NHS Confederation

Unlocking prevention in integrated care systems

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In partnership with

University of Stirling
University of Southampton
Newton

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Key points

- The government and ICS leaders agree that a shift to prevention is essential in helping people live longer, healthier lives and in ensuring the performance and sustainability of the healthcare system. Shifting from treatment to prevention is one of the three major shifts the new government wants to achieve and is a key priority for local government and burgeoning mayoral combined authorities.

- The NHS Confederation, in partnership with Newton and the Universities of Stirling and Southampton, undertook a project to explore what role ICSs can play in 'unlocking' the prevention agenda by overcoming persistent barriers to prevention and to uncover best practice that exists across the country.

- Partners across ICSs need to direct attention towards the most effective interventions at neighbourhood, place and system level and how evidence can be used to re-allocate resource from the acute sector to support people closer to home in primary and community care.

- System leaders are hopeful about the opportunities provided by ICSs and there are many examples of successful initiatives which are fostering system leadership; collaboration on the wider determinants of health; articulating new aims and connecting them to deliverable evidence-backed objectives; making prevention everyone's business; institutionalising prevention; and harnessing the power of high-quality data. Integrated care partnerships offer the opportunity to think beyond the NHS agenda to address the wider determinants of health.

- Most ICSs have prioritised prevention at a strategic level but there are others that are going further, often driven by leaders who are able to ringfence funding towards well-evidenced preventative interventions. Other systems, including those with quality or financial challenges, may be committed to doing preventative work but are being pushed to focus on immediate operational and financial pressures.

- There are persistent barriers to prevention and an enduring gap between commitment and progress, caused by insufficient clarity about the meaning of prevention, congruence with routine government business, and capacity to shift resource into prevention. There is no clear prevention framework that systems typically use to set targets, benchmark spending or monitor progress on prevention.

- System leaders also identify barriers to progress including short-termism; financial and operational pressures; making a business case for long-term investment; limits to system-wide cooperation; tapping into all system and community assets; and the lack of opportunity for peer learning and improvement. There is also a high burden of proof placed on demonstrating value for money or return on investment for preventative activity in comparison to other interventions.

- This report makes several recommendations to government and national bodies to accelerate work on a national framework for measuring prevention spending, including an agreed definition and metric for preventative services (both NHS and local government spending) so a 'left shift' can be measured at national and local levels. We also recommend: financial and regulatory incentives for work on prevention; ICSs are given autonomy to spend time and money where it will have greatest impact; the scope of the new government's health mission is truly cross-governmental; supporting the data, digital and technology workforce; and promoting a culture of learning and best practice.

Background

Shifting from treatment to prevention is one of the three major shifts the new government wants to achieve, along with moving to care closer to home and towards digitisation. The Hewitt review and the Darzi report have shown there is substantial agreement on the need for a fundamental shift in the model of health and care, from treating ill health to preventing it in the first place. The Hewitt review made recommendations to support a shift of resource towards prevention, to define and identify preventive services and to incentivise local and national prevention efforts (including through payment mechanisms). The government's upcoming ten-year health plan provides an opportunity to deliver such changes.

The core spend on health and social care dwarfs new pockets of specific money for preventive initiatives, which is currently around 5 per cent of overall NHS spend. The last Conservative government commissioned John Deanfield to write a report on personalised prevention, which estimated that applying early preventative interventions could achieve a 33 per cent reduction in ill health and unlock a £320 billion rise in GDP over 20 years.

In May 2024 the then Secretary of State for Health and Social Care confirmed that the government will be implementing the Hewitt review recommendation on defining prevention spend to support baselining by identifying and benchmarking health service prevention spending, with NHS England and the Department of Health and Social Care (DHSC) working closely together to develop guidance to help integrated care boards (ICBs) with decision-making. But government officials estimate that developing an initial definition and applying this for benchmarking will take several years. Simultaneously, the Chartered Institute of Public Finance and Accountancy (CIPFA) and the Health Foundation are attempting to define and categorise prevention spend within local government over two years.

In the lead up to the general election, various organisations in the healthcare space, including the NHS Confederation, developed 'manifestos' to influence a new government. Many of these included a focus on upstreaming and preventing ill health either as a core recommendation or as an overarching theme.

Labour's manifesto pledged a greater focus on avoidable ill-health prevention throughout the healthcare system and action on improving the health of the public ranging from multiple long-term conditions to banning advertising of junk food to children. Since the general election in July 2024, the new government has provided more detail on its national health mission. An early announcement was that DHSC will lead a ten-year health plan, which must ensure that the shift to a preventative healthcare system is a central tenet for improving population health outcomes. The Darzi investigation into the state of the NHS laid the groundwork for the ten-year plan and underscored the importance of achieving three shifts: from treatment to prevention, hospital to home and analogue to digital.

While there is broad consensus at both system and national level that, if done effectively, prevention will improve health outcomes and make the health and care system sustainable, there is still no national framework such as NHS England's Core20PLUS5 approach to reducing health inequalities. Moreover, this need and commitment offers no guarantee of effective action and there remains a gap between policy statements on prevention and outcomes in practice. Clearly, there are barriers that need to be overcome if we are to unlock the profound benefits offered by a preventative model of healthcare.

To support scalable learning and improvement across the NHS, the NHS Confederation, University of Stirling, University of Southampton and Newton have sought to understand and address barriers to at-scale preventive health and care within ICSs and provide guidance to local leaders.

The report is based on new research drawing on seven focus group discussions with approximately 60 participants from across 22 ICSs – just over half of all systems in England – with representation from all seven NHS regions. We also spoke to representatives from 19 national organisations, including voluntary, community and social enterprise (VCSE) organisations, think tanks, national providers, provider representative organisations and central government. See the methodological appendix for more information.

This report establishes:

- what prevention means to people working within integrated care systems
- the barriers, enablers and opportunities for prevention within systems
- best practice on overcoming those barriers
- the support needed at the national level to progress the prevention agenda through integrated care systems.

These lessons inform a practical guide, developed by Newton, to help leaders learn from others and support systemic change.

The national picture

Integrated care systems (ICSs) were created as formal partnerships in 2022 in recognition of the need to shift the organising principle of the NHS from one of competition to one of collaboration, where the NHS, local government and the VCSE sector work together to deliver improved outcomes to population health and wellbeing at a local level.

At their core, ICSs are partnership collaborators and many of the changes they will bring through new ways of working and commissioning of services will take place over a longer time horizon. Leading system-wide transformation such as the shift to preventative healthcare will take time and sustained commitment from many system partners. ICS leaders want to deliver against their four core purposes:

1. Improving population health and healthcare outcomes.

2. Enhancing productivity and value for money.

3. Tacking inequalities in outcomes, experience and access.

4. Helping the NHS to support broader social and economic development.

However, in the face of ongoing operational and financial challenges, political attention is driving their focus towards immediate problems of recovering elective and urgent and emergency care and improving primary care access. National policy and guidance does not always provide clarity or incentivise a focus on the prevention agenda. For example, NHS England's operational planning guidance drives higher focus, resource and capacity on meeting current 'nationally' set targets, focused on access and waiting times.

