10 Year Health Plan working group: 'I can stay healthy and manage my health in a way that works for me'

Co-chairs' report

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Introduction

The potential to increase the years lived in good health, and better manage conditions is vast. Evidence that secondary prevention can significantly reduce disease incidence and progression is some of the strongest in medicine (Chief Medical Officer and others, 2023). These cost-effective solutions should be expanded nationwide and proactively reach those who would benefit most. Innovation in how these are delivered can cut their cost and increase this reach. Emerging technologies will transform the way we predict, screen and manage conditions. Delivering this will require investment and a system that drives continuous innovation.

If the 10 Year Health Plan (10YHP) can provide this platform it will lead to a substantial increase in healthy life expectancy, reduced NHS and welfare costs, and increased tax revenue. This report sets out a vision of what this might look like in practice.

Through the 10 Year Health Plan, the government should commit to setting goals for health service prevention in 2035 that can encourage and incentivise ambitious action from the NHS and its staff, with a challenge to the public and patients to support these ambitions. This working group has not set those goals, but we recommend considering goals associated with reaching the lowest rates in Europe for high-priority risk factors such as smoking or unhealthy weight, or for those conditions with the strongest prevention evidence, such as cardiovascular disease. The government made a commitment in its manifesto to halve the gap in healthy life expectancy between the richest and poorest regions in England and on raising the healthiest generation of children ever. These are stretching targets and the 10YHP should give the NHS clear goals on how it will support delivery of these commitments.

Our vision seeks to achieve transformation:

1. From health services that reinforce inequalities, to narrowing inequalities by focusing prevention services on those most in need.

2. From one condition at a time, to every condition, every time. Each interaction will take account of someone’s whole health status and will be an opportunity to offer or request prevention services.

3. From a National Health Service to a national health system, where prevention is provided wherever people go - in homes, online, in schools, at work, and in other non-healthcare settings - with radical task shifting to wider health and social care professionals where appropriate and to people themselves.

4. From standardised and reactive health services that only kick into action when you are sick, to behaviourally informed prevention services that are predictive, personalised and proactive.

5. From inconsistent access to your health record, to a secure single data passport that can update your health status in real time with your consent.

6. From a national health service that struggles to fund prevention efforts, to one where adequate prevention funding is allocated sustainably to deliver on our prevention potential.

7. From a system that is slow to prioritise, learn and innovate, to one where the incentives, culture and capabilities support data-driven optimisation relevant to the local population.

The challenge we face

Lord Darzi's (2024a) report is clear: the deterioration in our nation's health creates a huge challenge for NHS performance and, more broadly, the economy. Health risks build up from before birth with the foundations for an individual's physical and mental health set in early childhood. Multimorbidity increases with age, increasing care needs (see annex C for more detail on action the health and care system can take at different stages of the life course to prevent ill health) (The Health Foundation, 2023). But it is possible to address these challenges with clear action and investment in the short term to deliver on long-term ambitions for population health and economic growth.

Despite spending more than ever on health services, the UK is getting sicker. This is because much of health is driven by factors outside of health services. Since 2016, the number of years a person can expect to live without illness has decreased (The Health Foundation, 2025) driving an increase in our burden of disease. Added to that, the burden of disease is also increasing due to our ageing population (The Health Foundation, 2023). The impacts of this are clear - with NHS waiting lists rising to 7.5 million (NHS England, 2024) and long-term sickness seeing 2.8 million people of working age economically inactive (Office for National Statistics, 2025). If trends continue, nearly 25 per cent more working-age adults will have a diagnosed condition like chronic pain or diabetes in 2040, with consequences on the economy (The Health Foundation, 2024). The numbers of people who are economically inactive due to ill health is set to rise by over half a million people during the course of this parliament, with associated rises in the welfare bill. The Office for Budget Responsibility (OBR) (2024) now forecasts that welfare spending on incapacity and disability benefits could rise from £64.7 billion in 2023 and 2024 to £100 billion in 2029 to 2030, increasing from 2.4 per cent to 3 per cent of GDP. This means that

if no action is taken, the government will need to allocate over £35 billion more to incapacity and disability benefits alone by 2029 to 2030.

Long term conditions and multimorbidity drive worsening health trends, with inequalities in outcomes. A small number of conditions drive over 60 per cent of premature mortality and morbidity in England, these are: chronic respiratory disease; cardiovascular disease (CVD) including heart disease, stroke, diabetes; mental ill health; musculoskeletal disorders (MSK); dementia; and cancer (NHS England, 2023). Multimorbidity (having more than one long term condition) is growing, with one quarter of people in England having 2 or more long-term health conditions (The Health Foundation, 2021). Even before the pandemic, the prevalence of major illness was increasing, with a 25 per cent increase in the number of adults (aged 20 to 69) living with a major illness over a decade. These conditions drive health inequalities and the gap in healthy life expectancy (figure 1). The longer life spent in good health, and longer life expectancy, of those in the least deprived areas in England demonstrates that we can - and should - have an ambition to prevent the earlier onset and increased multimorbidity, poor health and early death of people living in our more deprived communities.

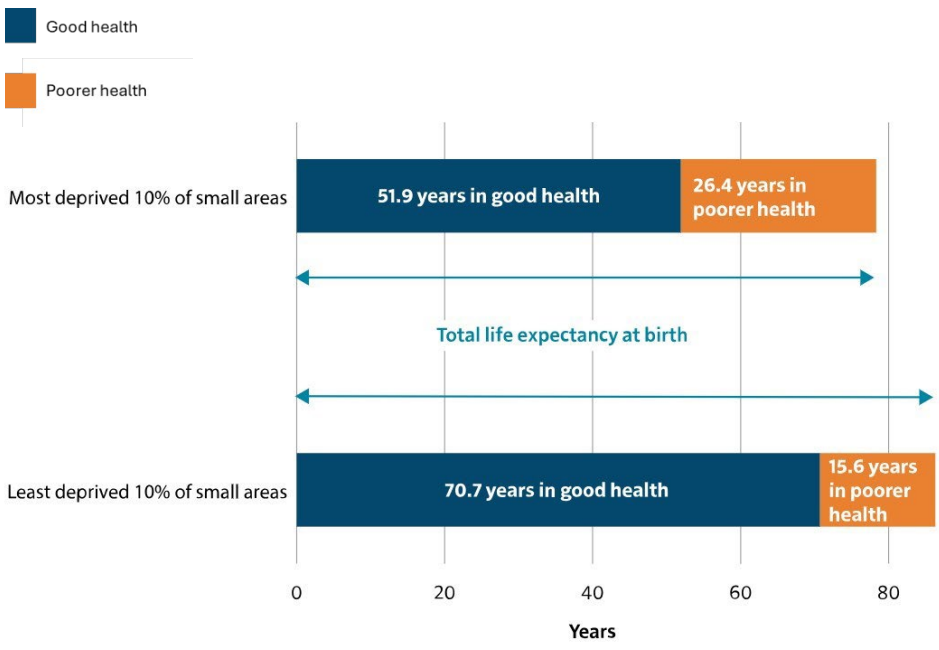

Figure 1: women in the least deprived areas live significantly longer and have fewer years of ill health (Department of Health and Social Care, 2023).

Figure 1 is a bar chart showing that, on average, females in the most deprived areas spend 51.9 years in good health and 26.4 years in poorer health, whereas females in the least deprived areas spend 70.7 years in good health and 15.6 years in poorer health, and live around 8 years longer overall.

Much of this could have been, and can be, prevented. Over 1 in 5 of all deaths in England and Wales in 2022 were considered avoidable (Office for National Statistics, 2024). These were people under 75 years of age who died from causes that are considered either preventable or treatable given timely and effective healthcare services and public health measures. Of this overall avoidable mortality rate, about two-thirds is preventable, driven by risk factors like obesity, smoking, physical inactivity and alcohol consumption (Institute for Health Metrics and Evaluation, 2024). Preventative action on these major risk factors should halt or delay the onset of new long-term conditions or stop their progression or exacerbation (British Heart Foundation, 2024). For instance, the death rate from CVD has fallen by almost 80 per cent since 1969 thanks to better availability of preventative interventions and public health programmes

Despite decades-long dialogue, we've seen limited progress. A shift to prevention is not new; the NHS Plan (Department of Health, 2000) outlined a "new focus on prevention". The Five Year Forward View (NHS England, 2014) said "the future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health". And the most recent effort, the NHS Long Term Plan (NHS England, 2019) devoted a chapter to NHS action on prevention and health inequalities. But to date, action to eliminate or mitigate risk factors have failed to curb the growing burden of illness. Action has been less successful than expected because the interventions haven't been at sufficient scale, haven't engaged with those who would benefit most, or have not had sustained funding.

