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"Putting it all Together"

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The Vision of Caring – A Description

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Abstract: This paper presents the results of a 4 year study addressing the provision of health, social care and housing for the elderly-frail members of a typical large rural community in Suffolk. It argues that the current structures of the NHS and Social Services are not suited to coping with the challenge of providing quality care in the long term and that innovative solutions must be explored. As a result of this research one such approach has been identified - "The Vision of Caring" - which is predicted to not only deliver a quantum step improvement in overall care, but also to achieve economic savings in the region of 8 to 10% per annum. It is suggested that without a new structure for the care of the elderly-frail the NHS and Social Services will become overwhelmed irrespective of any increased commitments to funding them. It is believed that the "Vision" offers a new direction in the provision of care which both matches the aspirations and needs of an ageing rural population, and is also affordable.

The paper describes how such a "Vision" may be implemented as a community-led **comprehensive community care trust** which seeks to locally provide all but the most acute services for the elderly and frail; centred around a multi-function resource centre which provides specialist housing, nursing care and a base for outreach services provided by statutory and voluntary sector (etc); governance by a Board of trustees comprising community representatives, health and social care representatives, housing support representatives (and large provider representatives); advanced health care technology; improved social care provision; etc.

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This paper was designed to be read on-line so that as the reader explores the document he/she can click on the relevant numbered footnotes to provide the detailed information and arguments that support it. It is an overview of the conclusion of the study which is based mainly upon two underlying documents: A Vision of Caring V3.3 , which provides the initial academic foundation for the "Vision" and Putting it all Together - A System for Care which advances and extends our thinking in the form of a series of notes.

The nature of our work is not in the form of a piece of academic research as it derives as a result of the development and evolution of The Debenham Project which means that it is both dynamic and on-going. The author apologises for any shortcomings in the form of typographical, grammatical and other errors on the grounds that he is also "looking after" this innovative community-based project.

1. Foreword: On the 23rd April 2009 at a public meeting it was decided that Debenham, which is a small town in Suffolk, would "get on and do something" to tackle the growing problem of dementia and its potential impact on our community. **The Debenham Project** was born and it has developed a unique and successful approach which has been recognised throughout Suffolk and well beyond. The story of the project is well documented[1] and has demonstrated how a community can respond to the needs of those who are struggling to cope with the impact of dementia on their lives. It is a model for a new approach to care.

However, at the very first public meeting we were also asked to **"have a vision"** for the future - how we want all those who are elderly and frail to receive the care and support they need without having to leave their homes and community – "7, 10, 14 miles is too far".

> Why should someone have to leave their family, friends, and neighbours when they need the extra care and security that cannot be provided in their own home?

[1] www.the-debenham-project.org.uk

Why should an elderly person have to be admitted to a hospital, or stay in hospital any longer than is absolutely essential, when their health and recovery would be so much better in their own community among familiar faces?

And, perhaps, the biggest question of all, what do we have to do to accept the challenge of caring for our ageing friends and relations?

The Debenham Project accepted this challenge and, without really knowing it, we embarked upon a significant 4 year (It may be longer!) study of how comprehensive care might be delivered in a rural and semi-urban setting, leading initially to the "Vision of Caring" paper[2] and followed by the subsequent "Putting it all Together" series of notes[3].

We now have confidence that an innovative community-based approach to the provision of health, social care, and housing is within our grasp – one which "breaks the mould"[4] and one which not only offers a quantum step forward in the quality of care, but will also be both cheaper and more responsive. This is **"A Vision of Caring"**[2]. It will require investment and some changes in practices and professional orientation, but it is predicted to save up to 10%[5] on the annual costs, to the NHS and the Local Authorities, of health and social care for the over 65s living in our community. Furthermore, it is suited to most rural areas and market towns and may have application in more urban environments.

It was developed through research, discussion and consultation with a very wide range of senior staff and council members in the local authorities, the NHS and important national charities, by exploring ideas with key personnel in housing associations, and by talking with people throughout the local community[6]. The concepts of the "Vision" have evolved, rather than been designed, by being continually and informally tested by exposure to professionals and local people.

The proposed scheme can be viewed as incorporating the recognised potential of innovative approaches such as The Swedish Way[7], the Dutch Hogewey's Dementia Village[8], The Buurtzorg Nederland nursing /personal care initiative[9], the PACE project in N. London[10], and the Beacon Hill Village Movement[11] in Boston, MA.

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[2] http://www.the-debenham-project.org.uk/downloads/steeringdocs/A_Vision_of_Caring_rltse7.pdf
[3] http://www.the-debenham-project.org.uk/downloads/steeringdocs/Putting_it_all_Together_fdfge4
[4] http://www.the-debenham-project.org.uk/downloads/articles/breakingthemould.pdf
[5] The overall economic benefits may be higher when considerations relating to housing and local employment are taken into account.
[6] Putting it all Together - Chapter 15. Discussions, consultations, presentations, research, and conversations
[7] "Putting People First -The Swedish Way", Dept of Health –East of England, 2008
[8] http://edition.cnn.com/2013/07/11/world/europe/wus-holland-dementia-village/index.html
[9] http://omahasystemmn.org/documents/2010-10-04ArtikelBuurtzorgInHetEngels.pdf
[10] An Evaluation of Bromley Post Acute Care Enablement Service July 2009 - April 2010, Charlotte Hails et al, July 2010
[11] http://www.beaconhillvillage.org/content.aspx?page_id=22&club_id=332658&module_id=77064

We believe that this is the first time any community has sought to systematically address the health and social care of its elderly-frail members, and to specify not only what is needed, but also to define how it might be achieved. Many individual research projects and initiatives have shown that there is potential for savings and improvements in the context of the existing NHS and Social Care. In essence, we are "Putting it all Together" and creating a person-centred, community-based "System for Care". However, in the process, we believe that this innovative approach could provide a new evolutionary pathway for the NHS, enabling it to successfully respond to the challenge of our ageing population.

