Ageing well and the NHS Long Term Plan

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Health and care leaders have come together to develop a Long Term Plan to make the NHS fit for the future, and to get the most value for patients out of every pound of taxpayers' investment. Our plan has been drawn up by those who know the NHS best, including frontline health and care staff, patient groups and other experts.

To support people to age well, the NHS Long Term Plan will:

- Increase investment in primary and community care services by £4.5bn a year by 2023/24.
- Bring together a wide range of professionals to deliver tailored support in the community, so that people can live independently at home for longer.
- Invest in developing more rapid community response teams, working between GP surgeries and hospitals, to prevent unnecessary emergency hospital admissions and speed up discharges.
- Upgrade NHS staff support, including GPs and nurses, to people living in care homes.
- Improve recognition of and support for carers, and provision for people with dementia.
- Give people and their families more say about the care they receive and where they receive it, particularly towards the end of their lives.

People in England can now expect to live for far longer than ever before, but extra years of life are not always spent in good health. Older people are now more likely to live with multiple and complex long-term conditions, or with frailty or dementia.

The way we provide care and support for the most vulnerable groups of adults therefore needs to change - moving from providing care in hospitals when people are unwell, to supporting people to stay well and recover in their own homes, with the right support in place in their communities.

The NHS Long Term Plan sets out a range of actions to achieve these goals, backed by significant additional investment in primary and community care.

We will work with GPs and their teams, as well as hospitals, community teams, social care and the voluntary sector to enable them to play a joint role in helping people to stay well and better manage their own conditions. We will invest in developing more rapid community response teams, working between GP surgeries and hospitals, to prevent unnecessary emergency hospital admissions and speed up discharges.

Technology, like wearable devices and digital health records, will also help professionals provide more personalised, pre-emptive support, including better recognition of people's preferences, including towards the end of their lives, and the vital role carers play in their lives.

We will also continue progress made to diagnose and support more people living with dementia, and roll out successful trials of closer NHS working with care homes, to ensure people with some of the greatest care needs receive regular health checks and medication reviews.

Case study

Analysis of the Wakefield Enhanced Health in Care Homes programme has shown a 27% reduction in ambulance calls from care homes for falls, and a 28% reduction in hospital bed days.

Cambridgeshire Community Services NHS Trust has used a model to identify 800 people who have high health needs, based around the frailty registers of GPs. These people are now proactively supported by multi-disciplinary teams. As a result, acute hospital usage, by these people, has fallen more than the target of 15%.

Integrating care between health and social care partners in Doncaster has reduced the number of unplanned hospital admissions, for people aged 65 and over, for trauma and orthopaedics by around 17% in the last two years.