There remains a complex landscape of responsibility for prevention, with mismatched incentives and budgetary arrangements, alongside significant financial constraint. Ongoing reductions in funding and political de-prioritisation have seen prevention dwarfed in importance compared to acute care and it is often not seen as a mainstream function of the health services. Evidence-based prevention interventions like alcohol care teams or stop smoking services haven't been funded sustainably, at scale, and so are not delivered to everyone who needs them. Basic preventative care like blood pressure management is seen as a programme that can come in and out of focus, rather than as standard clinical practice. And, in many areas, evaluation and evidence on effective interventions for prevention of key conditions is lacking - and we have not prioritised filling those critical evidence gaps.

The slow pace of progress on basic digital and data integration between health and other services, and within health services themselves, continues to undermine our prevention efforts. This hinders our ability to support the public to be healthier, efforts to make the most of private sector developments (like data from wearable devices), as well as opportunities to contribute to a research-led, learning health system.

Finally, individuals face barriers in engaging fully with prevention interventions and managing their own health. Through the 10YHP engagement exercise, the public has told

us the tone of health messaging too often blames those with the highest need for support. People feel disempowered, disconnected and overlooked. Some can struggle with digital literacy, or lack resources or agency to access support, they may mistrust health services or, given high levels of long-term conditions in particular communities, they can be fatalistic about developing certain conditions themselves.

These barriers contribute to evidence-based interventions not being fully implemented at scale, sustainably, and delivered to those who need it most, which drives and worsens health inequalities.

It is imperative we learn from our past attempts and do much better.

There is still a significant mismatch in healthcare needs and available services. We are currently reaching only a fraction of the populations that would benefit from secondary prevention interventions. This is a result of limited NHS funding going to prevention, national programmes, and through integrated care boards (ICBs), including relative funding of primary and community care compared to acute care (given this is where much prevention activity is delivered). There have also been reductions over time in expenditure in primary care and community settlings where prevention activities typically take place (Lord Darzi, 2024b), alongside broader constraints like workforce and capital, poor service design, and a lack of prioritisation (for example active case finding).

But we are much closer to success in some prevention efforts than others. Action on tobacco has been one of the UK's major success stories - we've halved smoking rates in the past 2 decades (as shown in Figure 2), with the decline seen at every level of deprivation (Office for National Statistics, 2023). This reduction is worth tens of billions in economic value with tobacco use rates significantly below European comparators (World Health Organisation, 2024). The number of deaths estimated to be attributable to smoking has also dropped (NHS England, 2023b). Our 70 per cent coverage of physical health checks for people with severe mental illness (above the NHS Long Term Plan ambition of 60 per cent) is driving early detection and effective management of people with hypertension and/or high cholesterol (NHS England, 2023c). And with vaccination often cited as the most effective health intervention after clean water, the introduction of the HPV vaccine for 13-to-14-year-olds resulted in a reduction of cervical cancer in young women after the vaccination programme was introduced (Falcaro and others, 2021).

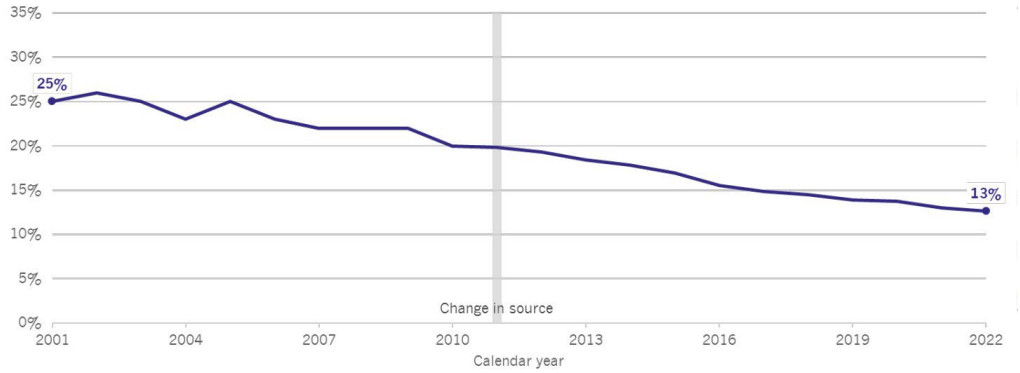

Figure 2: the percentage of adult smokers in England has fallen significantly, from 25 per cent in 2001 to 13 per cent in 2022 (Lord Darzi, 2024c).

Figure 2 is a line graph showing that the percentage of adult smokers in England has fallen from 25% in 2001 to 13% in 2022.

Our success in these areas shows us the extent of the gains that are on the table through a combination of effective primary and secondary prevention.

Primary prevention, being legislative and regulatory measures that seek to reduce disease and health problems before they occur, is out of scope for this report. While some aspects of improving the population's health are costly to address, such as poverty and poor housing, others such as smoking, alcohol and obesity can be reduced through regulatory or fiscal measures. These no-cost or revenue raising measures can have a double dividend: a) generating savings in other parts of the health system that can be reinvested in secondary prevention, b) strengthening the cost-effectiveness of secondary prevention, for example, by preventing people relapsing into obesity after finishing a course of weight-loss drugs. As a result, primary and secondary prevention need to be considered together as part of the 10YHP and Health Mission.

Our vision for 2035 and how it could be delivered

The challenge ahead is significant - we will not be able to meet it by making minor tweaks at the margins. We need an approach to health that recognises and harnesses successes, while being honest and radical on where change is needed. Only once we have a health service that truly has prevention at its core, will we have a healthcare system that empowers and enables people to 'stay healthy and manage their health in a way that works for them'. This future vision, outlined in the points below, will look and feel different for people, and it will also require a rewiring of the current healthcare system, including progress on primary prevention.

As important as this vision, is how it will be delivered. While it is beyond the group's remit to plan out how the health service should enable delivery of this vision, we have considered aspirational examples to help develop the vision further. We have not been exhaustive but have focused on inspiration for what a new healthcare system could be in the future.

How a re-oriented health service will look and feel different:

1. From health services that reinforce inequalities, to services that reach everyone but provide more support for those who need it most

Health inequalities are growing (Kings Fund, 2024). We should all be able to expect to live long healthy lives, irrespective of our ethnicity, income or where we live. Too many people are living for significant periods in ill health and dying early because of preventable ill health. Maximising the impact of prevention services will mean our efforts need to extend to population groups with historically low uptake. Disease prevalence is higher than average in many of these groups, so the benefits of secondary prevention are likely to be even greater (Lawson and others, 2020). Taking a proportionate universalism approach means providing services to everyone, but efforts are focused on reaching - and positively impacting - those who need them the most and who will benefit the most. Where low uptake is an issue, the system needs to be charged to intervene quickly and find ways to ensure increased uptake and positive outcomes. This will require some creativity in the development and testing of different delivery models, and it will involve working with and within communities. There are numerous good models of how to do this that need to be scaled up where there is evidence of impact.

How it could be delivered

Addressing low uptake and meeting people who most need them where they are:

Preventative services should find the people who are most at risk and have the most to benefit. This may be through needs assessment or risk stratification at population level or individual risk assessments. Where low uptake is an issue, the system needs to be charged to intervene quickly and find ways to ensure increased uptake and positive outcomes. They should draw on best practice from other areas and behavioural insights to tailor how they communicate and reach groups at greater risk.

Preventative services should be universal across the country, but resources should be in proportion to the size of deprivation and need. Services for people who have higher need should be seen as the standard model for delivery, rather than as separate add-ons to a model designed for those who find access easy. Lessons from services in more deprived

areas such as Deep End Practices and those that focus on groups at risk of exclusion should be shared and adopted (Watt and others, 2012)[1].