A vision of the way that the NHS can reassert its original aspirations.

2. Background: Debenham, together with the surrounding villages within a radius of about 4 miles, forms a natural community with a catchment population of approximately 6,500. As the core of the community, Debenham provides access to a range of amenities including schools, shops, a small library, a leisure centre, two pubs, sheltered accommodation, and the local GP practice. With regard to health and social care the only local support services, other than the GPs and community nurses, are those provided by The Debenham Project[12]. Personal care is provided by remote care agencies together with a limited number of local self-employed carers. The nearest residential nursing home is 7 miles distant (with no public transport) and it is 8/10 miles to the nearest extra-care facility. Hospital and specialist services involve travelling 14 miles minimum. The cost of providing health and social care to the over 65s is approximately £6.6M pa[13]. There are 150+ persons (42% with dementia) who may be classified as "elderly frail" within the catchment. However, there are also 100+ persons in residential, very sheltered[14], and nursing care whose previous address was within the Debenham Project catchment area i.e. they had to leave their family, friends, neighbours, because they were unable to safely remain in their own home, or to be cared for within, their own familiar community. In addition, each year there are more than 550 hospital episodes involving the over 65s and costing in excess of £1.3M pa.

This is a well-researched picture of the situation in Debenham. However, 52% of the population of Suffolk (41% nationally) live in rural communities similar to Debenham and if we consider the elderly population it rapidly rises to over 60%[15]. We believe that Debenham is typical, in terms of demography, social and professional cross-section, income, community involvement, etc., of most of these communities across the rural

[12] www.the-debenham-project.org.uk

[13] Putting it all Together - Chapter 11. The Local Scale & Cost of Health and Social Care

[14] This is often referred to as "extra-care" which provides an integral apartment-style accommodation and social care support arrangement.

[15] The population figures suggest that, across the UK, 41% (including metropolitan areas) of the population live in rural communities not too dissimilar to Debenham.

counties of the UK.

3. Introduction: The "Vision of Caring" is a proposal for a community-based organisation which will provide and manage the health, social care, and housing services and facilities necessary to meeting the following aspirations.

1. To provide community-led, person-centred and integrated health and social care for all elderly-frail members of our community[16] which meets their individual needs irrespective of their degree of frailty.

2. To respect and value their continued importance to their families, friends, and community, and enable them to remain active participants in the social life of the community.

We seek to focus firmly on supporting our elderly-frail residents within their local environment.

Caring in the Community
Caring for the Community
Caring by the Community

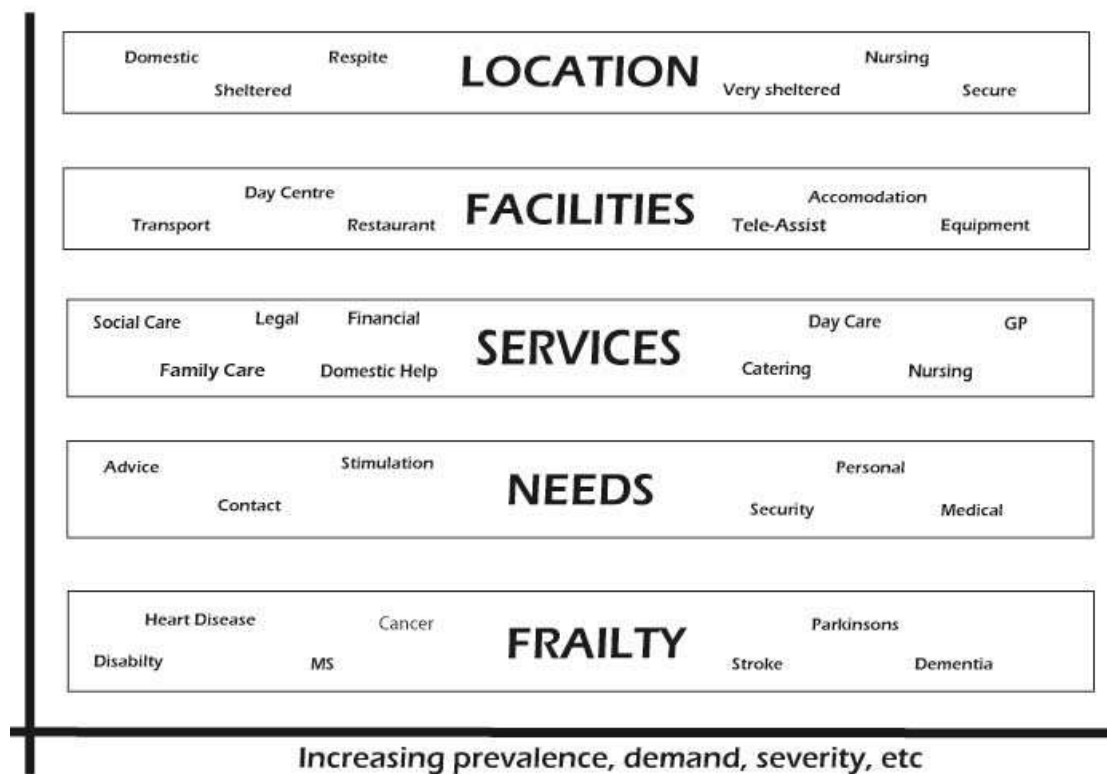
The "Vision" is a comprehensive care system specifically designed to tackle the crisis that faces the NHS and Adult Care Services presented by an increasing elderly-frail population in rural and semi-urban[17] areas of the UK. The central concept is to reverse the current "service provider" model and instead create a "System for Care" which is firmly driven by the pattern of the individual needs of the elderly members of our community at the local level[18]. It recognises that the structure[19] of the current provision of health and social care does not suit the needs of an ageing population - especially in rural areas[20,21] - and that a new approach is needed to support this sector. Without a quantum change in the way we care for our elderly population the NHS and Social Care services will be overwhelmed and unable to deliver anything like the quality care that will be demanded by them, their relatives and their friends.