National targets on prevention do not provide sufficient clarity on outcomes from prevention work, how this links to outcomes frameworks and also the

balance between national prescription and local choice. For example, NHS England could provide lists of interventions and activity across primary, secondary and tertiary prevention, with good evidence of cost-effectiveness or equity that local organisations and systems could select based on local need. In terms of long-term physical and mental disease prevention, an acknowledgement of changing disease patterns (epidemiology), ie. increase in multimorbidity, is needed. Given the current single disease management pathways model, this shift to cluster medicine is required to ensure the complex needs of multiple diseases are prevented and managed effectively.

Despite these challenges, our research has shown that there is a high level of commitment within systems to making the changes needed to drive improvements in population health and to ensure the long-term sustainability of the health and care system, and our research uncovers many examples of progress. ICSs are each on a different improvement trajectory, with some having up to five years head start of partnership working between NHS, local government and other key partners. Differences in demography, geography, politics, local configurations and ways of working call for different approaches and solutions, but there are learnings that can be gleaned from the way local areas and systems have unlocked prevention.

Why prevention is so difficult to secure

Prevention is often presented as the best solution to a social problem, from crime to social exclusion to healthcare. In the name of prevention, post-war UK governments have proposed to change policy and policymaking across the whole of government, to shift resources from the delivery of reactive public services to solve acute problems, to the prevention of those problems before they occur. This transformation could reduce inequalities by focusing on their underlying causes (the social or wider determinants of health), solve the problem of unsustainable public spending, and encourage collaborative policymaking between health and local authorities, stakeholders and communities.

However, the literature shows that post-war UK governments have not known how to take forward this prevention agenda. Research shows cycles of enthusiasm and bursts of initiatives, followed by disenchantment with slow progress and reduced activity when governments move on to other agendas.

The recurrent message is that health and social care policy makers, both locally and nationally, have tried and failed over several decades to make a shift to a preventative model of care. People agree on the need for prevention, but not what it is or what to do in its name. They agree on the broad need to change but have good reasons to protect current practices and resist challenge. They need, but do not have, the capacity to deliver for the long term.

This gap between intent and real-world practices can be explained in three broad categories:

Clarity: 'if prevention means everything, maybe it means nothing'

The language of prevention is vague. While this ambiguity can help to maximise initial support for 'preventing problems', it also delays much-needed discussion on how to translate abstract aims into concrete action. When these discussions take place, intense debates ensue about the main priority, such as reducing inequalities or costs, and preferred policy tools, from providing individuals with information to regulating behaviour, reorganising services or taxing/spending to redistribute income. These differences can reflect profound disagreement on whether the role of the state is to intervene and redistribute resources, or to foster individual responsibility for health and wellbeing. Different arms of the state and different sectors are set up to have fundamentally different goals, functions, accountabilities, funding structures and levers. This misalignment makes it difficult to achieve the kind of cross-sectoral prevention that is needed to improve outcomes. The scale of investable activity is also vast, including whole population efforts (primary prevention), identifying at-risk groups (secondary), and preventing known problems from getting worse (tertiary), across both mental and physical health.

Congruity: prevention is out of step with routine government business

When making the case for prevention, there can be a disconnect between what are seen as the most pressing issues and the benefits of prevention. Prevention does not generally deliver economic growth or immediate 'cashable' savings – two central imperatives for politicians. Further, prevention's offer of long-term improvements to health or wellbeing does not help an elected government measure and declare short-term success. Having said that, actions such as de-prescribing and shared decision-making are examples of tertiary prevention that can have impacts in the here and now for individuals. These actions require cultural change, professional awareness and skills-set development, alongside the tools to deliver and measure such inputs at scale across multiple providers across a system. For local public bodies, prevention sounds like a great way to collaborate, but only after they deliver their high stakes statutory commitments and respond to immediate demands.

Capacity: low support for major investments with uncertain rewards

No policy can improve lives, reduce inequalities and avoid political and financial costs. There is no magic bullet. Rather, preventive policies can involve hard choices. They are often akin to capital investment but the timescales for seeing a return on investment are longer for many preventative interventions. This offer is not attractive to governments seeking to avoid controversial or risky investments and reduce spending, in turn making them less appealing to cash-strapped national and local decision-makers. Rather, prevention may represent a political 'leap of faith' that few policymakers are willing to take and requires a level of 'systemic capacity' that is difficult to find.

The question posed by this research is therefore:

What would make the difference this time?

- How can ICSs further the prevention agenda where their predecessors have failed?
- What experiences of prevention can help to overcome routine barriers to change?
- What skills and strategies are most valuable to system leaders?

Key findings: views from systems leaders

Defining prevention

With previous research suggesting that the description of prevention is vague, it is important to identify a clear way of thinking about what prevention means and how it ought to manifest in the work of ICSs. One participant described 'prevention being anodyne' as the biggest barrier to progressing the agenda. Some prefer to use phrases such as health creation, wider determinants of health, living conditions or building blocks.

While a nationally defined definition will not be able to capture prevention in its broadest sense and local leaders may prefer definitions that reflect the particular needs of their populations, having an agreed understanding of prevention will be crucial to support increases in ICS's spending on preventative interventions. Without a national definition of what constitutes spending on prevention it will be impossible for ICS partners, local people, MPs, national government and regulators to know whether progress is being made towards shifting funding towards prevention.

In defining prevention, this project detected two distinct ways of thinking:

1. **A stronger, bolder, more expansive and more transformative view of prevention, sometimes referred to as 'primary prevention'**.

As one VCSE representative put it:

"Fundamentally it's that culture and mindset shift, moving from a medicalised model to one that recognises the wider determinants and the social and economic conditions that people live in. That's proving really, really challenging.

There's a lot of rhetoric around the 80 per cent of our health that isn't determined by health and care services. But then most of our activity and focus seems to be from the health and care services."

In general, this perspective was much more strongly held by those closest to the coalface of prevention work and local communities in practice, especially among general practitioners and place leaders, public health professionals in local government and representatives from the VCSE sector. For these individuals, prevention represents the moral case for state intervention, to foster the public good and challenge the idea that individuals should take sole responsibility for health and promoting a mindset shift towards the social determinants of health. In most focus groups, the phrase 'left shift' was used to refer to approaches to prevent ill health in the first place (addressing the wider determinants of health, supporting improvements to health behaviours) and to earlier intervention for those with disease, through better primary, community and social care.