For groups with higher need or low uptake, local areas may need to increase the use of outreach teams that will take services to the people or areas in most need (for example, alcohol and drug outreach teams, migrant outreach teams, school nurses for childhood immunisations, trauma informed services). This could include measures such as pop-up clinics in the community to target specific underserved groups (for example, health checks in homeless shelters or for those in the most deprived areas) or mobile clinics in rural areas with limited healthcare infrastructure. There are many successful models of community engagement in preventative activities and co-creation will be an important component of service design. For example, HPV self-screening in Denmark has increased engagement in those who had not been screening in over 10 years (Queen Mary University of London, 2023).

2. From one condition at a time, to every condition, every time. Each interaction will take account of someone's whole health status and will be an opportunity to offer or request preventative services

Some parts of the NHS, like general practice, are designed to think about the whole patient but capacity and time constraints can make this challenging. Other parts of the system, such as referral into hospital care, can risk treating patients one condition at a time. From a prevention perspective this can mean that risk factors are missed and treatable conditions like hypertension are not managed to delay or prevent the onset of other conditions. Complex personal circumstances and multiple conditions can make care particularly fragmented, and capacity, incentives and structural issues can mean that health professionals are not always able to consider, let alone address the preventative needs of the whole person.

In a decade, we will move to a system where every time a person interacts with the health service, their whole health status will automatically be understood. People will receive advice on their individual risks and will be offered care or treatment to delay disease onset or prevent worsening of conditions they may have. People will be empowered to understand their risks and what help is available, that they are equipped to request interventions, and they will see this as a fundamental entitlement from the health service. Healthcare professionals will be equipped with information, knowledge, tools and training on evidence-based prevention interventions and behaviour change to make sure they collaboratively help people, and will be able to deliver either digitally or face-to-face. Specialists should retain some generalist skills, including on preventing and managing

[1] Deep End practices are groups of GP services in areas with the highest socio-economic deprivation.

multi-morbidity. Secondary prevention of cardiovascular disease, for example, should be seen as much a responsibility for obstetricians and anaesthetists as it is for general practitioners and cardiologists.

How it could be delivered

A whole health approach:

- with the consent of patients, all healthcare professions should be able to access the whole health status of the person through the creation of single digital records where information on preventable conditions and risk factors are accessible. In line with the recommendations of the Sudlow Review (2024) this would require ongoing co-ordinated engagement with patients, the public, health professionals, policymakers and politicians to build and safely use these records. This digital health record could be expanded to social care and voluntary, community, and social enterprise (VCSE) organisations delivering preventative services

- health services should by default take a whole person approach so that prevention opportunities can be addressed. The workforce should understand that it is within their responsibility to sensitively address wider health concerns with individuals - and be empowered and resourced to do so. This should place a greater focus on preventable health conditions and preventative interventions. Shifting from hospital to community is key to this. And specialists should retain some generalist skills, including on preventing and managing multi-morbidity and its risk factors. Local systems should join data together to enable this approach.

3. From a National Health Service to a national health system, where prevention is provided wherever people go - in homes, online, in schools, at work, and in other non-healthcare settings - with radical task shifting to wider health and social care professionals where appropriate, and to people themselves

While primary care and hospitals will still have an important role in delivering preventative health services, opportunities to support people to stay healthy and manage their health will be ubiquitous - on mobiles and wearables, through home delivery and visits, through workplaces, schools and community settings. Wherever people go, the NHS will go with them.

Preventative services should meet people where they are, especially for the most marginalised communities or groups with low uptake. This includes simplifying service access through digital entry points, where that works for people, and providing services at times and locations that suit people who work shifts, don’t drive, have caring

responsibilities, or have additional needs. It means developing clearer signposting for services from trusted and recognised sources. New technology, including artificial intelligence (AI), will augment patient and clinician engagement with preventative services. For people who find it hard to use digital technology, support will be available in neighbourhood settings, and it will always be possible to engage with a real person when needed. Digitally-enabled community health and wellbeing workers, for example, may play a critical role in delivering prevention services. Currently, a range of wider health roles exist (for example: health champions, peer support workers) - these roles will create a more unified, highly mobile wider health expert workforce. As a result, every interaction with the NHS will be a prevention opportunity.

How it could be delivered

Shifting prevention support closer to the person:

- prevention services could be simplified with more services provided at home through your smartphone or computer, or through the greater use of at-home testing or screening for those people who need it. An individual's engagement will make them a partner in managing their health; and we will support people to use simple tools at home or in an easily accessed community setting, such as blood pressure monitors, and knowing how to respond to the results. More flexible appointments for preventative services should be available, including out-of-hours. We need a clearer offer of services that are well linked to one another, and a greater focus on making sure people who need support most are able to access it

- the Department of Health and Social Care (DHSC) and NHS England could evaluate the most cost-effective models of using non-healthcare settings to deliver services and improve outcomes and encourage the expansion of these models if they are cost-effective. This should include people accessing healthcare at mobile, drop-in or pop-up settings, and within wider community settings (such as supermarkets or places of worship). Success can be drawn from models like the Community Appointment Days model for MSK that has reduced waiting times thanks to engaging underserved patients and encouraging and signposting self-treatment

- relatedly, DHSC and NHS England could evaluate the most cost-effective models of using wider health staff to deliver services and improve outcomes and encourage the expansion of this workforce if they are cost-effective. Trained health champions and community health workers could be placed within local support services, such as job centres, housing support, or local GP surgeries to help manage the demands upon highly skilled clinical staff. Interventions should still be delivered by optimally skilled staff as a professional practice, appropriately supervised where needed, and consistently trained and accredited

Expanding prevention beyond healthcare professionals:

- the use of social prescribers could be rolled out to engage people in preventative interventions. Social prescribing connects people to local groups and services to address their social and practical needs that affect their health. They could play a key signposting role, backed by increased availability and accessibility of preventative services. We should evaluate and build upon successful social prescribing models

- responsibility for prevention could extend beyond the health system to include employers, schools, faith groups, and universities. These organisations should be incentivised and rewarded for benefits delivered. NHS funding could flow to the network of organisations that can best deliver population health, rather than defaulting to NHS providers. For example, schools or employers (including the NHS) that deliver improved health for their pupils or employees could be rewarded for their contribution, either through a commissioner, or based on minimum standards of provision linked to lower employer national insurance contributions. Private providers of preventative services (for example, gyms) could be rewarded for targeting particular populations. Making this work at a local level would be the responsibility of integrated care systems (ICSs). They could build on the Community Health and Wellbeing Workers (CHWW) model that originated in Brazil; CHWW serve as health workers and community representatives to proactively identify health needs and offer tailored support (Imperial, 2021).

4. From standardised and reactive health services that only kick into action when you are sick, to behaviourally informed prevention services that are predictive, personalised and proactive

Prevention currently requires people to make one-off decisions, for example to be immunised, as well as ongoing, habitual behaviours, such as adhering to treatments. Relying on people to make effortful behaviour changes is hard to sustain. Instead, we need to create environments and services that help people to be healthy including ensuring easy, attractive access to personalised prevention services. The potential is emerging for rich data from genetic testing and wearables, alongside screening programs, that will enable health services, and users, to understand the risk of experiencing health conditions at a much earlier stage before symptoms emerge. This is a positive both for individuals, who realise changes in their health earlier, and the health system, which benefits from a more efficient way of identifying the problem and does not need to spend as much treating it.

In secondary prevention, timely reminders (including the use of AI chatbots), trusted messengers, working with groups to shape social norms, making health a part of an aspirational identity, and potentially, where evidence exists, personal incentives are a

more effective route to influencing behaviour than admonishment and lectures on self-help. In essence, we need to design services in a way that is more informed by an understanding of human behaviour - for example, building on the success of offering financial incentives to pregnant women who smoke.

Future improvements in the ability of tests to accurately detect illness will mean that many more illnesses could be detected and caught quickly through simple, non-invasive tests. Instead of standardised treatments with heterogeneous effects, evidence-based services will become more personalised - increasing both take-up and efficacy. They will be built around people - not conditions, considering the whole person and their wider needs to support them to live the life they want to lead. This will be delivered in part through technology that allows people to monitor their own health and clinical pathways will reflect this holistic approach. Traditional face-to-face models must remain to ensure we continue to meet the prevention needs of those who are digitally excluded.

