The Five Year Forward View: the NHS needs to change

The NHS is the UK's most valuable – and most prized – asset but parts of it are under severe strain. For the NHS to continue to deliver safe, high quality and effective health care, embedding the principles of delivering universal health care free at the point of delivery, it has to adjust to the changing demographics and meet the challenges, especially of the growing elderly population with increased morbidity and complex health pathologies.

The Five Year Forward View (NHS England, 2014a) is, for the first time, planning to address the challenges of health care by taking a long-term view over a 5-year period. This document argues for more empowerment and engagement of patients and the public, for promotion of wellbeing, prevention of ill health, and suggests new models of care with diverse solutions, both locally and nationally.

The NHS has to address a number of challenges in relation to public health and prevention, empowering patients and engaging communities, but the biggest challenge for the NHS is to develop and deliver a model of care for the growing elderly population.

The UK has an increasing elderly population and as the demographics of society shift towards an ageing population, the health-care needs of the population over 65 years of age will undergo an enormous change. In 2010, 17% of the UK population was over 65 years of age, with the very elderly (over 85 years) accounting for around 2% of the total population. It is projected that by 2035 the percentage of the population over 65 years will rise by 50% to 23% of the total population and that over 85 years will more than double to 5% of the total population (Office for National Statistics, 2012). It is estimated that the prevalence of physical dependency, disability and chronic conditions will rise proportionately in these groups.

Care of older people

The elderly are a heterogeneous group with diverse health-care needs. These needs take them on a journey between their homes, community, primary care teams and secondary care facilities – a path that can sometimes be tortuous and lengthy.

Among this heterogeneous group the frail elderly carry a significant high mortality during this journey of care, because of associated comorbid conditions.

Currently services tend to cater mainly for patients with a single pathology, but are used by elderly frail people with multiple pathologies. As a result of the above, the continual stretch of emergency and social care, and the lack of functional reserve to adequately respond to external stresses in times of highly predictable and unpredictable needs, it is not surprising that the elderly are the greatest users of hospital services.

- Nearly two-thirds of people admitted to hospital are over the age of 65 years
- There are more than two million unplanned admissions per year for people over 65 years of age, accounting for nearly 70% of hospital emergency bed days
- When admitted, older people stay in hospital longer and have higher readmission rates.

The greatest growth can be expected in the number of people aged 85 years or over – they are the most intensive users of health and social care.

Continuity of care

Continuity and the coordination of care are fundamental to high-quality, cost-effective health care. In the context of acute care, the risks of fragmentation and breakdown in care coordination are high, especially for older patients (Future Hospital Commission, 2013). Too many patients and carers do not know 'who is in charge' of the patient's care, who they can talk to about it and how to get answers to their questions. Relatively small changes in practice can significantly strengthen patients' and carers' relationships with clinicians and contribute to greater consistency of clinical management.

Health care of older people: Sweden

The Swedish model for care of older people (Organisation for Economic Co-operation and Development, 2013) is recognized as a leading model for the changing demographics and viewing the elderly as a success rather than a burden. Of Sweden's 9.7 million inhabitants, 18% have passed the retirement age of 65 years. This is projected to rise to 30% by 2030. Life expectancy in Sweden is among the highest in the world. In 2010, it was 79.1 years for men and 83.2 years for women.

Sweden has the second largest proportion of people aged 80 years or over among the EU member states. Since more and more citizens in this age group are in good health, care requirements have declined since the 1980s. Most elderly care is funded by municipal taxes and government grants.

Elderly people with disabilities can receive assistance around the clock, which means that many are able to remain at home throughout their lives. The severely ill can also be provided with health and social care in their own homes.

New models of care

It is important that new models of care are centred on patient care across the whole pathway with integrated primary and acute care sectors. Community providers may take a number of different forms and smaller and community hospitals may need to provide new services if they are to remain viable. Care homes and care homes with specialization need input from community specialists and teams with the aim of developing protocols for models of care.

Workforce

The greatest strength of an organization is its people. For the NHS to continue to deliver high quality, safe and effective health care, it is important that the workforce is skilled, trained and motivated in order to deliver these values. The changing demographic challenges will require a workforce which works across hospitals and communities and which has flexible skills and the ability to adapt and innovate (NHS England, 2014b).

Consultants from various specialities, led by consultant geriatricians, physicians and orthopaedic specialists, will have a leading role in developing and delivering integrated health care, working in partnership with hospitals, GPs, allied health professionals and ambulance trusts. These community developments and improved care and support in the community will have a direct impact on the pressures on accident and emergency services and also improve the working life of existing staff which will attract returners to emergency medicine. In specialities such as accident and emergency medicine, it is important that workforce development, job satisfaction and work–life balance are given high priority in all future models.

Public health and wellbeing

There needs to be a comprehensive and concentrated plan and action on issues such as health education, health promotion, and public health and wellbeing. Smoking, alcohol, obesity, inactivity and sedentary lifestyles, the prevention of diabetes and encouragement of healthier lifestyles need to be addressed by a joined-up approach. In relation to the elderly, the prevention of falls, prevention of strokes, avoidance of unnecessary hospital admissions and the use of care plans and protocols for older people in care homes are all equally important. To address health inequalities it is important that there is a focus on vulnerable groups and groups such as black and minority ethnic communities who have an unusually high incidence of specific diseases, e.g. diabetes and heart disease. It is also important for commissioner providers and the Local Government Association to develop and deliver models of public health prevention in partnership with and addressing the needs of locally diverse communities.

Conclusions

As the demographics of a society shift towards an ageing population, the provision of health and social care needs will undergo an enormous change and pose considerable challenges. Improvements in public health and wellbeing, health education and health promotion, and patient and public empowerment will need to be accompanied by a flexible, well-trained workforce skilled to deliver new models of care throughout the whole pathway. By general consensus, the NHS will need an injection of funds to the tune of £25–30 billion. While there may be considerable debate on where this funding comes from and how, it is quite clear that for the NHS to survive it has to develop and deliver a different model of older peoples' care.

What is needed is a model that is not fragmented and focussed on isolated areas, but one that delivers integrated and joined-up care with services that are organized with patients right at their heart and delivered at the right place and the right time with an overriding focus on community and home care. Only with adequate planning and coordination between various teams and by providing an effective interface between them, can the frail and elderly, in a diverse society, be assured of a smooth, safe flow in their journey of care in acute hospitals, intermediate and community hospital services, homes and care homes. **BJHM**

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KEY POINTS

- The NHS needs a new model of integrated health care.
- It is essential that compassion underpins the delivery of care to the growing elderly population and that society views the demographics as a success rather than a burden.
- There needs to be a concentrated and comprehensive plan for health education, health promotion and public health.
- Workforce planning needs to focus on developing a highly skilled and flexible workforce which is competent to deliver care across the whole pathway.