2. **A more cautious, sustainable approach focused on incremental change in a context of extreme financial and operational challenges**.

As one ICB leader put it:

"I find NHS colleagues can over focus on the need to have an absolute definition of something before we're allowed to move on to the next step of anything... Sometimes that can be the reason for not doing anything. So I think we have to be clear that we don't necessarily have to nail it down so tightly because it'll be all the reasons why you haven't got enough evidence to actually make that that sort of thing happen."

Proponents of this view tended more often to be in strategic or system convenor roles and therefore to have a birds-eye-view of the system. They prioritise health-service-focused changes that can demonstrate short-term impact. While these individuals may accept the social determinants framing philosophically, given that they are accountable for overall system performance and therefore convincing politicians to invest in prevention, they may choose a framing that is more politically palatable. They fear that, under the more expansive guise, prevention work can too easily be seen as the 'holy grail',

or too big a problem to solve. They fear that if, for example, local authorities see prevention as solely their responsibility, it may inhibit rather than bolster collaboration. Instead, then, they favour a focus on achievable aims in relation to specific groups or priorities. They seek to identify interventions that can reduce the burden of disease in the population, to produce results that are societally beneficial and free up healthcare resources by preventing readmissions to emergency care or reducing demand on social care.

Others believe a third way might be opened up between these two extremes, one that centres around 'split-screen thinking' (both long-term transformation and incremental immediate action) and that positions tertiary and secondary preventive interventions as a bridge to wider primary prevention over time.

Overall, these findings demonstrate that simply providing a written definition of prevention does not resolve ambiguity and that, for ICS leaders, there is value in taking the time to establish common aims, language and understandings.

For the national picture, the findings indicate that a 'perfect' definition that is universally accepted will prove impossible to come by. However, there can still be significant value in a framework that gives shape to practice and offers parameters within which individual ICSs can manoeuvre more effectively. A definition and measurement plan would inform the delivery of the government's ten-year health plan.

Two ways to address the ambiguity of prevention

Option 1: Key actors, including the ICB chief executive/chair, directors of prevention/population health management and director of public health, define prevention on behalf of the system. This strategy can be effective if system-wide agreement is possible and clarity of terminology can boost fundable action.

Option 2: Collaboration between system partners to find a common meaning helps to boost wider cooperation. This strategy can be effective if agreement is lacking and definition is a negotiation rather than a technical exercise.

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> Coming together to reach a common understanding of prevention could prompt whole-system collaboration and therefore be a 'quick win', increasing the likelihood of confidence among partners when moving onto investment and action.

The NHS Confederation MEPS framework, which is widely supported by system leaders, can support both options. MEPS offers a way to identify how persistent barriers to preventive policy might be overcome.

Opportunities and enablers for prevention

Although participants identified many barriers to prevention, they were also hopeful about new opportunities provided by system working, in particular spurred by integrated neighbourhood and place working. When we asked for examples of progress in overcoming these barriers, they identified the successes of early action and provided a wealth of examples of promising or good practice.

Systems leadership for prevention

One set of promising practices relates to developing effective forms of systems leadership that can cut through some of the administrative barriers to progress on prevention. In the best cases, that leadership starts with a strong strategic vision shared across system partners that is championed by the leadership. For example, we heard a promising account from Nottingham and Nottinghamshire of sustained progress in the face of immense financial and service pressure. Participants described the essential and highly valuable direction and support from ICB senior leaders, able to lead new strategies and provide sustained support for delivery, with prevention being a key pillar in their ICS strategy. There is an impressive will to embed prevention across the system and clear guiding principles that resonate across the system.

More generally, much focus group discussion identified the need for 'bravery' to tackle unsustainable service models and redirect focus towards wellbeing and health creation Ultimately it rests on ICB leaders to increase the amount of money allocated to prevention, joining up with colleagues in local authorities and the VCSE sectors where possible.

In this context, ICB participants highlighted the potential for a more distributed form of systems leadership that drew on collaborations across its constituent

organisations and networks. A particularly promising avenue is to connect to 'place' agendas and use the coming together of health and local government devolution as a new opportunity to push for transformative change. For example, North Tyne Combined Authority has capitalised on its devolution deal to better join up existing prevention measures across the system, including by mapping activity. It has also taken the opportunity to push for a radical shared prevention budget between the ICB and combined authority. Early pledges from Labour suggest that this 'devolution revolution' is likely to accelerate.

Leaders often alluded to the notion of the requirement of system leadership and system thinking approaches, where collective action on prevention was required across organisational and professional boundaries grounded in the needs of their communities. It was felt that to maintain the momentum of prioritising prevention it was essential to consider the interplay between system culture and structure, alongside issues of power, uncertainty and trusting relationships.

North of Tyne Combined Authority's Child Poverty Prevention Programme

The north east has consistently had one of the highest levels of child poverty in England, with more than a third of children growing up in poverty. The region has experienced the steepest increase in child poverty over the last decade, with 67 per cent of those affected living in working households. In response, in 2022 the North of Tyne Combined Authority's Child Poverty Prevention Programme (CPPP) collaborated with local authorities, healthcare services and children's services to address poverty in schools, workplaces and family settings, developing interventions based on recommendations from the 2020 IPPR North report.

The programme operates under four pillars: poverty interventions in schools, welfare support through the school gate, working with employers to tackle child poverty, and focusing on the critical first 1,001 days from conception to school age. The North East Combined Authority has committed to expanding the programme across the region, ensuring ongoing support for families in need.

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The CPPP has achieved significant benefits for families living in poverty over the past two years. Through welfare support in primary schools, the programme has secured over £2 million in annualised benefits for families living in poverty. It has supported 99 employers in tackling in-work poverty, with 40 developing impactful poverty reduction action plans, resulting in workplace improvements for over 40,000 employees, such as flexible working hours and the installation of workplace showers. Additionally, 120 schools have accessed funded poverty interventions, including family learning sessions, grants, and poverty-proofing audits, mitigating the effects of poverty for children and families. The programme has also provided over 350 vulnerable families with 'baby boxes' from the Children's Foundation, with plans to distribute a total of 750 by autumn 2024. The programme supported the local population to avoid problem debt, mental health crises, long-term health conditions and relationship breakdowns.

Embedding collaborative ways of working

Leadership is an important part of the puzzle, but to be successful systems need to find and embed effective ways of integrating services and strategies. Participants described three types of promising collaborative work:

- Combining multiple professional roles in a single service.
- A common aim, shared ethos or reference point.
- Collaborating with community groups.

Several initiatives combine multiple professional roles in a single service, such as to provide housing expertise in NHS trusts, employ mental health nurses in in local authority housing teams, or draw on Citizens Advice in patient mental health wards.

