3rd July 2018

"Putting it all Together"- Resume

Introduction: On the 23rd April 2009 at a public meeting, it was decided that Debenham would "get on and do something" to tackle the growing problem of dementia. **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].

However, at the very first public meeting we were also asked to "have a vision" for how we want all those who are elderly and frail to receive the care and support they need without having to leave their community.

> 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?
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> 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?
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> 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 study of how comprehensive care might be delivered in a rural and semi-urban setting.

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 library, a leisure centre, two pubs, sheltered accommodation, and the local GP practice. With regard to health and social care the only local provided services, other than the GPs and community nurses, are provided by The Debenham project. Personal care is provided by remote care agencies together with a limited number of self-employed carers. The nearest residential nursing home is 7 miles distant (with no public transport) and 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 £6.7M pa. 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[2], 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%[3]

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

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

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

Aspirations:

To provide a community-led, person-centred, and integrated health care, social care, and housing approach for all elderly frail members of our community[4] which meets their individual needs irrespective of their degree of frailty.

To respect and value the continued importance of all who may be elderly and frail to their families, friends, and neighbours and to enable them to remain active participants in the social life of the village.

Proposal: We now have confidence that an innovative community-based approach to the provision of health and social care is within our grasp – one which not only offers a quantum step forward in the quality of care but will also be cheaper. This is **"A Vision of Caring"[5]**. 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 focusing only on the real needs of the elderly person and their family carers. It will require investment and some changes in practices but it is predicted to save more than 10% on the annual costs to the NHS and the local authorities. It is suited to most rural areas and market towns and may have application in more urban environments. This equates to more than 60% of the over 65 population in Suffolk.

The "Vision of Caring" is a system designed to maximise the amount and quality of care and support that can be delivered within the community. It is based upon the central concept that as we grow older, we increasingly "wear out" and "acquire" multiple chronic ailments. By and large these ailments intensify with time and with it, health, social care, and housing support needs to continually match the changing needs of the individual. This concept is known as "The Flow of Frailty". This can only be achieved through "local" management and understanding. In the long term it cannot be met by the current NHS and Local Authority organisational structures[6].

The "Vision of Caring" is an integrated care system (health care, social care, and housing) designed to provide comprehensive and holistic specifically designed to meet the needs of the elderly frail members of a rural or semi-urban community. Its fundamental concept is that the care of the elderly is primarily the responsibility of their community and that a new model is required to supplement those of the NHS and the Social Services. We see that hitherto care ahs been a bi-partite responsibility of the NHS Primary Care and Adult Care Services, but, we argue that when it comes to the problems presented by an ageing population, this must become tri-partite with the community taking a leading role.

In practical terms the "Vision of Caring" means that, in collaboration with the local GP practice and the local element of the Social Services, the community is taking responsibility for the management of the care of its elderly frail. To do this will require:

[4] The catchment area of the community is loosely defined by a radius of 4 miles from the centre of Debenham (total population 6,500. It is also related to the area covered by the group GP practice (pop. 8,500).

[5] http://www.old.the-debenham-project.org.uk/downloads/steeringdocs/A_Vision_of_Caring_rltse7.pdf

[6] Structural and systematic problems.

This model for rural care has, since its first proposal, been examined by a variety of senior professionals in the field[7], refined, and further developed in the light of their comments. In the process the model has been subjected to the rigour of the system design process which is used to translate the needs of the customer through to a valid implementation. On the way the key drivers, requirements, and design concepts for a **"System for Care"** have been identified and documented, probably, for the first time from a community perspective. The result is that we can present, not only a solution to the future needs of the elderly frail in our community based upon a sound well-researched foundation – service, business, and financial – but also that we can show how it might be realised. **"Putting it all Together"[8]** is all about saying "you are pushing against an open door", so "why not walk through"?

The pilot that we are proposing will demonstrate that there is an alternative approach (at least for the elderly frail who live in Suffolk's rural areas) to the care of our ageing population. It is fully understood that government and local authorities cannot "pay for" the sort of investment we propose on a county or national scale until it can be proved successful. Even then, their role would be of encouraging and enabling rather than direct investment. The current task is to recognise our aspirations and take the essential steps to show what is possible and that:

"If it is not good enough for my mother, it is not good enough".[9]

[7]From the SCC, NHS, housing associations, charities, etc

[8] https://www.old.the-debenham-project.org.uk/downloads/articles/2014/Putting it all Together - The Vision of Caring.pdf

[9] Judith Hawkshaw M.B.E.