However, this data-rich future will first emerge among early adopters and those able to pay for private services. There is a risk of a greater divide between an increasingly health-conscious minority, who have more access to information and support, and the rest of society. Health systems will therefore need to embrace and harness the rise in personal health data while maintaining focus and resources on offering services to those who need it most who may have the least data available.

How it could be delivered

Planning, accountability, and oversight:

- over the next decade, technology, business models, and consumer experiences that start with early adopters must be supported to expand into mainstream health, so that the whole population benefits

- health systems should design services around those who have the least information and data, while leveraging the benefits of an increasingly data-rich population to target services. For example, the group heard the work of the Brazilian healthcare system which was able to utilise population data in Rio de Janeiro to identify pockets of low rates of child vaccinations, enabling them to send health visitors directly to those areas, vastly increasing uptake as a result

Shifting prevention support closer to the person:

- preventative services should be designed in a way that is informed by an understanding of human behaviour. It should be as easy as possible to make healthy choices and sustain healthy behaviours. NHS support should be designed to engage and empower individuals and communities to be partners in their own health

- preventative services should make it easy for people to do the right thing to protect their health. Professionals need to communicate to people in a way that makes sense to them, is easy to understand, and is achievable within the life that they lead. They should draw on best practice from other areas and behavioural insights to tailor how they communicate with and reach groups at risk of exclusion

5. From inconsistent access to your health record, to a secure single data passport that can update your health status in real time with your consent

People and healthcare professionals do not always have the information or tools available to them to be able to fully assess one's needs and plan their approach accordingly. Data is not readily shared, nor is it effectively used for tailoring prevention, considering interactions across different health conditions or for research and development. This stops us from maximising the benefits of the latest innovations and unlocking the potential provided by the latest scientific or technological innovations. The NHS App is a welcome tool but is under-utilised. While there are pockets of good practice, such as use of at-home screening or testing, these have not been seized upon and expanded.

We need to put ourselves on an effective footing for where the world will be in 2035. A single trusted, secure and timely digital health record covering all health interactions from cradle to grave will improve our ability to help a person stay healthy or manage their health.

The capacity to screen and diagnose at low cost will expand vastly as AI augments clinicians in routine screening and diagnostics, and wearables, home testing, and genetic screening become widely available. The NHS App will be a trusted source of information, be accessible to all, and be a gateway to programmes with an evidence base.

How it can be delivered

Maximising the use of data to allow prediction and empower individuals to act:

- every person and healthcare worker could have access to a single, trusted, secure, and timely digital health record covering all health interactions from cradle to grave. Within this, primary and secondary care should be linked as a priority given their role in secondary prevention

- by 2035 this record may be linked to wider public sector records (for example, benefits and care) as well as private medical provision (for example, cholesterol monitoring or prescription of weight loss drugs outside of NHS). Within the clear legal information

governance framework there are potential benefits at population and individual level which should be explored, such as data sharing being part of the GP contract

- by 2035, this record will include information on whole health status, including information on own personal risk of poor health through health assessments or screening. Ethically it is very important that any identification and communication of risk is as accurate as possible and allows individuals to link to effective services which are proved to change outcomes and don't just present them with worrying information and leave them with no support

- DHSC should accept and implement the recommendations from the Sudlow Review (2024) (Sudlow, 2024). The recommendations provide a pathway to establishing a secure and trusted health data system for the UK

- the NHS could develop and procure digital and AI tools for preventative health management, risk stratification and support for adherence (for example, automatic reminders for hypertension medication). The purchasing power of the NHS should be leveraged where national level rollout of tools is appropriate. A prerequisite to this is that basic technology capabilities for staff must be met - there is no use asking a district nurse to use a new AI risk stratification tool if they are unable to connect to the institutional network. We can learn from the Israeli health organisation Clalit, who developed an AI-driven preventative platform to guide doctors through routine consultations. The platform creates detailed clinical pathways based on the most up to date guidelines and cross-references with the patient's medical record

- the NHS app has the potential to be very valuable from a prevention perspective as an opportunity for self-referral and providing access to National Institute for Health and Care Excellence (NICE) approved digital interventions. The app will always ensure personal privacy for any areas that the patient prefers to remain hidden. An alternative access through more traditional methods will always be made available for those who cannot use the app to avoid increasing health inequalities due to the digital divide. For children and young people, this will be in the form of the digital Red Book.

6. From a national health service that struggles to fund prevention efforts, to one where adequate prevention funding is allocated sustainably to deliver on our prevention potential.

The health system has a long list of goals to deliver. In pursuit of these, it can spread itself too thin, by attempting to do it all at once, or over-valuing particular treatment services due to historic allocations and political pressure. For too long prevention has been viewed as less important than hospital waiting lists and access to treatment, ultimately crowding out our ability to act early, target the cause, and prevent people from needing more intrusive or

intensive care later. Currently it is hard to know how much is being spent in the NHS on prevention, best estimates place this at £9 billion in 2019, or around 4.5 per cent UK healthcare expenditure, but the data has limitations (Office for National Statistics, 2023).

For example, NICE uses a threshold of £20,000 to £30,000 per Quality Adjusted Life Year (QALY). This means that for a medicine or programme to be considered cost-effective it should typically generate one additional year of perfect health (or equivalent combination of additional life expectancy and quality of life improvements) for £20,000 to £30,000 or less. A vast number of preventative interventions, from smoking cessation and CVD preventative interventions to weight management, and diabetes management, have vastly lower cost per QALYs than the NICE threshold (£1,900 for local Stop Smoking Services, £557 for Tier 2 Digital Weight Management Programme) yet are chronically under-funded, with resources being subject to fluctuations and short-term allocations in recent years. The health system would generate more health for less by delivering prevention but does not do it.

This is because the system is incentivised and pressed to deliver on acute or tertiary services - this will always be at the cost of more preventative care. Health systems need to be set up in the right way to enable prevention and the wider societal benefits of delivering preventative services should be considered in designing the financial incentives for providers. A prevention programme can offer savings for the NHS due to treatments no longer being needed and reduced cost to the state through reduced welfare payments, alongside higher productivity and tax revenue from a healthy workforce. All prevention interventions should be viewed in this light which will incentivise the state to pay providers substantially more to deliver these programmes. In turn, this will solidify the place of prevention as part of the NHS' activity as it will become more valuable to a provider's bottom line than it currently is. This model would nudge the NICE model as applied to prevention towards a view of the benefit to wider society. It is worth recognising that the government values the wider societal benefit of a QALY at £70,000, showing that even a minor shift in financial incentives would deliver a net gain for society (HM Treasury, 2024).

The government and health service do not consistently rank interventions by cost per QALY on a comparable basis - the calculation that determines a QALY often takes into account different variables for different interventions which means that it is not possible to compare the relative cost-effectiveness of different interventions on a like-for-like basis. If this were the case, then prevention measures would present a far stronger case for investment. At the same time, QALYs on their own are not sufficient for decisions on allocating resources as they do not necessarily capture the wider benefits to the state and society. To properly enable decision making with HM Treasury, the savings that would build to the state in the form of reduced NHS spending, reduced welfare payments, increased productivity, and higher tax revenue need to be properly considered as part of affordability criteria. By improving our ability to compare cost-effectiveness across interventions, and considering the impact on the state of society, we can radically shift the

current prevention landscape by making spending on prevention activity far more attractive for those balancing the accounts of the state and of health service providers.

By 2035, preventative services should have contributed to a manageable level of demand for hospital services and while people will still need treatment, particularly towards the end of their life, prevention will have reduced the length of time they live in ill health. The system should spend more on prevention activity with provision of services at sufficient scale to achieve the ambition needed. Health professionals should be incentivised to deliver prevention interventions. The system should be clear on what its objectives for prevention are and have plans in place that are sufficient to achieve the ambition needed. There should be clear accountability for preventing ill health in the same way there is for reducing waiting lists. Health services must feel responsible and accountable for delivery and confident they have sufficient control and budget to deliver targets.

Funding, resources and provision should be targeted towards areas where the greatest impact and benefit could be realised. Decisions on provision should be informed by current performance, the availability of proven cost-effective interventions and the need for new research or innovation. For these priority conditions and beyond, approaches will differ based on the quality and delivery of current provision. For some of these issues, such as smoking and cardiovascular disease prevention, we are already close to being world leading, but we don't reach those who will benefit the most, widening inequalities within our population. We need to scale what works and design services for those who need them most - evidence-based, at scale and sustainably to ensure we deliver on the potential that prevention brings.