Hitherto, the health and social care of the elderly-frail has been a <u>bipartite</u> responsibility shared between the NHS and the Adult Care Services. However, it is clear that only by fully engaging with the community is there any potential to balance the projected need against the potential resource. The care of the elderly frail must become a <u>tripartite</u> responsibility with the local community, in collaboration with the local GP practice and local Adult Care professionals, taking on

[16] Putting it all Together - Chapter 8. Project Aspirations and Requirements
[17] Population growth and statistics: see references in http://www.the-debenham-project.org.uk/downloads/articles/0907prevalence.pdf
[18] Putting it all Together - Chapter 9. Project Concepts
[19] Putting it all Together - Chapter 16. Structural and Systemic Issues with the NHS and Social Services
[20] Putting it all Together - Chapter 4. Strategic Issues (Rural)
[21] Putting it all Together - Chapter 5. A Rural Strategy

the leading role in its specification, provision, management, and resourcing. Nevertheless, the reality is that finances will remain limited in relation to the rapid growth in demand, and any new approach must demonstrate that it offers real potential for delivering substantially increased quality of care at a lower unit cost.

It is in this context that the "Vision of Caring" was researched and developed[22] as an innovative solution to the future care of the elderly-frail in Debenham and its surrounding villages. It is believed that it is applicable to rural and semi-urban communities in which more than 50% of the over 65 population of the UK reside. It offers a natural match between the nature of the health and social needs of the elderly and a way that they can be met. In the process, we have developed a number of concepts[23], e.g. the "Conceptual Flow Model" and the "Virtual Hospital Bay" which provide the basis of a blueprint for a structure which satisfies the current community needs and can evolve naturally to meet an uncertain future. We believe that this is the first time that any group has attempted to apply the principles of complex systems design[24] towards creating a new approach to caring for our ageing population.



Furthermore it draws together all that has become recognised as best practice into a coherent system:

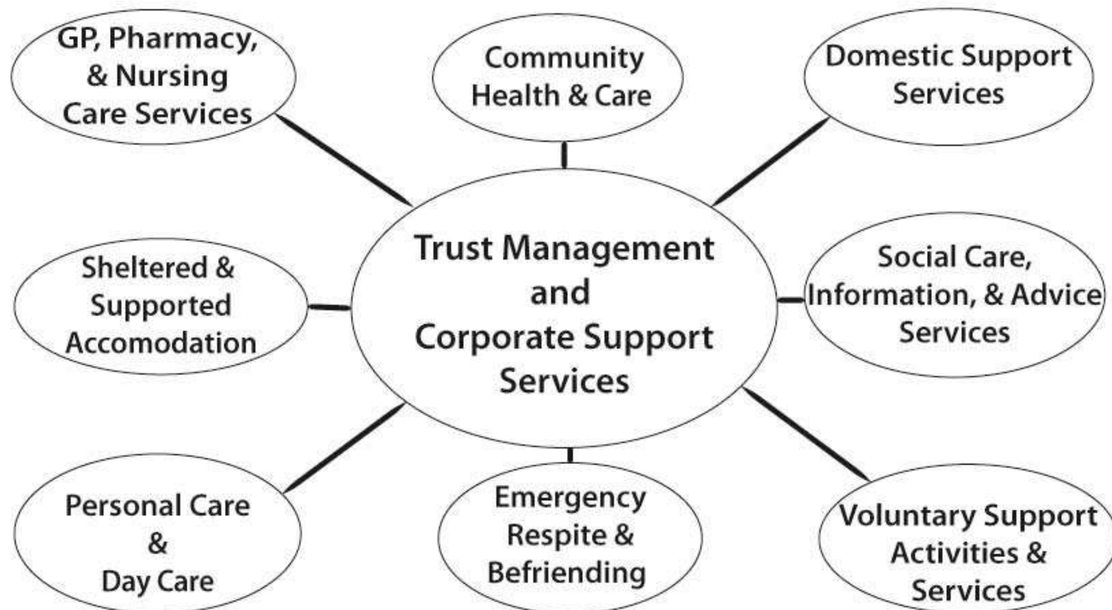
[22] "A Vision of Caring", Jackson and Hawkshaw
[23] Putting it all Together - Chapter 9. Project Concepts
[24] Putting it all Together - Chapter 9. Project Concepts

Person-centred	Integrated services
Continuity of care	Personal knowledge of the individual
Independent living	Multi-disciplinary team working
"Enabling" care and support	Named support team members
Local volunteer involvement	Community ownership
Local services	Local access to information and advice
Visible and strong quality control	Choice
Clear accommodation options	Resource sharing
Clear and accessible responsibility for care and service quality	
Future proofing	Evolutionary capability

4. Description: The central concept lies in a Comprehensive Community Care Trust (CCCT) jointly and locally governed and managed by the local representatives of the CCG, Adult Care, and the Community, and which takes on the responsibility for the care of the elderly-frail population within the catchment area[25]. It will provide a comprehensive care package which, when required, and using currently available on-line IT technology, can draw on the expertise and consultant resources of the acute (hospital and other) services. The aim is to do as much as is possible to support and care for elderly people, for both routine and minor emergency conditions, in their own homes. However, if and/or when this may not be possible, to offer high quality supported independent living accommodation in a next generation extra-care unit within the community which is appropriate for their future needs, together with limited but "hospital grade" medical and nursing care. Elderly-frail patients should only be committed to remote A&E, hospital, nursing, and dementia care when the severity of their condition presents no other alternative.