Hampshire and Isle of Wight Healthcare NHS Foundation Trust and New Forest District Council embedding mental health expertise in housing teams

Hampshire and Isle of Wight Healthcare NHS Foundation Trust (formally Southern Health NHS Foundation Trust) and New Forest District Council (NFDC) partnered to embed a mental health nurse within NFDC's housing team, focusing on early intervention and support for tenants with mental health issues. This initiative reduced hospital admissions, enhanced communication between community mental health teams and housing teams and promoted early intervention for mental health issues within the community. Prior to this initiative, NFDC's housing team frequently sought support from community mental heal teams due to deteriorating mental health among tenants, causing friction between the teams and causing delays in care.

Acknowledging the need for improved collaboration, the organisations secured funding under the Rough Sleeper Initiative to embed a mental health nurse within NFDC's housing team. This strategic move aimed to enhance early intervention for mental health issues, ensuring individuals received support before reaching crisis points.

The embedded nurse's role brought immediate benefits, including reduced hospital admissions and improved discharge planning for complex cases. The nurse also conducted medication checks, educated housing staff on mental health issues, and assessed new applicants with mental health conditions to ensure appropriate support. Key outcomes included improved communication between teams, decreased CMHT workload from housing-related crises and enhanced overall service quality. The success was attributed to strong leadership support, clear role delineation and proactive collaboration between clinical and non-clinical teams.

Further analysis revealed that only 31 per cent of the people who were supported by the mental health and housing practitioner were already open

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to secondary care mental health services. This highlighted that over two-thirds of the people supported through this partnership were not accessing the support services they needed in the community. Making mental health services more accessible and immediately available enabled those individuals to engage with the support they needed. The data indicated that individuals with at least one admission prior to this intervention have not had any admissions since the intervention, effectively breaking the cycle of repeated admissions and discharges to homeless services. Additionally, individuals who had not required admission before the intervention also did not need to be admitted post-intervention.

In some instances, planned admissions were agreed upon as part of the interventions. Those facilitated admissions proved to be shorter and more effective than involuntary detentions or emergency admissions. The sustainability of community living post-discharge following a facilitated admission was also notably high, with zero re-admissions. Based on the ongoing success of the model, expansion continues with other local authority partners. Currently, five posts cover six local authority areas, ensuring that more individuals receive the mental health support they need in a timely and effective manner.

A common aim, shared ethos or reference point can help multiple partners make sense of their collective objectives. This can include shared training and workforce development strategies across teams that enhance may specialist and generalist approaches to prevention.

West Yorkshire ICB's trauma-informed approach

The West Yorkshire Integrated Care Board (ICB) is committed to becoming a trauma-informed and responsive system by 2030, driving culture change and fostering collaboration across all sectors and systems. This initiative emphasises building meaningful relationships between two key groups: individuals using or influencing services, and the West Yorkshire workforce, which faces significant stress due to increasing demands. By having trauma as a central framework, the ICB focuses on the critical importance

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of avoiding re-traumatisation for those seeking support, aiming to provide more tailored and effective care.

At the heart of this initiative is the West Yorkshire Adversity, Trauma, and Resilience Programme, a collaborative effort between the West Yorkshire Health and Care Partnership and the West Yorkshire Violence Reduction Partnership. Implemented across the system's five areas, the programme aims to prevent trauma, mitigate harm and prevent re-traumatisation across the life course. It supports organisations in becoming trauma-informed and responsive, while also ensuring that the workforce is well cared for and supported. By deepening the understanding of the population's needs and evaluating the services available, the programme strives to deliver interventions and influence care that ensures equitable and accessible services, responsive to the challenges faced by both service users and providers.

Many groups identified visions of the wider 'communities' side of prevention, which includes public sector organisations collaborating with community groups. The aim is to value routine or continuous conversations with people you would not normally relate to, and vice versa. For example, continuous professional development should include time to speak directly with communities, and strategic discussions should involve routine and meaningful meetings between service leaders, stakeholders and citizens.

Zooming in allows system leaders to better engage with an area-specific narrative of prevention. An integrated care area with a small population allows for good stakeholder discussion and leadership, and bursts of cooperative activity help to get programmes such as the NHS health check off the ground.

Making prevention everyone's business

Some participants expressed concern that making prevention everyone's business can mean that it is tricky to pin down who has prevention in their portfolio and that no one takes responsibility for key choices and outcomes. Here, we find a difficult balancing act: prevention needs to be part of the day

job of more people, but you also need someone or an organisation to oversee the whole system and strategic direction.

This responsibility should not only be in the hands of one or two impassioned individuals, there needs to be wide ownership, longevity and corporate memory in systems where there is inevitable staffing churn. This responsibility can vary by organisation and system (the CMO, director of strategy, or director of public health may take the lead), which can help innovation and learning between ICSs, but only if the responsibility is clear in each case. For example, we heard of initiatives in Nottinghamshire to identify primary, secondary, tertiary and structural aspects of prevention and use these categories to identify responsibilities and actions, backed up by a strong public health team. We also heard, from the ambulance service, of the value of consensus statements to foster a vision, design a plan, identify key roles for partners and show how to assess progress.

Health creation in East Surrey

East Surrey has made significant strides in improving local health and wellbeing through a co-creation approach that integrates place-based prevention into a neighbourhood model.

The Growing Health Together initiative launched in 2021, enabling primary care networks (PCNs) to collaborate with communities and partners to support population health, health equity and sustainability. This holistic approach emphasises creating conditions for health and wellbeing rather than solely focusing on treating illness. The work has included integrating NHS primary care with existing and emerging community development initiatives led by local authorities, including a well-established community development programme led by Reigate and Banstead Borough Council.

Following publication of the Fuller stocktake, Growing Health Together worked with GP federations to host workshops in major towns across East Surrey, engaging community members and professionals based in local neighbourhoods in discussions about local health and wellbeing. Their insights shaped a neighbourhood care model for East Surrey Place that adopts a citizen-led approach to prevention and health creation.

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Five health and wellbeing networks have since been established covering the geography of East Surrey. The networks meet quarterly to foster collaboration among various partners, including the NHS, local authorities, voluntary sector organisations, community leaders, health champions, schools, police, fire services, faith leaders and businesses. These networks address local issues affecting community health and wellbeing and build local health-creating capacity. The networks also integrate into the formal governance structure of NHS Surrey Heartlands ICS, ensuring that unresolved local issues are escalated appropriately.

Numerous new relationships and initiatives have emerged from these networks. These range from initiatives to improve GP access and facilitate ordering of repeat prescriptions for digitally excluded populations, through to community-led dance and creative arts programmes to support mental and physical wellbeing, and community cookery classes to support healthy eating at low cost.