How it could be delivered

Planning, accountability and oversight:

- metrics for prevention activity should be identified, and NHS performance should be rebalanced to put prevention targets on an equal footing with targets for acute or hospital care, such as waiting times. They should be outcomes-focused covering the conditions or risk factors with the greatest need and potential, noting that there can be some time lag in realising the benefits of prevention measures. For example, measuring smoking status at the time of elective surgery would give an indication of the success of support in the community and within acute pathway

- at national, regional and ICS level there should be a named board-level individual who is the budget holder for secondary prevention activity, and accountable for the overall strategy and delivery of activity on secondary prevention. They should have the power to intervene to re-allocate spending or change service provision to achieve the agreed outcomes. Public health expertise will play a critical role in delivery of this function

- accountability mechanisms need to be designed around other areas of the health system that have a role to play in prevention for example electives and urgent and emergency care

- DHSC and NHS England should work with local areas through ICSs to consider and translate central priorities into localised plans. This should be incorporated within ICS 5-year plans with prevention being given a greater focus. ICSs - with the involvement of local authorities, voluntary sector, employers, private providers, and civil society - should outline how they will increase prevention activity and achieve outcomes across priority areas, noting the impact of the Devolution White Paper (Ministry of Housing, Communities and Local government, 2024). Workforce resource will need to shift according to priorities with public health leadership at all levels

Funding and contracting structures:

- a target to increase prevention spending by one per cent of total health expenditure per year, with the baseline being established as part of the Spending Review process. The budget for prevention activities should be ring-fenced with the categorisation of what is and is not prevention activities being agreed as part of the Spending Review process

- changes to spending at a national level should be reflected in budgets and priorities set for local areas covering both local authorities and ICSs. The Hewitt Review (Hewitt, 2023) recommendation to increase the share of total ICS budgets going towards prevention by at least one per cent should be enforced to reflect changes at a national level. Sustainable long-term funding is critical to building the infrastructure for significant preventative spending

- existing funding or contracting structures should be reviewed and reformed for local authorities, ICBs, primary care networks (PCNs), and GPs, including the Quality Outcomes Framework (QOF) to develop incentives that encourage the delivery of the most cost-effective and impactful prevention interventions. There should be a rebalancing of financial incentives from delivery of treatment to delivery of prevention within prioritised areas, with a public acknowledgement by government of what these trade-offs may mean for other parts of the system in the short term

- as part of the Spending Review, DHSC and NHS England should analyse the cost to society of preventable conditions, such as obesity or MSK. This analysis should inform the funding and contracting structures by increasing the price paid to providers for prevention programmes so they can achieve wider societal benefits

- alongside wider contracting changes, reporting on the Public Health Outcomes Framework (PHOF) should be made statutory. The PHOF should be updated to provide greater clarity on what outcomes should be prioritised to rebalance towards prevention and address inequalities in uptake

- given the relative cost-effectiveness of prevention activities, it should be possible to fund preventative services from within the health service but innovative financial mechanisms should be examined particularly around increasing targeted uptake by particular populations

- population based bonuses for meeting agreed health targets which result in a financial reward distributed among contributing organisations; reductions in national insurance contributions based on a minimum standard of health promoting behaviour or micro-payments (finders fees) for referring entities such as pharmacies or influencers. The finance group should examine a way of sharply incentivising outcomes rather than the activities currently within QOF and ensuring these funds flow to the organisations most able and willing to shift people's behaviour

Investing in the priority areas:

A set of criteria could be used to identify areas or conditions where prevention provision and funding should be prioritised, which could include:

- prevalence of ill health in the population

- future trends in ill health

- contribution to health inequalities (for example, measured by prevalence among the most deprived groups or areas)

- the severity of impacts on individuals, including on workforce participation and healthy life expectancy (for example measure by Disability Adjusted Life Year ((DALYs)) and SRH)

- the cost-effectiveness of solutions is available (for example, measured by cost per DALY or QALY for given intervention)

- the effectiveness of local and national interventions

We recommend that there are 3 groups of priorities for prevention:

- retain and scale-up areas where the prevention evidence is strong, and services are in in place but not reaching everyone:

- CVD prevention (such as heart attacks, strokes, multi-infarct dementia). The beneficial effects of secondary prevention of cardiovascular disease, including risk-based advice and prescription of appropriate antihypertensive agents and statins, are profound and rapid (UCL Partners, 2022). If hypertension treatment optimisation rates were improved to just 80 per cent, this would prevent 17,000 heart attacks and strokes in England in 3 years, saving around £200 million in NHS spend alone

- Stop Smoking Services in care pathways and by referral from GPs. In 2022, the estimated gross cost of smoking to public finances was £20.6 billion in the UK. If England became fully smoke-free this could go back into communities' and families' pockets (Cancer Research, 2023)

- vaccination coverage up to World Health Organisation (WHO) recommended levels for childhood immunisation. If the new Respiratory Syncytial Virus (RSV) programme for pregnant women reaches 60 per cent it will save 20,000 GP consultations, 5,000 fewer admissions and 200 fewer infants admitted to intensive therapy units every year (UK Health Security Agency, 2024). Cervical cancer will be almost eliminated if HPV vaccination coverage targets are met

- screening programmes, for example breast screening - increasing the screening uptake to 80 per cent would see a net cost saving in 2034 in the range of £96 million to £111 million for both economic and wellbeing costs (Breast Cancer Now, 2024)

- diabetes prevention and pathway to remission of type 2. Approximately 200,000 people are diagnosed with type 2 diabetes every year. The type 2 pathway to remission (T2PR) programme has been shown to achieve remission by almost 30 per cent - with 200,000 people diagnosed every year, expanding access to T2PR could help more of these people to achieve remission (Valabhji and others, 2024)

- Expand services and improve the evidence: areas where the prevention evidence is strong but service provision is currently inconsistent across the country and more evaluation is needed for optimisation:

    - physical activity within care pathways (for example for cancer or frailty) and during rehabilitation (for example, for cardiovascular disease or pulmonary disease)

    - alcohol care teams in acute trusts

    - fracture liaison clinics

    - weight management and the optimal pathways for behavioural change support, medication and surgery
    - mental health (including perinatal mental health services, child and adolescent mental health support teams, and access to talking therapies)
    - oral health prevention
- Areas where more research is needed on prevention to strengthen the evidence base:
    - musculoskeletal prevention - for example, back pain, frailty
    - mental health prevention for adults
    - prevention of Alzheimer's disease

These priorities span the life course from preconception, maternity, through childhood, working age and older age, noting that there are different needs and opportunities at different stages of life. This targeted approach to prevention delivery and research could form the basis of a National Service Framework for Prevention.

Provision could be rolled out at sufficient scale for conditions where need and impact are high, and we have high confidence in the impact and cost-effectiveness of the measure. For example, this government could be a world leader in the eradication of smoking-related illness, if they were to ensure that all known measures and interventions are delivered.

7. From a system that is slow to prioritise, learn and innovate, to one where the incentives, culture and capabilities support data-driven optimisation of preventative interventions relevant to the local population.

The health system moves slowly. It can be hard to intervene and innovate. Pockets of best practice in prevention can appear but aren’t always adopted elsewhere. We rarely conduct rigorous evaluation of innovation in the prevention field. Issues with delivery struggle to be quickly identified and altered. Innovation needs to be incentivised, and not just from within the system. We need a system that is powered by the collective intelligence and innovation of the wider sector, which adapts successful models to match local needs, and supports their implementation.

For certain conditions (such as adult mental health or musculoskeletal conditions), there are fundamental preventative evidence gaps that need to be addressed. There has been failure to invest in sufficient research and development or innovation activity and

incentivise the private and voluntary sector to focus on the most pressing evidence issues. This action will not deliver results in the short-term but will put in place measures so that in 2035 we can confidently say we know what to do to significantly reduce the levels of these conditions.

A critical question for the 10 Year Health Plan and the research, life sciences, and innovation working group is whether to build prevention within the NHS or create an entirely separate system with sharper incentives and for-profit providers able to compete to deliver preventative services, or whether hybrid systems can emerge. At a minimum, patient data will need to flow between public and private systems.