The overall aim is to create a fully integrated system by delivering and facilitating the following local services for our elderly-frail residents within the overall umbrella of the proposed Trust.

[25] Putting it all Together - Chapter 8. Project Aspirations and Requirements



Modular Elements of Local Support for Health and Social Care

The CCCT lies at the centre of the organisation. In essence it a) provides leadership, guidance, and support to the people / providers / groups who are providing the services, b) ensures that the necessary facilities in terms of buildings / accommodation / bricks and mortar/ equipment are all available, c) looks towards the types of services and opportunities that might be commissioned / encouraged, in the future and d) creates the focus for integration at the working (local) level.

It is a way of integrating health and social care and housing for the elderly-frail. It will enable sharing of facilities and resources, and reduce hospital admissions, but above all focus only on the real needs of the elderly person and their family carers.

Although, as will be seen later, the scheme involves significant investment in physical infrastructure, the reader is cautioned about thinking of the "Vision of Caring" in these terms i.e. as a "bricks and mortar" project. It is about the creation of an organisation or system to meet the needs of the elderly and frail, which incidentally requires accommodation, buildings, equipment, and other facilities essential to the provision of a comprehensive care package.

5. In more detail: Each element of the "Vision of Caring" stands on its own but works closely together with the other elements in order to match the needs of their individual clients. By virtue of the scheme being community-led and locally staffed, those who are professionally or voluntarily involved with it will naturally develop informal working relationships to the "holistic" benefit of their clients. Also, because everyone is "known" and

"named" the effectiveness of the formal multi-disciplinary team structure will be much enhanced. Please note that the services provided by the vision are "tenure blind" i.e. they serve equally those who live in their own homes with those who may be resident in the extra-care / residential / nursing facility.

The Trust: The Trust forms the central core of the scheme and "organises" / "commissions" / "arranges" / "encourages" the provision of services matching the needs of the community and individuals. It provides an overall organisational structure supporting the various activities and services and is responsible for corporate activities such as oversight, policy, quality monitoring, HR, funding, finance, etc., where these are not already being carried out. It is likely that GP group practice, community nursing, social care, and accommodation management will all have most of these elements already in place by virtue of the way they are provided within the system. The Trust also provides the framework for integration and community team working. Initially, it will comprise the Trust CEO, accountant/treasurer, and an administrator/secretary. These paid professionals will be responsible directly to the Board of Trustees as indicated below in the section on governance and policy.

GP group practice: The GP group practice will operate in very much the same way as hitherto but with the expanded support of the nursing team, together with a satellite surgery, and treatment room with diagnostic equipment and IT access to remote consultation, as a part of the extra-care unit. It is ultimately believed that GPs and Nurse Practitioners will take the lead in diagnosing and treating as many elderly-frail episodes as possible in the community with the assistance of advanced remote consultation technology and, thereby, reducing avoidable A&E and hospital admissions. It is also anticipated that it will facilitate the rapid return of elderly patients to be monitored and cared for following more serious treatments in hospital.

Pharmacy Services: The local pharmacy, together with the prescription facility provided by the GP practice is expected to operate in its current form. The pharmacy, in line with NHS guidelines, offers a range of services in support the GP practice including advice, medication monitoring, medication management, etc. as well as filling prescriptions and the sale of non-prescription items.

Nursing care: Augmentation of the existing community nurses (3), part-time CPN (1), and other community directed shared nursing resources (dementia, diabetes, CPD, etc.) by additional SRNs (2), HCAs (6) and a nurse manager to provide a community-wide team with the capability to provide care from basic domiciliary to hospital quality general nursing, patient monitoring, psychiatric support, etc. It is also expected that there will be a small (6 – 12) volunteer (mainly retired) team of trained nurses who will be prepared to offer their services on a limited regular and/or emergency basis.

Specialist nursing and therapies: A range of additional

services are currently available on referral by the GP/consultant e.g. physiotherapy, occupational therapy, counselling, pain management, speech and language therapy. However, the level of provision is certainly not adequate for an ageing population. Therefore it is intended that the existing resources allocated to the catchment will be increased.

Continuing and End-of Life care: The provision of a coordinated approach to the nursing and social care support essential to those with serious health needs and/or terminal conditions. The aim is to draw upon the range of professional agencies including Macmillan, Admiral, St. Elizabeth's Hospice, Sue Ryder, etc.

Social care: Focusing of the existing social work services organisation together with the dementia advisors (and other specialist advisors) so that there are known (named) and familiar professionals allocated to any clients within the community catchment area. This is already working well (albeit informally) with regard to the Dementia Advisor Service.

Advice and information: Provision of a common source for first-call and basic health and social care information and advice, and linking to other accredited sources and agencies. This has already been implemented with regard to dementia. Having a team of professionals and volunteers who are all known to each other greatly facilitates rapid access to the right person and the right information.