To evaluate the efficacy of these initiatives, Growing Health Together collects patient level data from consenting participants in a sample of the funded initiatives to assess quantitative impacts on variables such as GP consultation frequency, weight, BMI and HbA1c levels. An independent evaluation of Growing Health Together is also underway by the University of Kent, using a mixed-methods design and incorporating qualitative data. The evidence base for informing all supported initiatives is also supported by existing models and literature demonstrating the effectiveness of similar interventions elsewhere. For example, initiatives that promote physical activity, social connection and nature connection are particularly well supported by research. Additionally, system-level monitoring of population health outcomes helps to ensure the work can target inequities in health outcomes, while also supporting overall improvements across the health of the population.

Overcoming obstacles required dedicated time and funding to foster relationships between statutory and non-statutory groups and the local population, but the benefits of these collaborations are evident in improved patient outcomes. For example, patients attending an inclusive exercise class, established in response to local demand, were noted to have

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experienced a reduction in GP attendances and reductions in weight, body mass index and blood pressure between 2023 and 2024, and they described self-reported improvements in their mental, physical and social health and wellbeing.

Using data effectively

Participants described the need to value the process of gathering, analysing, storing, and integrating data. Effective processes require a dedicated data profession and career path (including intelligence, advanced analytics and modelling), a public health profession focusing on the implications of the evidence gathered, and an infrastructure to support this work. These roles are essential to make better use of data on interventions and service performance that are routinely under-analysed or analysed in silos.

Systems including Nottingham and Nottinghamshire, Greater Manchester, Dorset, Surrey Heartlands, North West London, Frimley, and Cheshire and Merseyside have sophisticated and well-linked-up data through developing population health management capability and capacity. This data-integrated approach to informing commissioning of service, segmentation and risk stratification of populations can connect resources to need and allows systems to be in a better position to 'make every contact count'.

Hertfordshire and West Essex ICS has a sustainable system-wide research and innovation hub that includes local authority and health analysts, bringing people together for peer support, pooled capacity to seek additional resources, alignment with ICS priorities and aligning data.

Dorset's population health management approach

Dorset ICS launched a programme using population health management to prevent cardiovascular disease by improving high blood pressure management and reducing health inequalities. A key aim of the initiative was to achieve an 80 per cent healthy blood pressure rate among diagnosed

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individuals, preventing an estimated 141 strokes and 94 heart attacks over three years and saving up to £2.7 million.

Dorset has a well-established population health management approach and uses an advanced intelligence and insight service for data analysis, but its potential for cardiovascular disease (CVD) prevention was untapped. Existing care models failed to address barriers to blood pressure management and lacked integration of organisations across the system. Faced with rising healthcare demands, the ICS needed to shift towards prevention to improve life expectancy and address health disparities.

The clinical lead for CVD, prevention teams, digital teams and public health colleagues collaborated to apply population health management techniques to CVD prevention, prioritising stroke prevention through blood pressure management. A real-time data dashboard was developed to identify variations at different care levels, allowing practices to target specific populations based on various factors including deprivation, health-related behaviour and digital literacy. The Implementation Decay Model helped identify intervention opportunities, revealing that older individuals had better blood pressure management than younger populations.

All 19 PCNs joined a scheme to develop improvement plans, embedding hybrid care models for supported self-management, remote home monitoring and incorporating personalised care, behaviour change services, health coaching and social prescribing. System partners formed a steering group to support PCNs and practices, ensuring comprehensive evaluation and easier navigation of available support.

The programme enabled primary care to better support prevention and self-management, with PCNs establishing clinical and operational leads, reviewing data, reducing health inequalities, embedding behaviour-change approaches and strengthening community links.

Effective access to such datasets helps to identify where the demand is coming from, areas of greatest need of intervention and health interventions that work, such as addressing cardiovascular risk via hypertension screening

and management. Participants were quick to reflect that just having the data available means little if it is not accompanied by effective skills, infrastructure and incentives to enable its use across the system, and that those capacities are currently spread very unevenly across ICSs. More generally, there are significant gaps between the strategic objective and ambitions from government and the reality of a reduced digital, data and technology workforce to meet these ambitions. One director of public health responded to tales of effective data infrastructure in places like Dorset with a tinge of frustration:

"I would love for us to do a really coordinated properly funded programme where we ran using our dataset query [to identify patients at risk in a particular disease category]. But I just don't think we've got the capacity and even if I have the money, I don't have the staff to recruit to do that to supplement the staff that are already there."

Data access and integration are key enablers to drive early intervention and prevention. However, some participants also expressed the need to further develop datasets that segment and risk-stratify populations with multimorbidity and those living with frailty. These are currently not readily identifiable in many existing data sets.

While quantitative data clearly matters to an evidence-based case, positive qualitative data can demonstrate the impact of prevention work. For example, what did it improve in a person's life? How many people in an area are not developing conditions, or avoiding harm, following interventions? What would be the financial cost if we don't act compared to if we do? Can we model future demand to back up this longer-term case? The example of high-intensity user analysis (a small percent of people need a large percent of healthcare appointments) also helps to demonstrate a combined focus on quantitative and qualitative approaches.

Making the case

Participants describe the need for system leaders to free up space to speak with voluntary sector groups and local citizens to better understand the impact of preventive interventions on day-to-day life, in relation to better homes, jobs and green spaces.

Nevertheless, many leaders will not engage with prevention-relevant policy problems if they do not see the evidence for interventions' feasibility. There may be understandable nervousness about new solutions. Here, there is a need to better communicate success stories about, for example, the value of early health detection, or wider initiatives such as pollution control, with particular focus on the benefits of such interventions in specific neighbourhoods. These success stories should connect to information about the progress of promising current projects, such as by using prevention pilots in areas with high levels of deprivation to ask 'what works well on the ground?' Piloting and rapid evidence-gathering can help persuade policymakers and enable initiatives to be rolled out on a larger scale. Pilot studies can reshape assumptions and prompt new conversations on data.

The challenge is that 'making the case' pragmatically often runs into the fundamental problems associated with the commissioning model: that pilots are often small-scale, have limited time horizons for impact and lack a secure financial footing to reap real benefits. In this context, participants described the importance of engaging mindfully in split-screen thinking to translate quick wins into longer-term transformation. One promising model explored in the research was the preventive work of the fire service. Here, a slow transition to more preventive intervention – the everyday work of installing smoke alarms, speaking to people about hazards and good practices – has reduced demand and emergency incidences. A positive feedback loop has emerged of greater and more stable investment into the 'softer' work of prevention and less need for investment in the hard infrastructure of equipment.