How it could be delivered

Scaling innovation:

- decisions on provision of preventative interventions are best made using evidence of need and comparative cost-effectiveness. At national level DHSC and NHS England should ensure they have a central record of the cost-effectiveness of prevention interventions and how this compares to cost-effectiveness of treatments in other parts of the NHS. This should be used to identify and offer direction on which services should be prioritised for scaling. In areas, such as stop-smoking services, where we already know we have cost-effective measures in place, then scaling should be prioritised now without the need for collating cost-effectiveness data

- 'Test, Evaluate and Iterate' units could be established to develop prevention interventions for areas and conditions where there is strong evidence of what works but they are failing to effectively scale or are not being accessed by those who are most at risk and who have the most potential to benefit. Innovation in prevention should be encouraged and supported at ICS level. Service providers should be required to constantly iterate their prevention services as they adapt in real time and improve to deliver better outcomes. There should be open communication across commissioners and providers to ensure lessons learnt can be translated to other areas. This does not mean that what works in one area automatically translates to another with different needs and service infrastructure, but the emphasis should be on speed of knowledge transfer and constant improvement. We could explore the concept of an 'open healthcare network', where multiple providers can plug in, interoperate, compete, and evolve. This is likely to be better than either monopoly service provision or centralised procurement in driving innovation. Staff should have the time and appropriate skillset to implement, iterate and scale innovative approaches

Investment in research, development, and innovation

- the Department of Health and Social Care (DHSC) should identify and communicate their prevention priorities for research, development, and innovation. These would be

for areas where there is currently a lack of evidence on preventative interventions that are high impact and cost-effective or for specific cohorts such as children and young people or people at risk of exclusion. Funding for research should be earmarked through the National Institute for Health and Care Research (NIHR) and other research council programmes or through challenge prizes and other more agile methods

- the healthcare system and private providers can be incentivised to develop, test, iterate and scale evidence-based prevention innovations through mechanisms such as reimbursement or accelerated regulatory approval. For example, the approach to incentivising digital prevention interventions could be more aligned with the way pharmaceuticals are introduced. Clinical standards for new technologies should also be published so developers have better guidance on the criteria required for approval

- alongside the development of a digital patient record, an anonymised, trusted longitudinal database of linked NHS records should be prioritised for research on preventable conditions and evaluation of interventions targeting key evidence gaps. This would be the same database that will have been developed to enable digital patient records

Annex A: summary from engagement exercises

As part of the 10 Year Health Plan engagement exercise, we have heard what the public and NHS staff think about the shift to prevention.

1. The public are supportive of the shift to prevention in principle, recognising that a preventative approach will keep the public in good health, which the public think will reduce pressure on the NHS and improve the economy as people will continue working. The public support an increase in education and interventions to prevent severe disease such as cancer. There is openness from the public to making prevention interventions more accessible by expanding the settings where they are delivered.

2. However, the public don’t want to feel obliged to use preventative interventions out of a sense of responsibility to the NHS. They feel that the NHS is responsible for promoting interventions and reducing any friction in uptake. The public also feel they should have a choice about how to respond to interventions.

3. Key symbols of success that mark a focus on prevention include fewer people getting sick, people spending more of their lives in good health, and an overall culture of prevention.

4. The workforce also supports moving towards prevention, with an emphasis on early intervention and education from a young age. However, they recognise that this would require continued investment and better cross-system co-ordination. They are sceptical about the potential of weight management programmes and personalised digital prevention tools to help achieve the shift. They also think the shift to prevention is least likely to improve the staff working environment.

5. The public and NHS staff see many levers for prevention as sitting outside the NHS. The public see prevention as relying on better education in schools, tackling the wider determinants of health, and relying on the public to change their behaviour. People who work in the health and social care system see co-ordination between NHS, local authorities and others as a barrier to the shift.

6. Emerging priorities for prevention focus on what the NHS, rather than the public, can do. For instance: improving access to interventions, including in non-healthcare settings; improving public knowledge, including working to debunk misinformation, so people can make an informed choice; and investing in interventions which prevent perceived severe illnesses, for example, screening for cancer or mental health support.

7. The public see several opportunities in this shift, including:

    - saving lives by identifying illnesses or health issues earlier
    - saving time and money by preventing illnesses or conditions from escalating and allowing treatments to focus on conditions where prevention has less impact
    - increased personal responsibility by educating the public and teaching healthy habits from a young age
    - more education would mean the public access the right services and alleviate pressure elsewhere in the system
    - greater access to screening to help detect issues early
    - making better use of community services and infrastructure to keep people healthier, longer
    - care feeling more patient-centred and holistic, with health and lifestyle concerns taken more seriously
    - prioritising important areas include tackling poor diet, lack of physical activity, smoking and/or vaping, and poor mental health

8. The public identify several risks and considerations around the shift to prevention:

    - fears of a ‘nanny state’ where people lose their freedom of choice and there are too many restrictions
    - scepticism about whether people will listen to and follow preventative advice
    - concerns about the creation of a blame culture if a patient has failed to prevent their illness
    - financial or other lifestyles barriers to people engaging in healthier behaviours
    - delayed response to current needs and/or neglect of current health issues due to focusing too much on prevention
    - concerns about effectiveness and achievability changing people’s behaviours and habits is difficult
    - it will take time to see results - and it can be harder to prioritise something with a longer-term vision when so many issues feel like a priority
    - diverting focus and funding away from delivery of care, especially in hospitals
    - concerns about services focused on prevention feeling ‘removed’ from the rest of the NHS

9. Staff identify quick wins and advice for longer-term success. Quick wins include strengthening local healthcare delivery, focusing on preventative healthcare measures, improving service availability and ease of use, and making healthy choices easier. Longer-term ideas include focus on preventative care and early intervention, working with and understanding local communities, sustained investment in preventative services and a fundamental shift in the healthcare approach.

10. The early findings from the portal support thinking about the shift to prevention in 2 different ways:

    - shift focus to root causes and structural challenge
    - shift focus beyond state and individuals to others who have a responsibility for health such as schools and workplaces. Additionally, early insights from the deliberative events show that a focus on capability may be more effective than personal responsibility

Annex B: consolidated list of recommendations

Addressing low uptake and meeting people who most need them where they are

1. Preventative services should find the people who are most at risk and have the most to benefit. This may be through needs assessment or risk stratification at population level or individual risk assessments. Where low uptake is an issue, the system needs to be charged to intervene quickly and find ways to ensure increased uptake and positive outcomes. They should draw on best practice from other areas and behavioural insights to tailor how they communicate and reach groups at greater risk.

2. Preventative services should be universal across the country, but resources should be in proportion to size of deprivation and need. Services for people who have higher need should be seen as the standard model for delivery, rather than as separate add-ons to a model designed for those who find access easy. Lessons from services in more deprived areas such as Deep End Practices and those that focus on groups at risk of exclusion should be shared and adopted.

3. For groups with higher need or low uptake, local areas may need to increase the use of outreach teams that will take services to the people or areas in most need (such as alcohol and drug outreach teams, migrant outreach teams, school nurses for childhood immunisations, trauma informed services). This could include measures such as pop-up clinics in the community to target specific underserved groups (such as health checks in homeless shelters or for those in the most deprived areas) or mobile clinics in rural areas with limited healthcare infrastructure. There are many successful models of community engagement in preventative activities and co-creation will be an important component of service design. For example, HPV self-screening in Denmark has increased engagement in those who had not been screening in over 10 years.

A whole health approach

4. With the consent of patients, all healthcare professions should be able to access the whole health status of the person through the creation of single digital records where information on preventable conditions and risk factors are accessible. In line with the recommendations of the Sudlow Review this would require ongoing co-ordinated engagement with patients, the public, health professionals, policymakers and politicians to build and safely use these records. This digital health record could be expanded to social care and VCSE organisations delivering preventative services.

5. Health services should by default take a whole person approach so that prevention opportunities can be addressed. The workforce should understand that it is within their

responsibility to sensitively address wider health concerns with individuals - and be empowered and resourced to do so. This should place a greater focus on preventable health conditions and preventative interventions. Shifting from hospital to community is key to this. And specialists should retain some generalist skills, including on preventing and managing multi-morbidity and its risk factors. Local systems should join data together to enable this approach.