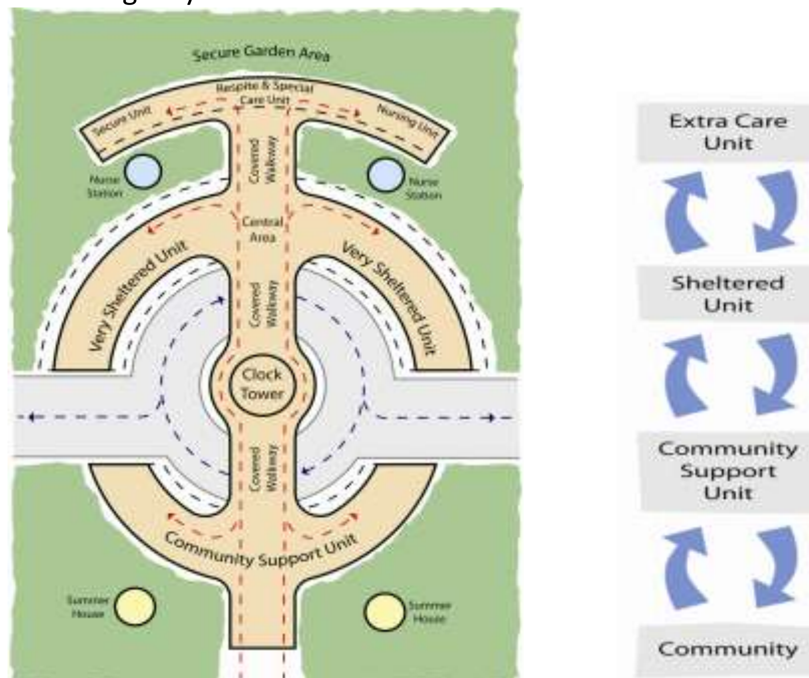
Personal care: A team of high quality professional domiciliary carers (12+) drawn from existing local self-employed carers and agencies who are prepared to offer top quality care and collaborate in offering an informal network of domiciliary personal carers. This is already in embryo form as "the Carers Co-op" which links family carers to professionals who are DBS checked and for whom references have been obtained. The trust will arrange training and DBS accreditation of individual professional carers when required.

Domestic support: Provision of a network or register of domestic support workers (6+) and tradespersons (6+) who are, at least, well known within the community and can be vouched for. The scheme will provide training in awareness and basic care if required.

Sheltered and supported accommodation:- Provision of a 40 apartment extra-care (very-sheltered) unit with additional capability for a small number intensive en-suite bedsits for nursing (6), secure (6) and respite (6) care[26]. In addition there is an already existing 33 unit basic sheltered scheme. The extra-care plus facility is a totally flexible and integrated housing approach for the elderly frail ranging from "own home", through sheltered and extra-care, on to intensive residential style and full nursing. It will incorporate the latest concepts in housing for

[26] Specifications for the "Vision of Caring" integrated health and social care support scheme

the elderly-frail, assisted support technology, access to remote medical support, and interactive community support services. However, it does not require a dedicated hospital ward. Since it is not possible to maintain 100% occupancy in any housing scheme, the "Vision" dynamically utilises temporarily empty apartments or bedsits to create a "virtual 3 or 4 bed hospital bay". The facility can be similarly used should a public health emergency arise.



Conceptualisation of the Facilities

Lettings and Leases: A professionally supported committee to arrange purchases and tenancies in the sheltered, extra-

care, and residential/secure/nursing accommodation.

Technical and IT Services: The "Vision of Caring" has been designed to use and offer the maximum benefits of modern communications and computer technology. It will enable facilities ranging from remote diagnostics and consultancy (PACE), interactive patient monitoring and security, to on-line services and support for patients and carers.

Voluntary care and support services: A comprehensive package of local volunteer-based support activities and services similar to those already provided by The Debenham Project. These currently include emergency and short-term care and support cover for family carers, a fitness club, activities and social sessions, confidential telephone helpline, lunch clubs, a Carers club and Info Café, and an advice and information centre.

Hospital and emergency transport: A community-led team of volunteer drivers who offer transport for individual elderly-frail residents to attend hospital and other important appointments. This is in the early stages of implementation.

Emergency respite: A team of volunteer carers (8-10) who are trained to basic professional personal care standards, dementia awareness, and other skills so that they can "stand in" in an emergency or offer short-time respite for the family carer. This has already been set up as one of the Debenham Project's services.

Day care: A professionally-led team of volunteers who can offer a day-care/wellbeing facility on a regular basis for the whole community within dedicated accommodation in the extra-care unit.

Community resources: Facilities and accommodation built into the extra-care unit for use by other groups of all interests to encourage and link integration with the wider community.

6. Management structure: The "Vision of Caring" is designed to be flexible and to be able to evolve with time as the needs in the community change, medical science advances, best practice in social care develops, and funding issues for the care of the elderly-frail are resolved. In keeping with modern principles of system design it adopts a modular approach which delegates control to those who are closest to the client. The principle is for the Trust to guide and stimulate the creation of services whilst maintaining the overall vision for the community.

This shows one possible picture. It will depend upon on exactly how the scheme is implemented as to the best way of placing particular services in the management structure. So, for example, it may be that domestic services are more appropriate to the "community" thread.

Governance and Policy: The "Vision of Caring" is led by the Board of Trustees of the charity representing the community and who understand its needs. In addition, the trustees will include representatives of Adult Care Services, NHS Primary Care, and Local Authority Housing who can provide direct links to the statutory authorities, and including input from those with particular knowledge of, and/or active involvement in, the local care of the elderly-frail. Their role is to suggest and monitor the provision of services and to ensure that quality standards are met. The trustees are also encouraged to be active participants in the scheme and get involved in one or more voluntary roles.

Trust management: The task of the Trust is to specify and implement the care system. In one sense it is a "commissioning" role but not quite in the same sense as that of Adult Care and the NHS. The aim is to follow the model developed by the Debenham Project in which the project "gets on and does something" and draws in the professional services as needed. It is expected that individual services will be implemented in a variety of ways:

- Collaboration
- Volunteer-based
- Secondment

Service contract
Research contract

The job of the Trust CEO is to implement the scheme by whatever means seem appropriate. It is not the job of the Trust to manage and control – it is to encourage, enable and support those who are closest to the clients.