There is also a need to think differently about how to demonstrate a return on investment for longer-term preventive work by robustly measuring outcomes. System leaders are trying to move away from a reliance on output measures such as referrals towards measuring the end result of the activity, but this also needs to be incentivised by the national financial and performance management regime.

The idea that preventative interventions always take a long time to deliver impact is a misnomer. This comes back to the intended outcome of preventative interventions. On the one hand this could be to reduce costs, but on a more person-centred approach would be to prevent disease onset for as long as possible, prevent poor-quality care or prevent disability. It could

even extend to measures such as completing your life well, having optimal informed choice and control and dying well at the end of your natural life. Preventative interventions for most complex of population segments already living with advanced illness can have demonstrable short-term impact. For example, reducing harms from polypharmacy through higher-quality structured medication reviews (stopping medications identified to be causing more harm than benefit to a person) or advance care planning delivered to populations living with frailty and/or dementia, can significantly reduce rates of hospitalisation.

Institutionalising prevention

Although prevention is not always congruent with routine government business, it is sometimes possible to change how things are done. The aim is for new strategies, rules and incentives to signal change in the short term then become the long-term norm. First, we heard of the importance of a clear strategy to signal commitment and drive a change of approach. Most integrated care strategies include reference to prevention, population health or health inequalities.

Second, there are ways to build incremental or symbolic spending rises in prevention. In some cases, participants described joint funding pots for specific initiatives, such as to connect thinking on debt support, employment, mental health and disability support.

One example we heard was the People in Mind programme in Cornwall and the Isles of Scilly, which involves meaningful mental health and suicide prevention work with the voluntary sector, aided initially by a small pot of money that allowed joint ICS work and led to a five-year commitment to co-design and co-commission services with many partners.

Another was Nottingham and Nottinghamshire's Health Inequality and Innovation Fund, which provides £4 million to foster prevention and equity innovations. The joint forward plan describes a meaningful commitment to increase funding year on year, and wide and continuous dialogue on how to use the investment effectively. The fund is an expression of the 'guiding mind' of the

health response as well as a symbol of commitment, albeit small in relation to the whole-system budget. This commitment allowed Nottingham and Nottinghamshire to navigate early uncertainty about how to invest and evaluate agreed-upon schemes and retain confident commitment during funding pressures.

Barriers to shifting to a preventative model of healthcare

Beyond the definition of prevention as a barrier to progression, further discussion helped to identify challenges in key parts of the system or faced by professionals whose responsibility it is to deliver preventative interventions.

Challenge 1: Balancing short- and long-term priorities

The classic challenge is to maintain focus on an ICS long-term preventive agenda while managing short-term pressures demanding immediate attention. But there are limited resources for prevention to take off the pressure and little leadership 'bandwidth' to think differently. Some have suggested that this is the role of the integrated care partnership (ICP), which is able to look beyond the urgent NHS agenda. Patricia Hewitt's review of integrated care systems recognised the leadership of ICPs in accelerating the scale and pace of change towards prevention, a focus on wider determinants of health, and real impact on health inequalities and social and economic development. The ICP has the role to drive strategic direction of the ICS through delivery of the integrated care strategy. This needs to be aligned with existent work and strategies, such as the health and wellbeing boards, to create place-level plans and shared outcomes frameworks. In previous work by the NHS Confederation and the Local Government Association (LGA), ICP leaders have highlighted 'a tangible shift towards prevention' as a key ambition over the next three-to-five years. The LGA's white paper highlights the need for 'joint action with the NHS to keep people well from birth to later life, alongside action on housing and homelessness.'

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In theory, there is scope for split-screen thinking: to simultaneously address immediate pressures while tackling longer-term issues, for example by identifying the negative impact of ignoring at-risk groups and the long-term conditions likely to drive A&E demand. One ICB participant summed up an extended discussion from one of the focus groups this way:

"I've been using this metaphor around bifocal lenses because it feels like people's focuses are all over the place, but actually we're all looking in the same direction. Some of us are a bit more focused on the near distance and some of us are focused on the long distance. But actually we're all seeing one picture."

Indeed, this challenging focus on the biggest sources of healthcare spending, such as emergency pathways and acute trusts, is crucial to preventive efforts not least because even a small shift in such funding would make a large difference to practice. For example, reducing avoidable deaths and other often irreversible harms. New models of care at home and personalised proactive care even in the urgent and emergency care (UEC) pathways can create quicker shifts if prioritised and delivered at scale.

Challenge 2: Securing funding

Chronic and acute financial challenges make it hard to present a case for health investment. One ICB leader explained that in their system there 'used to be ring-fenced health inequalities funding' but now 'lots is in the baseline' and the current financial challenges make things 'even harder than ever'. Funding for prevention projects is non-recurrent and the continuous need to make the business case is resource-intensive and frustrating.

One national policymaker reflected:

"Have we really disciplined ourselves to understand what we expect from a focus on prevention?... I think if we get ourselves on the kind of cashable-savings-for-NHS-services treadmill, we're kind of doomed because it doesn't work like that."

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One community provider representative explained that they were trying to change the norms:

"I'm trying to kind of bring a bit of a cultural change around how my exec colleagues look at value, so looking at it much more from a social value perspective than a financial return perspective... But it's all grant funded at the moment. So we need to build the evidence base to bring it into some sort of recurrent funding stream."

These operational and financial pressures on all system partners are intensifying, which risks crowding out longer-term ambitions such as increasing social and economic development. Funding pressures are immediate and the impact of acute funding is visible, which adds pressure to translate an abstract and long-term prevention agenda into an eye-catching way to support much needed quick fixes. Systems can spend a long time making the business case and then the agreement is for one year only. This is the case even where the strategic commitment is strong. One ICB leader reflected on the 'impossible task' of making a 'decision today that you're going to spend £5 million next year' and expect to have a case to spend it and get it spent in a couple of weeks.'

ICBs, under pressure from the centre to meet financial balance and recover services, have found it challenging to maintain a commitment to increase or even maintain current levels of spending on prevention. ICSs want to make best use of the money they have but are working within the limitations of their payment mechanisms set by government. Moreover, because there is no universally used definition of prevention that can be applied to financial data, ICSs are unable to calculate how much they are spending on prevention locally in a uniform way. This renders baselining impossible and, with it, arguing for funding proportionate to need.

Challenge 3: Demonstrating impact

It is difficult to connect a long-term preventive agenda to short-term, often NHS-focused, measures of performance or success. While the Treasury Green Book has produced a way to measure aspects of prevention such as disability adjusted life years (DALYs), we heard examples of the Treasury seeking 'cashable savings' rather than 'jam tomorrow' and resisting the idea of an unevidenced social return on investment. This can also cause tensions between NHS and other system partners.

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One director of public health put it starkly:

"The NHS are very keen to invest upstream. But then aren't happy with the answer, 'but I can't give you the outcome measure that you want. I can only give you an output of a fluffy kind.'"