Shifting prevention support closer to the person

6. Prevention services could be simplified with more services provided at home through your smartphone or computer, or through the greater use of at-home testing or screening for those people who need it. An individual's engagement will make them a partner in managing their health; and we will support people to use simple tools at home or in an easily accessed community setting such as blood pressure monitors and know how to respond to the results. More flexible appointments for preventative services should be available, including out-of-hours. We need a clearer offer of services that are well linked to one another, and a greater focus on making sure people who need support most are able to access it.

7. DHSC and NHS England could evaluate the most cost-effective models of using non-healthcare settings to deliver services and improve outcomes and encourage the expansion of these models if they are cost-effective. This should include people accessing healthcare at mobile, drop-in or pop-up settings, and within wider community settings (such as supermarkets or places of worship). Success can be drawn from models like the Community Appointment Days model for MSK that has reduced waiting times thanks to engaging underserved patients and encouraging and signposting self-treatment.

8. Relatedly, DHSC and NHS England could evaluate the most cost-effective models of using wider health staff to deliver services and improve outcomes and encourage the expansion of this workforce if they are cost-effective. Trained health champions and community health workers could be placed within local support services, such as job centres, housing support or local GP surgeries to help manage the demands upon highly skilled clinical staff. Interventions should still be delivered by optimally skilled staff as a professional practice, appropriately supervised where needed, and consistently trained and accredited.

Expanding prevention beyond healthcare professionals

9. The use of social prescribers could be rolled out to engage people in preventative interventions. Social prescribing connects people to local groups and services to address their social and practical needs that affect their health. They could play a key signposting role, backed by increased availability and accessibility of preventative services. We should evaluate and build upon successful social prescribing models.

10. Responsibility for prevention could extend beyond the health system to include employers, schools, faith groups and universities. These organisations should be incentivized and rewarded for benefits delivered. NHS funding could flow to the network of organisations that can best deliver population health, rather than defaulting to NHS providers. For example, schools or employers (including the NHS) that deliver improved health within their pupils or employees could be rewarded for their contribution, either through a commissioner, or based on minimum standards of provision linked to lower employer national insurance contributions. Private providers of preventative services (for example gyms) could be rewarded for targeting particular populations. Making this work at a local level would be the responsibility of ICSs. They could build on the community health and wellbeing workers (CHWW) model that originated in Brazil; CHWW serve as health workers and community representatives to proactively identify health needs and offer tailored support.

Planning, accountability and oversight

11. Over the next decade, technology, business models and consumer experiences that start with early adopters must be supported to expand into mainstream health, so that the whole population benefits.

12. Health systems should design services around those who have the least information and data, while leveraging the benefits of an increasingly data-rich population to target services. For example, the group heard the work of the Brazilian healthcare system which was able to utilise population data in Rio de Janeiro to identify pockets of low rates of child vaccinations, enabling them to send health visitors directly to those areas, vastly increasing uptake as a result.

Shifting prevention support closer to the person

13. Preventative services should be designed in a way that is informed by an understanding of human behaviour. It should be as easy as possible to make healthy choices and sustain healthy behaviours. NHS support should be designed to engage and empower individuals and communities to be partners in their own health.

14. Preventative services should make it easy for people to do the right thing to protect their health. Professionals need to communicate to people in a way that makes sense to them, is easy to understand and is achievable within the life that they lead. They should draw on best practice from other areas and behavioural insights to tailor how they communicate with and reach groups at risk of exclusion.

Maximising the use of data to allow prediction and empower individuals to act

15. Every person and healthcare worker could have access to a single, trusted, secure and timely digital health record covering all health interactions from cradle to grave. Within this, primary and secondary care should be linked as a priority given their role in secondary prevention.

16. By 2035 this record may be linked to wider public sector records (such as benefits and care) as well as private medical provision (such as cholesterol monitoring or prescription of weight loss drugs outside of NHS). Within the clear legal information governance framework there are potential benefits at population and individual level which should be explored, such as data sharing being part of the GP contract.

17. By 2035, this record will include information on whole health status, including information on own personal risk of poor health through health assessments or screening. Ethically it is very important that any identification and communication of risk is as accurate as possible and allows individuals to link to effective services which are proved to change outcomes and don't just present them with worrying information and leave them with no support.

18. DHSC should accept and implement the recommendations from the Sudlow Review. The recommendations provide a pathway to establishing a secure and trusted health data system for the UK.

19. The NHS could develop and procure digital and AI tools for preventative health management, risk stratification and support for adherence (for example, automatic reminders for hypertension medication). The purchasing power of the NHS should be leveraged where national level rollout of tools is appropriate. A prerequisite to this is that basic technology capabilities for staff must be met - there is no use asking a district nurse to use a novel AI risk stratification tool if they are unable to connect to the institutional network. We can learn from the Israeli health organisation Clalit, who developed an AI-driven preventative platform to guide doctors through routine consultations. The platform creates detailed clinical pathways based on the most up to date guidelines and cross-references with the patient's medical record.

20. The NHS App has the potential to be very valuable from a prevention perspective as an opportunity for self-referral and providing access to NICE-approved digital interventions. The app will always ensure personal privacy for any areas that the patient prefers to remain hidden. An alternative access through more traditional methods will always be made available for those who cannot use the app to avoid increasing health inequalities due to the digital divide. For children and young people, this will be in the form of the digital Red Book.

Planning, accountability and oversight

21. Metrics for prevention activity should be identified, and NHS performance should be rebalanced to put prevention targets on an equal footing with targets for acute or hospital care, such as waiting times. They should be outcomes-focused covering the conditions or risk factors with the greatest need and potential, noting that there can be some time lag in realising the benefits of prevention measures. For example, measuring smoking status at the time of elective surgery would give an indication of the success of support in the community and within acute pathways.

22. At national, regional and ICS level there should be a named board-level individual who is the budget holder for secondary prevention activity, and accountable for the overall strategy and delivery of activity on secondary prevention. They should have the power to intervene to re-allocate spending or change service provision to achieve the agreed outcomes. Public health expertise will play a critical role in delivery of this function. Accountability mechanisms need to be designed around other areas of the health system that have a role to play in prevention, for example, electives and urgent and emergency care.

23. DHSC and NHS England should work with local areas through ICSs to consider and translate central priorities into localised plans. This should be incorporated within ICS 5-year plans with prevention being given a greater focus. ICSs - with the involvement of local authorities, voluntary sector, employers, private providers, and civil society - should outline how they will increase prevention activity and achieve outcomes across priority areas, noting the impact of the Devolution White Paper. Workforce resource will need to shift according to priorities with public health leadership at all levels.

Funding and contracting structures

24. A target to increase prevention spending by one per cent of total health expenditure per year, with the baseline being established as part of the Spending Review process. The budget for prevention activities should be ring-fenced with the categorisation of what is and is not prevention activities being resolved as part of the Spending Review process.

25. Changes to spending at a national level should be reflected in budgets and priorities set for local areas covering both local authorities and ICSs. The Hewitt Review recommendation to increase the share of total ICS budgets going towards prevention by at least one per cent should be enforced to reflect changes at a national level. Sustainable long-term funding is critical to building the infrastructure for significant preventative spending.

26. Existing funding or contracting structures should be reviewed and reformed for LAs, ICBs, PCNs and GPs (including the QOF) to develop incentives that encourage the delivery of the most cost-effective and impactful prevention interventions. There should be a re-balancing of financial incentives from delivery of treatment to delivery of prevention within prioritised areas, with a public acknowledgement by government of what these trade-offs may mean for other parts of the system in the short term.

27. As part of the Spending Review, DHSC and NHS England should analyse the cost to society of preventable conditions, such as obesity or MSK. This analysis should inform the funding and contracting structures by increasing the price paid to providers for prevention programmes so they can achieve wider societal benefits.

28. Alongside wider contracting changes, reporting on the Public Health Outcomes Framework (PHOF) should be made statutory. The PHOF should be updated to provide greater clarity on what outcomes should be prioritised to rebalance towards prevention and address inequalities in uptake.