Service management: The range of services is nominally divided into 4 threads each looked after by a coordinator/enabler. Their role is to help each of the activities within their thread to work closely together and to ensure that coordination, information flow, and decision making between all activities is simple and straightforward. The "overall" service management is the core of the multi-disciplinary team approach of the "Vision". The aim is to encourage cooperative working in "individual" service provision, the maximum of one-to-one integration on a personal level (eg "Hi Mary, I was a bit worried about Peter this morning. Do you think you could call in on him and then perhaps we could have a chat?), and the minimum of formal meeting-based case management. It is very important that these coordinators are also active practitioners – It is seen as a part-time role which is combined with leadership of one of the activities within their remit – they must be personally connected with their clients.

Activity management and "getting on with the job": The "Vision" has been designed so that individual activities are as nearly as possible "stand-alone" and "sustainable" so that the overall scheme does not go into crisis if one element encounters a major difficulty or, for one reason or another, a key person is unable to continue to be involved. This is the great advantage of a loosely coupled distributed system. Each activity has a Task Leader who takes responsibility for driving forward their activity/service to the benefit of the local community. The total range of individual services will automatically reflect the priorities and needs of the elderly-frail members in the community. The aim is that whenever a need is recognised that every effort is made to respond with a local service. It is not a top-down hierarchic organisation - it is a bottom-up distributed system.

7. Costs and Savings: In the initial paper proposing the "Vision of Caring"[27] as a potential solution in tackling the problems our community faces in supporting our elderly-frail population, we made it very clear that any proposal must not only offer significant improvements in the quality of care but also be "value for money" (i.e. an attractive investment for the NHS and the Social Services). Our initial basic financial assessment[28] showed that focusing care for the elderly-frail in the community would deliver an estimated saving (in revenue) of about £600,000 pa for a typical rural community such as Debenham.

More recently, as part of the "Putting it all Together" series of notes we have extended, updated and revised that assessment to reflect our increased aspirations

[27] "A Vision of Caring", Jackson and Hawkshaw
[28] Scheme Financial Model V3.3

as proposed above. It remains very clear that a "local solution" can deliver health, social care, and housing with more effectiveness and at a lower overall cost than under the current approach. This comprehensive analysis[29,30] indicates that the implementation of the scheme will, not only yield significant savings in the overall cost of providing health and social care for the community, but also deliver a quantum increase in quality when measured in terms of meeting the care needs and aspirations of the elderly-frail. Broadly, we have been able to estimate that the overall cost benefit, in purely financial terms, could be as much as between 8% and 10%[31] over the current health and social care expenditure in the catchment area of approximately £5.2M pa[32].

The basic aim is for the "Vision" to at least "balance the books" in terms of delivering the level and quality of services that are currently delivered by the NHS, the Social Services, and other agencies (extra-care, residential, nursing and secure (dementia) care). The financial model shows this is achievable for, although it indicates a small annual deficit of £154K (6% of the annual expenditure of £2.5M), the scheme will provide a significant increase in local health and social care resources which counterbalance this figure.

However, implementing the "Vision" will also provide additional and substantial direct cost benefits of about £550K pa. Direct Cost Benefits are those reductions in the costs of the NHS and Social Services which will result from the existence of the scheme e.g. due to reduced hospital admissions, shorter stays, reduced crises, more people able to be cared for at home, etc[33]. Thus, as summarised below, the scheme should provide a positive overall economic benefit of approaching £400k pa. Looked at in purely financial investment terms, it could produce an annual return of about £1M (£0.4M plus the £0.6M interest payable on the loan capital) on an investment of a little over £10M i.e. 9% pa.

Overall Scheme	
Direct Income	£2,414,045 pa
Expenditure	£2,567,795 pa
Profit	-£153,750 pa
Plus Cost Benefit	£553,050 pa
Cost/Benefit Balance	£399,304 pa
Capital Debt	£10,273,250

It should also be noted that investment in community-based facilities, which reduces the requirement for the hospitals to provide care for the elderly and frail, will also reduce their requirement for capital funding.

[29] Putting it all Together - Chapter 13. Economic Modelling
[30] Putting it all Together - Financial Model
[31] Putting it all Together - Chapter 13. Economic Modelling
[32] Putting it all Together - Chapter 11. The Local Scale & Cost of Health and Social Care
[33] Putting it all Together - Chapter 13. Economic Modelling

The purpose of developing the financial model lay in the belief that it should be possible, in the face of perceptions that economies of scale, specialisation, and competition must always militate against local community solutions, to show that the “Vision” is economically viable in comparison with the current options. We believe that this has been demonstrated. The question is why! - The reasons are various e.g. effectiveness (rather than efficiency) of local team working, lean management structure, resource sharing, flexibility, volunteer involvement, low overheads, collaborative working, coordination, visibility, simplicity of structure, motivation, etc. All of these can be relatively easily achieved at the relatively small scale of the individual community but represent major difficulties in large organisations which are seeking to tackle a problem for which they were not originally designed. Also, and in particular, the scheme’s integrated and flexible design of the extra-care facility enables clinical grade nursing to be provided without a dedicated hospital ward.

8. Benefits to patients, families, and the community: Whilst the economic argument generally has to be satisfied before any new initiative, approach, or project can be considered for adoption, this study was initiated by local people seeking better and more available care, and definitely not about making financial savings. We believe that, by and large, the population accepts the overall cost of health and social care, but is concerned that the money spent should lead to significant improvements in the provision of services at the patient/client level.