Some system leaders describe frustration with the 'artificial precision' measures of £ per quality adjusted life year (QALY) as it is not always possible to quantify the health impact of complex and joined-up measures in this way. Many seek more meaningful measures, such as qualitative evidence. One VCSE representative saw community engagement as the solution:

"I think if we want to overcome some of the political dimensions, we really need to have a stronger focus on how we work with our local residents and communities to work through some of this really, really challenging and difficult decision-making."

Participants also describe prevention as being under greater pressure to demonstrate value for money or return on investment than other interventions such as cancer treatment and surgery for heart disease, which do not have a high return on investment. This emphasis on measurement can also be a source of administrative burden. As such, participants describe the value of a more qualitive approach. One place leader explained:

"People already have fatigue from transactional interactions with people in statutory services and so focusing on the qualitative and building the relationships and allowing communities themselves to evidence how things are having an impact can feel more heart centred."

During focus groups the challenge posed by the current fiscal environment were brought into sharp relief. Budget cuts facing local authorities including to the public health grant, and the wider public sector including housing and education, are leading to disinvestment in the wider determinants.

In this context, they note trying in vain to simultaneously take costs out of the NHS system, cope with current pressures, and allocate spending to anticipate future costs. It is too difficult to do all three well and the third option will always lose out. This dilemma

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prompted some hopes for an explicit national conversation about shifting from current spending in favour of 'capitalising' prevention, building on 'social investment' ideas to frame prevention as a long-term investment for a future return.

We also heard about the increasing proportion of costs for reporting. When budgets are cut and operational pressures are high, performance management and reporting procedures tend to ramp up as politicians want greater assurance that care is being delivered effectively. The metrics used to evaluate performance in this context tend to focus more on activity than outcomes.

Challenge 4: Re-engineering the system

The collaborative ways of working established in the Health and Care Act 2022 are still being embedded and this will take a sustained commitment over many years. The shift to integration is difficult given the well-known challenges of collaboration and integration, involving sensitivities about traditional silos and divisions of resources and responsibilities. Do you focus on particular cohorts, such as the frail elderly, deal with emerging disease clusters or try and embed a preventative approach across the whole population?

One participant whose organisation spans multiple ICSs explained: "Prevention is contentious in some systems that I'm working with because local authorities own it. They didn't like somebody else to be on their turf." However, many others did highlight the important role played by local authorities in bringing agencies together around the needs of residents and empowering local communities. A compounding factor is the long legacy of reforms promoting competition and choice in healthcare in previous decades.

System leaders highlighted a lack of joined-up working as a barrier to system-wide preventative healthcare. Problems with fragmentation include organisations or silos operating according to different incentives and having access to different policy levers whose overall impact is difficult to coordinate. As convenor and commissioner of the system, the role of the ICB is to nourish and scale initiatives and programmes that take place at place and neighbourhood level across primary care, acute, community and mental health providers, VCSE organisations, place-based partnerships and local authorities. The legacy of competition may still act as a barrier if prevention is seen as the responsibility of one of these sectors.

Challenge 5: Maintaining focus

Some participants describe the importance of intrinsic motivation as an initial boost to prevention work, but with limited prospects for long-term sustainability and scaling. For example, a primary care leader described how in Shropshire and Birmingham, ten PCNs and 34 practices are working on the wider determinants of health despite siloed budgets, the lack of incentives to do so, and little involvement from the ICB. In among the firefighting, there is a strong will to do more and proactive individuals are achieving quick wins by relying on initiatives like social prescribing and seeking to diversify income via grants. We also found major challenges in the areas described as following best practice or taking the lead, to the extent that they may now represent a cautionary tale. Even in systems such as West Yorkshire ICB which have a strong focus on tackling the wider determinants of health, a greater focus on elective recovery and challenges of partnership working are crowding out the focus on preventive work – according to one participant. Organisations and systems that adopt a more distributive model of leadership have had more success in making prevention 'everybody's business'. For example, a place-based leader described how they have built up their local partnership over three-to-four years:

"...to a place of mutual understanding, trust and positive relationships between senior executive and clinical leadership. It is this that sustains our innovative approaches to sharing responsibility for addressing health inequality and prevention."

Challenge 6: Tapping into system and community assets

Almost all focus groups identified the untapped potential of all system partners in making the shift to preventative healthcare, most notably the VCSE sector, which offers a unique set of knowledge, local connections and long-term aspirations for social change. There is already scope for routine involvement via place-based boards. Some suggest that VCSE partners have a lot to contribute at the strategic level: to change how leaders describe prevention, interpret and supplement key data, and provide more access to meaningful engagement with citizens. And, at an operational level, to work 'upstream' and provide more holistic social support in relation to pressing issues like like hospital discharge and waiting list management, for example the Waiting Well programme. The VCSE sector is valued particularly in mental health prevention, focused on keeping people well and literate in mental health rather than waiting for people to go to the NHS.

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The main barrier is unsustainable funding and commissioning, which makes it hard to plan for the future or demonstrate success. One VCSE representative commented:

"Obviously the dream would be that you have sustainable funding so you know people aren't hiring staff on a one-year contract and then not sure if they'll be there the next year."

A greater long-term commitment during service planning and procurement planning, including breaking down huge grants into constituent parts, would be mutually beneficial. It would allow NHS organisations access to community values and knowledge as well as the untapped potential of small projects, which can enhance engagement with a non-clinical language; early intervention on a small scale; and engaging with marginalised social groups to address highly unequal service provision. But there are obvious challenges to such forward-thinking approaches when systems and organisations are struggling to meet financial balance.

Challenge 7: Tapping into system and community assets

A final challenge comes from the relative newness of ICS arrangements and efforts to drive prevention through new institutional architecture. Despite helpful repositories of good practice such as NHS England's Population Health Academy, participants reflected that in most places there were not yet sufficient opportunities to learn and share effective ways to promote prevention in the new landscape.

One set of barriers here relates to learning within systems. One recurrent image was of a lot of people doing their best and showing goodwill to further prevention, but not yet in ways that were enabled to share insight and best practice: One ICB leader reflected:

"We see fantastic evidence of preventative measures and impacting communities very locally with this drive now to place-based partnerships. But it's almost a created a 'them and us' between ICB-wide system and local place...It creates even more of a barrier and a challenge in terms of sharing good practice."

The role of ICB and ICP leaders is to bring together the work that is happening across systems and to support and scale it. If these leaders do not get opportunities to speak to stakeholders across the system about these specific initiatives, they will simply not be aware of them and the opportunity to unlock will be missed.

