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"Putting it all Together"

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The Vision of Caring – Financing, Implementing and Realising the "Vision"

The operating financial and economic viability of the proposal appear 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.

However, a necessary feature of the "Vision of Caring" is the provision of buildings, equipment, and facilities which represent a significant financial investment. For the purposes of establishing economic viability, the "Financial Model"[1,2] assumes that this will be in the form of a loan charged at about 6% pa. This is considered to be a "tolerable" funding arrangement provided some form of "guarantee" can be arranged with the DoH, or other government agency, to offset any perceived risk. 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[3] and thus reduce the dependency on loan capital, spread the risk, and encourage "local investor" participation in the policy 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

[1] Putting it all Together - Chapter 13. Economic Modelling
[2] Putting it all Together - Financial Model
[3] Putting it all Together - Chapter 17. Funding Aspects and Financial Security

Tax-free debentures: redeemable against future care costs

Care investment/insurance packages:

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.

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[4] 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 the study have suggested

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

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, and
>
> 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.
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> Ensure that the current legislation and funding will encourage and support new ways of caring for our ageing population.
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> Sponsor, enable, and fund a number of community-based innovative projects which will test new approaches to the care of the elderly-frail.
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> Set up a low interest loan guarantee arrangement to encourage local communities to invest in their health and social care.
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> Share the estimated savings to the NHS and Social Services with the schemes to provide for further investment.
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> 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.
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> 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"[5] 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 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 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 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 new "renaissance" in the NHS and care services.

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