In the initial “Vision of Caring” paper we showed that the approach proposed would offer a multitude of benefits at the local level, and further benefits were identified in “Putting it all Together”[34]. Just some of these can be broadly expressed as follows:

Patient Care: Continuity and smooth escalation of support, familiarity with the team who are providing care, simple and straightforward access to information and advice, visibility of who is in charge of their care, excellent housing and domiciliary facilities and services, integration providing a simple and coordinated approach to their care, person-focus, choice (of being cared for in the community), maintenance of relationships, continued community involvement, Holistic approach to care, time for the patient, increased services and resources, etc.

Quality standards: A local and named team of professionals provides a natural visibility of quality service, monitoring and reporting of problems is encouraged, local people caring for local people encourages high motivation and commitment, a clear and straightforward management structure and allocation of responsibilities leads to simple but effective care, etc.

Family and community involvement: Providing care in the community when domiciliary care is not possible allows family, friends, and

[34] Putting it all Together - Chapter 14. Patient, Client and Community Benefits

neighbours to continue to provide (unpaid) care and maintain relationships, etc.

Community ownership: Strong / leading community involvement ensures that the provision of services meets the needs. Community ownership fosters a strong sense of pride and a desire to both, give more in terms of volunteer involvement, and to develop further facilities and services.

Employment: Opportunities for jobs during the development of buildings and facilities. Opportunities for local full-time and part-time employment in personal care and care support for youngsters, mums, dads, grandparents and others. Opportunities for professional career development and training lead to high level skills within the community.

Housing: The ability for an elderly individual and couple to move out of a large home and into an extra-care apartment releases property for young families, and affordable accommodation. It also provides an efficient and low cost form of equity release in order to cover social care costs.

Overall, in its potential benefits, the "Vision" potentially overcomes many of criticisms of the current system.

9. Financing: The operating financial and economic viability of the proposal appears positive, provided that the NHS is prepared to fund the scheme for clinical nursing, intermediate care and residential nursing care, and continuing care at the equivalent tariffs currently applicable to hospitals, nursing homes, and the other current service providers. Also that Adult Care services are prepared to do similarly for the social care services. Finally, that the NHS and Adult Care services are willing to create funding streams which represent a (negotiable?) proportion of the cost savings which will accrue to their organisations. This proposal is not about making savings – it is about providing a future for the elderly-frail in our rural counties.

However, a necessary feature of the "Vision of Caring" is the provision of buildings, equipment, and facilities. This represents a significant financial investment. For the purposes of establishing economic viability, the "Financial Model"[35,36] assumes that this will be in the form of a commercial loan charged at about 6% pa. This is considered to be just about a "tolerable" funding arrangement provided some form of "guarantee" can be arranged with the DoH, or other government agency, to offset any perceived risk. The servicing of such a loan represents the major single item in the operating costs. Ideally, we would hope that an interest rate significantly closer to the 10 year bond rate could be negotiated. However, we are also confident that other forms of finance will be possible[37] and thus reduce the dependency on loan capital, spread the risk, and encourage "local investor" participation in the policy

[35] Putting it all Together - Chapter 13. Economic Modelling
[36] Putting it all Together - Financial Model
[37] Putting it all Together - Chapter 17. Funding Aspects and Financial Security

management of the scheme.

Of particular interest are schemes which actively encourage local people, or people with local connections, to play their part through innovative arrangements such as:

Development:

Shares: dividends payable in future care provision

Tax-free debentures: redeemable against future care costs

Care investment/insurance packages: delivering attractive transferable returns to use for care provision.

Care savings plans: allowing regular payments into a pot which is supplemented through the tax/NI system when drawn out for payment of care costs.

As well as the more traditional sources of finance such as loans, grants, ordinary and preference shares, shared equity, etc.

Operating:

The financial model has identified the key funding streams which include;

GPs authorising payments for clinical, intermediate, continuing and residential nursing care at the current tariffs applicable to hospitals and registered care providers.

The designated community social worker authorising payments for intensive residential care, day care, and domiciliary personal care at average rates paid to registered providers.

The CCG and Adult Care Services providing a regular payment based upon the estimated cost benefit savings.

Those patient/clients charged in full (private), or in part (supported), for services.

The NHS and Adult Care Services paying for staff who are currently allocated to the catchment area.

The aim is for the “Vision” to, at least, balance the budget but preferably to be able to invest in additional services e.g. out of hours GP on-call and on-duty attendance.

10. Implementation and Realising the "Vision": The adoption of the concept of the "Vision of Caring" and then putting it into practice would represent a significant change in current health and social care philosophy[38] and could not be considered without one or more pilots to practically demonstrate its viability.

However, once this has been achieved we hope that a decision will be taken to encourage communities, CCGs, local authorities, and housing associations to create similar schemes across, initially, the rural counties and medium sized towns, and subsequently, to adapt the concept for urban environments. We see the role of government as creating the "environment" in which the development can occur as a natural evolutionary process. Our discussions over the life of this study have suggested that the "Vision" defines the ideal, and that when it is seen to be working in reality, other communities will be keen to follow the examples and invest similarly. As a first step we have suggested the promotion of a set of aspirations**:**

> To provide community-led, person-centred, and integrated health and social care for all elderly-frail members of our community, and which meets their individual needs irrespective of their degree of frailty.
>
> To respect and value the continued importance of all older people to their families, friends, and community, and to enable them to remain active participants in the social life of their community.

In order to achieve these, some changes and investments will/may be required but all are felt to be readily achievable - although requiring some organisational adjustments and, in some cases, shifts in the NHS and Social Care "mind-set".

Recommendations:

> Adopt and publicise a set of "aspirations" for the care of all elderly frail people.
>
> Ensure that the current legislation and funding will encourage and support new ways of caring for our ageing population.
>
> Sponsor, enable, and fund a number of community-based innovative projects which will test new approaches to the care of the elderly-frail.
>
> Set up a low interest loan guarantee arrangement to encourage local communities to invest in their health and social care.
>
> Share the estimated savings to the NHS and Social Services with the schemes to provide for further investment.
>
> Give local GPs (i.e. the patient's GP) the authority (and confidence) to decide the best course of treatment and care for their patient.

