Draft V1.0

18th July 2018

"Putting it all Together"
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The Vision of Caring – The Key Features and Concepts

Providing quality health, social and housing care for the elderly-frail is the prime determinant, as a nation, of our claim to be a caring society. However, each of these 3 pinions is struggling to meet the need within their current structures. Innovative approaches are needed which are more effective in matching the available resources to the reality of an expanding demand in the face of a static funding regime.

The Vision of Caring[1] was researched and developed in response to the challenges that our ageing population represents for the NHS, Social Care, and Housing particularly in rural and semi-urban communities[2]. Its primary objective is for the local community to take responsibility (with the support of the NHS, Adult Care Services, and Local Authority Housing Services) for the provision of comprehensive care of the elderly frail in their catchment area.

The key features of the "Vision" are:

1. A community-led solution to the care of the elderly-frail.
2. A "System of Care" integrating health, social and housing care at the working level.
3. A next generation extra-care facility incorporating assisted living, residential, general nursing, longer-term nursing, dementia and end-of-life capacity.
4. A "First Port-of-Call" for non-critical emergencies.
5. An approach which manages the care of our elderly residents in most cases within the community but when needed, draws in the specialist and more experienced professional services of hospitals and Adult Care when necessary.
6. A person-centered bottom-up structure, which matches the local needs of the elderly-frail, to the provision of integrated and holistic care services.
7. A lower cost alternative to the current approach[3].

The aspirations of the "Vision" are:

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

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[1] http://old.the-debenham-project.org.uk/downloads/steeringdocs/index6/Putting_it_all_Together_The_Vision_of_Caring_wtniyc6.pdf

[2] Together, it is estimated that more than half of the over 65s reside in these two sectors of the population. In addition, it is known that on an individual basis they are significantly disadvantaged in terms of provision and ease of access to services

[3] The estimated savings are in the region of £400,000 pa relative to an expenditure of between £5M to £6M pa.

2. To recognise the importance of the elderly to their families, friends, and community; and to assist them to continue to be active in the social life of the locality.
3. To enable family, friends, volunteers and neighbours to continue to support those they care for irrespective of their frailty.
4. To offer those who are unable to remain safely and securely in their homes the choice of remaining within their community with their family and friends, and to minimise the potential separation of partners due to increasing frailty.

The objectives of the "Vision" are to create a "System of Care" by which:

1. No-one who is elderly and frail should have to be admitted to hospital except in the most serious of situations.
2. If someone has had to be admitted to hospital they will be able to be returned to their community at the earliest moment to be monitored, nursed and cared for in their own community, in collaboration with their hospital consultant.
3. Hospital A&E attendance should no longer be considered as the first choice. The capability of local assessment with the assistance of remote (IT) hospital-based consultants should be used to limit unnecessary admissions.
4. Frail-elderly people should mostly be treated and/or cared for in their own homes, but when this may not possible or advisable, they can be cared for in a local extra-care facility until such time as they are enabled to return home (or they can be cared for longer-term in the local facility).

In order to realise this, the "Vision" proposes the following:

1. A "Comprehensive Community Care Trust" that encourages, develops, implements, and manages all the local aspects of the care of the elderly frail in the area[4] care. This is to be led by the community's stakeholders – local charities, service users, local council, GP practice, social services, accommodation management, etc.
2. An organisation which provides staff and facilities so that most health and social care problems can be handled within the community - Four (named) local teams, integrated within the trust, providing nursing, social care, housing, and community services across the community.
3. A next-generation extra-care[5] facility which provides 40 apartments for those who may not be able to remain safely in their own homes but with social and/or health care support can continue to live independently. The building will also provide limited residential, nursing, and dementia care accommodation either as satellite units or by dynamically utilising temporarily empty apartments.
4. 24 hour emergency digital X-ray, ultrasound, ECG, on-line access to A&E consultants and other specialisms, bloods/tests (increasingly local but otherwise fast-tracked by the hospital path lab), etc.
5. The capability for simple orthopaedic treatments and other minor procedures which would normally be carried out in an A&E department
6. Collaboration with specialist hospital staff to provide remote/on-line consultation and advice for initial assessment, diagnosis and treatment, access to pathology and technical services, monitoring patient recovery and rehabilitation, etc.
7. Responsibility for the health and welfare of the person to be the joint responsibility of their GP and the "Practice Social Worker ".
8. New funding arrangements.

An initial list of the key anticipated benefits of the "Vision" is:

1. Continuity and familiarity of care as people get older and need more support.
2. Reduced hospital admissions and durations of stay.

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[4] Broadly, within either a 4 mile radius of the centre of Debenham, or the group GP practice catchment area. This relates to a population of between 6,500 and 8,500.