29. Given the relative cost-effectiveness of prevention activities, it should be possible to fund preventative services from within the health service, but innovative financial mechanisms should be examined particularly around increasing targeted uptake by particular populations.

30. Population based bonuses for meeting agreed health targets which result in a financial reward distributed among contributing organisations; reductions in National Insurance contributions based on a minimum standard of health promoting behaviour or micro-payments (finders fees) for referring entities such as pharmacies or influencers. The finance group should examine a way of sharply incentivising outcomes rather than the activities currently within QOF and ensuring these funds flow to the organisations most able and willing to shift people's behaviour.

Investing in the priority areas

31. A set of criteria could be used to identify areas or conditions where prevention provision and funding should be prioritised, which could include:

    - prevalence of ill health in the population

- future trends in ill health
- contribution to health inequalities (for example, measured by prevalence among the most deprived groups or areas)
- the severity of impacts on individuals, including on workforce participation and healthy life expectancy (such as measure by DALYs and SRH)
- the cost-effectiveness of solutions is available (for example, measured by cost per DALY or QALY for given intervention)
- the effectiveness of local and national interventions.

32. We recommend that there are 3 groups of priorities for prevention:

- Retain and scale up - areas where the prevention evidence is strong and services are in in place, but not reaching everyone:
    - CVD prevention (such as heart attacks, strokes, multi-infarct dementia). The beneficial effects of secondary prevention of cardiovascular disease, including risk-based advice and prescription of appropriate antihypertensive agents and statins, are profound and rapid. If hypertension treatment optimisation rates were improved to just 80 per cent, this would prevent 17,000 heart attacks and strokes in England in 3 years, saving around £200 million in NHS spend alone
    - Stop Smoking Services in care pathways and by referral from GPs. If England became fully smoke-free, over £13.7 billion would go back into communities' and families' pockets. This is equivalent to the annual salaries of almost 700,000 nurses, half a million GPs, half a million police officers, or over 500 million GP appointments
    - vaccination coverage up to WHO recommended levels for childhood immunisation. If the new RSV programme for pregnant women reaches 60 per cent it will save 20,000 GP consultations, 5,000 fewer admissions and 200 fewer infants admitted to ITU every year. Cervical cancer will be almost eliminated if HPV vaccination coverage targets are met
    - screening programmes, for example breast screening - increasing the screening uptake to 80 per cent would see a net cost saving in

2034 in the range of £96 million to £111 million for both economic and wellbeing costs,

    - diabetes prevention and pathway to remission of type 2. Approximately 200,000 people are diagnosed with type 2 diabetes every year. The Type 2 Pathway to Remission (T2PR) programme has been shown to achieve remission by almost 30 percent - with 200,000 people diagnosed every year, expanding access to T2PR could help more of these people to achieve remission

- Expand services and improve the evidence - areas where the prevention evidence is strong but service provision is currently inconsistent across the country and more evaluation is needed for optimisation:
    - physical activity within care pathways (such as for cancer or frailty) and during rehabilitation (for example, for cardiovascular disease or pulmonary disease)
    - alcohol care teams in acute trusts
    - fracture liaison clinics
    - weight management and the optimal pathways for behavioural change support, medication and surgery
    - mental health (including perinatal mental health services, child and adolescent mental health support teams, and access to talking therapies)
    - oral health prevention
- Areas where more research is needed on prevention to strengthen the evidence base:
    - musculoskeletal prevention, for example, back pain, frailty
    - mental health prevention for adults
    - prevention of Alzheimer's disease

These priorities span the life course from preconception, maternity, through childhood, working age and older age, noting that there are different needs and opportunities at different stages of life. This targeted approach to prevention delivery and research could form the basis of a National Service Framework for Prevention

33. Provision could be rolled out at sufficient scale for conditions where need and impact are high, and we have high confidence in the impact and cost-effectiveness of the measure. For example, this government could be a world leader in the eradication of smoking-related illness, if they were to ensure that all known measures and interventions are delivered

Scaling innovation

34. Decisions on provision of preventative interventions are best made using evidence of need and comparative cost-effectiveness. At national level DHSC and NHS England should ensure they have a central record of the cost-effectiveness of prevention interventions and how this compares to cost-effectiveness of treatments in other parts of the NHS. This should be used to identify and offer direction on which services should be prioritised for scaling. In areas, such as stop-smoking services, where we already know we have cost-effective measures in place, then scaling should be prioritised now without the need for collating cost-effectiveness data.

35. 'Test, Evaluate and Iterate' units could be established to develop prevention interventions for areas and conditions where there is strong evidence of what works but they are failing to effectively scale or are not being accessed by those who are most at risk and who have the most potential to benefit. Innovation in prevention should be encouraged and supported at ICS level. Service providers should be required to constantly iterate their prevention services as they adapt in real time and improve to deliver better outcomes. There should be open communication across commissioners and providers to ensure lessons learnt can be translated to other areas. This does not mean that what works in one area automatically translates to another with different needs and service infrastructure, but the emphasis should be on speed of knowledge transfer and constant improvement. We could explore the concept of an 'open healthcare network', where multiple providers can plug in, interoperate, compete, and evolve. This is likely to be better than either monopoly service provision or centralised procurement in driving innovation. Staff should have the time and appropriate skillset to implement, iterate and scale innovative approaches.

Investment in research, development and innovation

36. DHSC should identify and communicate their prevention priorities for research and development and innovation. These would be for areas where there is currently a lack of evidence on preventative interventions that are high impact and cost-effective or for specific cohorts such as children and young people or people at risk of exclusion. Funding for research should be earmarked through NIHR and other research council programmes or through challenge prizes and other more agile methods.

37. The healthcare system and private providers can be incentivised to develop, test, iterate, and scale evidence-based prevention innovations through mechanisms such as reimbursement or accelerated regulatory approval. For example, the approach to incentivising digital prevention interventions could be more aligned with the way pharmaceuticals are introduced. Clinical standards for new technologies should also be published so developers have better guidance on the criteria required for approval.

38. Alongside the development of a digital patient record, an anonymised, trusted longitudinal database of linked NHS records should be prioritised for research on preventable conditions and evaluation of interventions targeting key evidence gaps. This would be the same database that will have been developed to enable digital patient records.

Annex C: preventative interventions across the life course.

Life course:	Prenatal	Age 0 to 2	Age 3 to 10	Age 11 to 18	Age 19 to 40	Age 41 to 65	Age 65 and above
Objective	Promote a healthy pregnancy to set up the unborn baby for a healthy life	Build the foundations of good physical and mental health and cognitive development	Prevent disease, build and develop protective behaviours, and prevent the uptake of unhealthy behaviours	Prevent disease, build and develop protective behaviours, and prevent the uptake of unhealthy behaviours	Prevent the early onset of disease and ensure continued labour market participation	Prevent the early onset of disease and ensure continued labour market participation	Improving life quality and promoting independence
Providers	Maternity services, Primary care, Family services, Public health services	Families, Family services, Primary care, Health visiting	School nurses, Families, Schools/colleges, Primary care and community health services, Youth services	School nurses, Families, Schools/colleges, Primary care and community health services, Youth services	Public health services, Primary and secondary care, Employers, Mental health services	Public health services, Primary and secondary care, Employers Mental health services	Adult social care, Primary care and community health services
Prevention interventions	Good diet and nutrition for baby health, Stop smoking incentives for	Supporting parental attachment, Routine immunisations, Supporting parental mental health, Substance	Routine immunisations, Free eye and hearing checks, Speech and language therapy, Supervised toothbrushing,	Early intervention in mental health support, Sexual health services	Sexual health services, Weight management services, Smoking cessation services,	Diabetes prevention programme CVD and diabetes health checks Identification, treatment and	Falls prevention, Early social care to prevent escalating needs, Seasonal vaccines, Supported

Life course:	Prenatal	Age 0 to 2	Age 3 to 10	Age 11 to 18	Age 19 to 40	Age 41 to 65	Age 65 and above
	pregnant women! Prevent maternal distress! Antenatal checks Perinatal: targeting substance abuse	misuse treatment for parents, Breastfeeding support, Neo-natal screening, Healthy start vouchers (0 to 4)	Active play, School-based emotional and learning programmes		Mental health services	management of CVD risk Screening (45 to 70), MSK services Perioperative care	housing, Treatment and management of CVD risk factors

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