[38] Putting it all Together - Chapter 4. Strategic Issues (Rural)

Define the management of the health and social care of the patient/client as the joint responsibility of their GP and a social worker dedicated to their community.

Enable GPs to pay for the care of their patients locally (provided the facilities and resources are available), at the current tariffs that apply for the same level of nursing care in hospital.

Lend full support to such "on the ground" changes in practices within the NHS, Adult Care, and housing services as will lead to a local integrated team-based approach to the care of the elderly.

Develop and implement a "Rural Strategy"[39] to balance the support of the rural elderly population relative to its urban equivalent.

We cannot predict how fast the UK-wide adoption of community-based, community-led, provision of health, social care and housing for the elderly-frail might be. However, once the clear benefits and economic viability of the "Vision" (and other potential innovative approaches) have been demonstrated, we believe that there will be an exponential growth in demand to begin with – starting slowly but accelerating as awareness and the availability of finance increases – and then steadying if and when the DoH introduces a national programme to manage the rate of implementation. If it is treated as an important national infrastructure project it may be realistic to see something like a 90% penetration within 2 decades.

On the basis that a pilot to prove the economic and patient/client benefits will need about 2 to 3 years to create, 2 to 3 years to mature, and a further 2 to 3 years to establish its effectiveness, it is argued that any pilot should be commissioned to run for at least 10 years. Nevertheless, it will become clear whether the approach is likely to confirm the predictions of positive cost benefits, improvements in quality of service, and potential in addressing the care of our ageing population, within a five year period. Therefore, planning for roll-out could start as early as 4 years.

As to the investment cost of implementing such a programme for the rural and semi-urban communities of the UK, estimates cannot be made with any confidence until the financial model presented here is backed up by one or more pilot implementations. However, and this is "back of the envelope" calculation, taking the investment identified in this study, and assuming that this will be typical on a per capita basis across the UK, the total funding needed would be in the region of £33B over 20 years or about £1B pa rising to a peak of about £3B pa. This is probably a very much top-end estimate since, as the programme progresses, experience will lead to cheaper ways of implementing the accommodation and facilities. It is

[39] Putting it all Together - Chapter 5. A Rural Strategy

suggested that much of this investment will come from the housing associations in the form of government backed loan capital. It should be born in mind that this level of national investment must occur in any event to meet the needs of the elderly population irrespective of what approach on health and social care is taken. The choice lies in whether it is spent in the current way or whether it is spent in a way which can lead to a new "renaissance" in the NHS and care services.

11. Some Final Points: Clearly our viewpoint is that of the rural and semi-urban communities and reflects their particular range of situations. However, we strongly believe that a lot of what has been presented will have relevance in other settings. A number of points, which are particularly relevant, have emerged over the period of the study and which are worthy of consideration.

1. Elderly people are generally very reluctant to move into residential care when looking after them safely and securely in their own homes becomes impractical. However, they would be much more positive if they saw it as "just moving down the road into more suitable accommodation" and they could remain in their community, still being supported by nearby family, friends, and neighbours.

2. Many families feel guilty about persuading their spouse, mum or dad to move into residential care. This is particularly difficult when it means a separation of partners, and especially so when it involves them being separated by 7, 10, 14 miles with limited transport systems available.

3. Generally, amongst elderly people, there does not seem to be an obvious desire (or ability) to exercise choice between NHS hospitals providing the same service, in order to get the best (or avoid the worst). They are primarily concerned that they receive a quality standard of service appropriate to their needs, and <u>when</u> they need it. They trust "the system" to "be fair and honest".

4. Some elderly people view moving to a retirement village as a way of downsizing, planning a simplified lifestyle, and also, perhaps, releasing equity, but others are very concerned about becoming segregated.

5. Those who are elderly and frail (and their family carers) overwhelmingly ask for a maximum of services to be provided locally by familiar professionals and volunteers with whom they can develop positive relationships.

6. Transport can be a massive problem, especially when the family carer is an elderly spouse who may never have held, or is now prevented from holding, a driving license. It is also a significant problem (in terms of travelling time) in the provision of professional care by domiciliary care agencies.

7. Elderly persons (and the rest of us!) often express a lack of understanding or control in their relationships with the NHS - significant communications problems- lack of visibility - handed from one consultant/doctor to another - no clear personal responsibility for their care – etc

8. Over 40% of those who are elderly and frail have significant symptoms which are consistent with a diagnosis of dementia (as well as their other ailments). For them, familiarity of carers and surroundings is essential – the level of disorientation due to hospitalisation or commitment to residential/nursing care can be overwhelming for them and initiate a downward spiral in their condition. For family carers having to cope with the illness, locally available services, understanding by the medical profession and community-based support are of prime importance.

12. Conclusion: This paper has presented the results of a 4 year research and consultation activity in the form of **"The Vision of Caring"** - a new approach to the care of the elderly and frail in rural and semi-urban communities. It has shown that developing a local "System for Care" could offer a significant step forward in the quality of life for those who need health and social care services and support. However, it has also suggested that this can be achieved at or below the current cost of delivery.

In developing this model it has become clear that the present form of the NHS is not structurally suited to tackling the scale of the problems presented by our ageing population and a medium to long term strategy is needed which explores innovative approaches such as this one. We believe that a number of pilots should be commissioned to evaluate the potential of the "Vision".

It is believed that the only solution to the care of the elderly-frail lies in fully engaging individual communities in their support, and their taking a lead role in the provision of their care.

The challenge is to explore the ideas presented in this paper and to invest in them.

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