree trust and we are Quakers and therefore we will accept what they say...We took it on trust...If we'd started querying it all we'd have been too nervous to have gone ahead. With any other body I'm sure we wouldn't have involved ourselves*'. The strong connection with the Quaker community ensured that there would be a core demand, with people willing to travel from outwith the area to Hartrigg Oaks because of the specialist nature of the provision. Indeed, the Quaker residents who were interviewed said that they had moved in because they had wanted to be with other Quakers. However, for other people, the Quaker ethos and the Rowntree name *per se* was less important than agreement with the general principles of the community; the basic fact that the CCRC was being run on non-profit grounds; and the guarantee that fee increases would be contained.

In the development of Hartrigg Oaks, the JRHT has to a substantial degree, achieved its aim of creating a community in which elderly people are able to use both their assets and their income to secure housing and appropriate levels of care, in a stimulating and fulfilling environment. Ongoing monitoring of Hartrigg Oaks is being set in place to ensure that lessons will be learned from the community's development, and this report has reflected its first stages.

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Note that within the text, JRMT with date, refers to the minutes of the Joseph Rowntree Memorial Trust. References marked with an asterisk can be found in the Hartrigg Oaks archives, held at Hartrigg Oaks.

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Appendix one
Residence fees and community fees: worked example

Single person aged 75 in a two-bedroomed bungalow

Residence fee	
Fully refundable	£86,000
Non-refundable	£50,138
Annualised	£6,450
Community fee	
Standard	£4,600 pa
Reduced	£29,800 plus £2,300 pa
Fee for Care	£1,900 pa plus cost of care received

Mrs X, aged 75, moved into Hartrigg Oaks after selling her house, which left her with substantial capital. There were three ways in which Mrs X could pay the residence fee, which is the initial payment which essentially covers lease of the bungalow. Her children thought that Mrs X should opt for the lower *non-refundable* payment of £50,138, which her capital could easily cover, and use the remainder to boost her income. However, Mrs X decided to go for the higher *fully refundable* payment of £86,000. She was swayed towards the option by the fact that the payment would be refunded to her estate on her death, and she wanted to be able to hand something down to her children. Mrs X knew a couple at Hartrigg Oaks who were paying the annualised option - which converts the residence fee to a yearly payment. Although the couple had limited capital they could cover an annual payment easily through their income from two private pensions.

Mrs X also had to decide how she was going to pay the community fee, which covers basic services and entitlement to care. She was attracted to the idea of making a down-payment of £29,800 against future care costs, which would have meant her having to pay a *reduced* community fee of just £2,300 a year. However, her capital was insufficient. Of the remaining options, Mrs X could have decided in favour of the cheaper *fee for care* option, which comprises a lower payment of only £1,900, but where additional payments would have to be made for any care which she received. Although Mrs X was currently in good health, she decided that she did not want to be uncertain about possible payments for care in the future. As a consequence she opted to pay the *standard* fee. Although this was the more expensive option - £4,600 a year - she appreciated the security of knowing that she could have unlimited care.

Note: fees at February 1999 levels.