The Health and Social Care System in 2025 – A view of the future

Supplementary note to House of Lords Committee on Public Service and Demographic Change

The King's Fund

Introduction

This note sets out the key features of how the health and social care system might look in 2025. It draws on four King's Fund publications, attached for the Committee's reference.

- *Transforming the delivery of health and social care: The case for fundamental change* (2012)
- *Overview: Future trends* (2012)
- *Where next for the NHS reforms? The case for integrated care* (2011)
- *Transforming our health care system: Ten priorities for commissioners* (2011).

The vision set out is a preferred vision and not necessarily the most likely vision. Medical and technological advances offer new means to treat disease and enable a much more collaborative and integrated approach to care that truly empowers patients and service users. However, unprecedented financial pressures in the short to medium term, alongside growing demand for care, pose a number of threats: first, to the viability of many providers of health and social care; second, to the NHS's capacity to provide a comprehensive range of services; and third, to the quality of health and social care services.

The way in which health and social care are delivered needs to be fundamentally reformed if services are to rise to the financial pressures facing the system and provide care appropriate to the needs of the population in future.

The population being served in 2025

As the Committee will be well aware, in 2025 the population will have many more people aged over 65, with the numbers aged over 85 expected to grow rapidly. These people are the most intensive users of health and social care services and account for a high proportion of the costs of care. For example, the current health and social care costs of people aged over 75 are more than twice those of an adult aged 35–44.

The population as whole will also be carrying a high burden of chronic disease with many people having multiple chronic conditions. By 2018 the number of people with three or more long-term conditions is predicted to grow from 1.9m to 2.9m. Many people will also lack immediate social support as the number of people aged over 65 living on their own is also expected to grow.

A new model of care

Demographic changes and the shifting burden of disease require a re-assessment of the hospital-centred model of care that currently prevails. A new model of care is needed, less oriented to treating people when they become ill and more focused on prevention. This must be accompanied

by a progressive shift in resources away from acute hospitals to providing care in and closer to people's homes. Meeting the needs of an ageing population, and especially people with multi-morbidity, requires services to be integrated to overcome the divisions between primary and secondary care, physical and mental health, and health and social care that inhibit the provision of high-quality co-ordinated care.

Key elements in the new model

Prevention of ill health: *action at the population/community level and targeted at individuals to identify people at risk, address risk factors and fully engage the population in bringing about further improvement in life expectancy and quality of life, and reduce health inequalities.*
What this means in practice: doctors, nurses, health and social care providers and commissioners making much greater use of population-based information and then working in partnership to improve the wellbeing of the local population. Targeted approaches, including brief interventions by GPs, could result in improvements in people's health-related behaviours such as smoking and drinking. These interventions need to recognise the clustering of risk factors and unhealthy behaviours, and the wider determinants of morbidity and premature mortality that lie behind this clustering. Action across government is also needed to tackle risk factors such as obesity and overweight.

Supported self-care, shared decision-making and self-directed care: *action to enable individuals, carers and families to make choices about their care and to continue to play a key role in looking after themselves.*

What this means in practice: People will be actively involved in decisions about their care and fully informed about the risks and benefits of different treatment options. Individuals will be equipped to manage their own health and care. This could include the use of smart phone apps, assistive technologies in the home, home adaptations, access to personal budgets and training programmes. The miniaturisation and automation of drug delivery will also enable more drugs to be self-administered and more care to be delivered at home, for example, the provision of intravenous antibiotics. It is important to note that each individual will have a different degree of enthusiasm and capacity to take on responsibility for their care and services will need to adapt to this.

Enhanced primary care: *action to reduce variations in the quality of primary care and to provide additional services that help to keep people out of hospital.*

What this means in practice: This requires a network of primary care providers in each locality in order to promote and maintain continuity of care with local people and act as hubs not only for the provision of generalist care but also for access to diagnostics and chronic disease management. There will need to be active support to help practices improve practice and reduce unwarranted variation in standards of care. Primary care needs to be more accessible to patients out of hours to reduce inappropriate demand on overstretched hospitals.

Co-ordination and integration of care: *action to link primary care teams more closely with specialists and with health and social care professionals to ensure patients and service users receive care that is effectively co-ordinated.*

What this means in practice: This will be facilitated by IT systems that connect different parts of the care system, health and social, mental health and physical health. Access to a shared care record, active support for team-working, investment in new skills for many workers – particularly frontline care staff – and greater clarity about the respective roles of specialists and generalists within the team will enable effective multidisciplinary working. Networks of primary care providers must work closely with community nurses, social workers and other community staff to provide a rapid response to the needs of patients and to make a reality of care closer to home.

High-quality, safe specialist care: *action to concentrate specialist services in centres of excellence able to deliver the best outcomes where this is supported by evidence, supported by networks that link together expertise in different settings.*

What this means in practice: Hospital provision will become increasingly differentiated. People will no longer be able to look to their local hospital as a comprehensive provider of care. In many cases, patients currently cared for in hospitals will be looked after in their own homes with support from multidisciplinary teams. In other cases people will be treated in more distant hospitals able to deliver better outcomes for patients needing some forms of specialist care. Developments in care co-ordination should mean that any stay in hospital is not experienced as an isolated episode of care but part of a continuing relationship with care services. Hospitals will work together in networks to provide access to the right care in the right place.

Conclusion

The approach we advocate requires a shift in the way care is delivered, with much less reliance on clinicians practising autonomously in a 'cottage industry' model and greater emphasis on standardising care around best practice guidelines supported by routine monitoring of performance and transparent reporting. This includes understanding in real time the experiences of patients and service users and using the results to bring about improvements in performance. The focus in future needs to be on the whole system of health and social care and how this can be effectively co-ordinated around the needs of patients to deliver high-quality care in the most appropriate settings. More care will be provided in people's homes and in the community and hospitals will focus mainly on the treatment of patients who need the specialist expertise that cannot better be provided elsewhere.