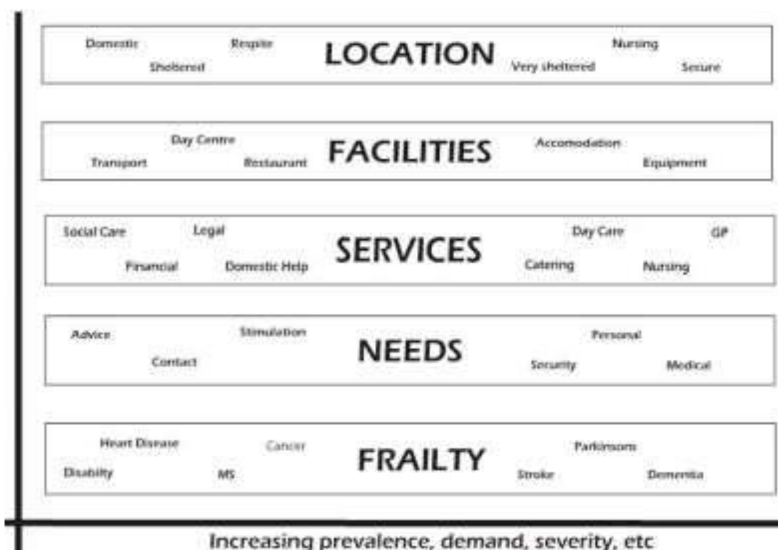
[5] Apartments (homes) in which elderly-frail residents can live an enabled life with close access to personal and health care. Residential, nursing and dementia care hotel style accommodation for those who need more intensive support is flexibly incorporated in the design.

3. Significant improvement in quality of care and availability of local services.
4. Reduced cost.
5. Maintenance of family involvement and relationships.
6. Graded response to an individual's increasing frailty.
7. Significantly improved recovery times and outcomes.
8. Direct involvement of family and friends in the care process.
9. Reduced cases of husband/wife separation.
10. Reduced demand on current GP appointments.
11. Straightforward access to services.
12. Improved illness and crisis prevention.
13. Increased ability to enable elderly-frail people to stay in their own homes.
14. Improved health and wellbeing of the elderly.
15. Enhanced wellbeing and community services for the elderly and their family carers.
16. Community "ownership" of the problem and the willingness to initiate further services.

The "Vision" has developed some new (in terms of the field of health and social care) concepts:

1. "The Flow of Frailty": This is expressed in the conceptual flow model which tries to show that as

Figure 1. The Conceptual Flow Model



we age there is an increasing risk of medical and psychological conditions which combine to lead to frailty and the need for health and social care support. It also provides a model that simply and logically maps these conditions to the needs of the individual and relates those through to the services and facilities which are necessary to their care.

2. "A System Solution": This is generally thought to be essential in building a sound solution to complex problems. It follows the natural pattern of firstly assessing the "client" requirements and then logically moving through to specification, design and implementation.

3. "Modularity": This involves structuring the solution into (broadly) independent parts which work together within the whole system but have freedom to evolve to meet changing needs.

4. "Object orientation". This is a way of simplifying the design and construction of very complex systems. It defines an approach in which the local management (core system) accesses the standard services (objects) provided by the NHS, Adult Care, charities, community, etc. as required whilst maintaining overall control.

5. "Localisation": This is the process by which the services that are provided (and perhaps discarded) are defined and managed locally as a result of "getting on and doing something" (you will quickly know if it's not a good idea!) together with the continuing attention to "on the street" feedback.

6. "An integrated multidisciplinary team": This means having access to all the essential health and social care professional skills on a personal (**named**!! and **team!!)** basis so that access in a crisis is direct and clear, and communication between professional disciplines is maximised. The perception of

the client must be of a team of friendly professionals rather than a number of disparate amorphous organisations.
7. “Structured care facilities” This expresses the need for a local, integrated, and flexible approach to the provision of domiciliary, day, very sheltered, intensive residential, secure, respite, and general nursing services.
8. “Community responsibility”: This indicates that the organisation of the health and care of the elderly frail must be guided by those who are close to them. By and large, those “on the ground” are, within an overall framework, best placed to know what is appropriate for the individual and the community.
9. “Immediacy”: This is defined in both time and geography inasmuch as, unless it is clear that care has to be provided remotely e.g. in a major medical crisis, the preferred option is to provide care using local facilities and professionals. It is easier for local professionals to respond quickly and triage cases as appropriate.
10. “Tele-consult”: This seeks to make the diagnostic skills of the experienced consultant available in the local situation. Given that an experienced nurse or GP is available to know / take patient histories and be guided in their examination and assessment of symptoms, it should be practical, using current technology, for the A&E consultant to respond to the patient’s immediate medical needs and recommend treatment. On-line local X-ray, Ultrasound, ECG and fast-track bloods facilities should normally be sufficient for most circumstances.
11. “Personalisation” This means that professionals must be prepared to develop personal relationships with their clients - to know, understand, and care for them in their current, historical and emotional contexts – delivering a service is not sufficient.
12. “Virtual hospital bay”. This is a way of dispensing with the need for a dedicated hospital ward by so designing the extra-care facility that temporarily unoccupied apartments and bedsits can be used for clinical nursing. “The Virtual Hospital Bay” concept includes the care of persons in their own homes.

Finally:
Based upon the above, the “Vision of Caring” has been developed. The reader is cautioned against viewing the “Vision” as a physical “bricks and mortar” entity – it is an community-led organisation encompassing the extension and integration of existing services which utilise current community-based facilities, together with the provision of new local care capabilities.

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