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Another set of barriers related to learning across systems. In theory, shifting to a decentralised ICS model provides the potential for a laboratory of policy learning and experimentation, with best practices developing in context and spreading to other places to help solve common problems. But one local government leader expressed some frustration that these peer learning opportunities are not always joined up in practice.

Indeed, for some participants the opportunity to participate in the focus groups was beneficial primarily because it offered a rare opportunity for peer support and learning. ICS leaders need more protected time to learn from their peers to support self-directed improvement, through formal peer support and challenge processes or buddying arrangements.

Conclusion

This report has provided insights into the challenges and opportunities of shifting towards more preventative models of healthcare within the context of integrated care systems.

There were some promising examples of how local leaders are driving forward change against a challenging backdrop. Participants pointed to examples of effective systems leadership, where prevention has become a strategic pillar of integration in which they have embedded integration in governance processes to ensure shared ownership and accountability to make local prevention initiatives everyone's business. In particular, participants highlighted examples of systems that have been using data effectively to target and benchmark prevention activity, and others in which savvy actors across the system have become adept at making the case for prevention in spite of unpromising circumstances.

Some key challenges emerged from our research. Firstly, system leaders are trying to overcome issues related to congruity by balancing short- and long-term goals to keep prevention on the national policy agenda. Secondly, they are trying to overcome issues related to clarity by progressing an agenda that is seen as important by almost everyone but means many different things to different people. Thirdly, system leaders encounter capacity challenges in securing funding for preventive interventions and then in demonstrating impact from those interventions. The government and national bodies need to ensure there are sufficient incentives to deliver prevention. For example, through system oversight and by looking at changes to payment mechanisms to support a focus on outcomes, and that system leaders have capacity to deliver. Finally, they are attempting to re-engineer services that have been traditionally geared for acute services towards a more preventative and 'upstream' model.

The timescale for impact of preventative interventions is unclear, resulting in the use of short, non-recurrent funding pots on the sorts of preventative strategies that may take far longer to deliver the expected impacts on population level.

Looking at allocating shorter-term funding resources for those, often tertiary, prevention measures targeted to the right population group may be a way of unlocking some quicker gains.

Participants were frustrated at what they saw as a rhetorical commitment to prevention from the centre: one which has not been met by positive action. Indeed, successive governments have disinvested in local public services such as the public health grant, housing and social care that contribute negatively to the wider determinants of health.

There are several things the government and national bodies could do to support ICS leaders to finally shift towards a more preventative model of healthcare. To help overcome issues related to clarity, system leaders want a clearer framework through which they can justify and benchmark meaningful action, while tailoring specific interventions for local needs. The new government's health mission board could be an opportunity to take a truly cross-government approach, ensuring prevention is congruent with its wider agenda. The government and national bodies need to ensure there are sufficient incentives to deliver prevention, for example through system oversight and ensuring that commissioning can be done based on outcomes. ICS leaders can enhance their capabilities through some of the suggestions and tools contained in the accompanying practical guide to this report, but nationally they need enough autonomy to spend time and money on prevention, to develop their workforce and to learn from best practice.

Perhaps the loudest and most consistent message was for a concerted effort within the centre to allow ICSs to do more on prevention with their existing funding and to support baselining of prevention spend both locally and nationally to support incremental increases in funding going into prevention. Without this, prevention remains a 'nice to have' – something that systems latch on to via short-term grants and pilots. It can be a challenge to maintain focus on prevention within the context of a financial and performance management framework that is focused on activity-based measures such as reducing waiting times. The government's work to develop a practical definition is welcome and will allow ICS leaders to baseline their prevention spend, in turn supporting a shift in investment towards preventative services. But this can and should be delivered much faster, informed by local definitions that have already been developed.

Several other policy issues were raised:

- Addressing the wider determinants of health will require relevant government departments to work together, mirroring ICSs' local partnerships.

- A longer-term and more stable commitment to institutionalising prevention can only happen if system leaders are able to plan ahead and be more agile and adaptable in how they designate funding, working with VCSE and other local partners.

- Data is a key enabler to unlocking prevention. yet the government has not invested in its data, digital and technology workforce.

- There is a great deal of hunger from systems to experiment and to learn from one another, particularly in the context of the constrained environment they are working in. The centre has a key role to play in creating an authorising environment in which leaders feel emboldened to try new things, and a forum in which to share frankly the successes and failures of innovation in trying to promote prevention.

Recommendations

While this report addresses some actions that can be taken from central government and arm's-length bodies to support a shift towards a preventative model of healthcare, the accompanying practical guide includes suggestions and tools geared towards local system leaders involved in delivering and overseeing preventative interventions. Based on our research findings, we make the following recommendations to government and other national bodies with responsibility for oversight and coordination across ICSs:

To improve clarity:

1. The government should accelerate work on a national framework for measuring prevention spending, including an agreed definition and metric for preventative services (both NHS and local government spending) so a 'left shift' can be measured at national and local levels. This work should be broken into phases, starting with agreeing a workable definition that can be iterated, to allow ICSs to baseline consistently. This work should be supported by Cabinet Office and HM Treasury and include such targets in spending and public services agreements. This measure should inform delivery of the forthcoming ten-year health plan.

To increase congruity of prevention with routine government business:

2. The government should ensure the scope of the recently announced health mission chaired by the Prime Minister is truly cross-government by:

a. ensuring the Health Mission Board, supported by a Health Improvement Delivery Unit, develops and implements a health improvement strategy that addresses all of the social determinants of health. This work should be done in close partnership with local government and NHS leadership, including the National ICP Forum now being established by DHSC and subject to approval by the new Secretary of State for Health and Social Care

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b. ensuring prevention is included in the terms of reference for the Health Improvement Delivery Unit

c. conducting a review of funding and spending opportunities as well as current spend by HM Treasury. Additionally, HM Treasury should review current barriers to funding collaboration at national and local level to ensure these do not prevent the health improvement strategy from being successfully implemented.

To support ICSs to increase their capacity for prevention:

3. The government and NHS England should create incentives for work on prevention by:

a. Updating the NHS Payment Scheme in 2026 to better allow ICSs to pursue outcomes-based payments in key pathways. This will give ICSs more flexibility to plan ahead and invest in interventions that prevent poor outcomes rather than investing in poor outcomes themselves. Setting out an expectation that ICBs will commission based on population health outcomes, not just activity

b. moving towards longer-term funding cycles that are aligned across the NHS and local government. This would support more sustainable funding of VCSE sector projects and programmes

c. balancing local and national outcome-based measures of prevention to oversee performance of providers and ICSs

d. rebalancing the attention given to both short- and long-term priorities, including prevention and ICSs' four purposes, in formal oversight and in meetings with ICS leadership on performance and operational issues.

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4. NHS England should support the data, digital and technology workforce by:

a. including a commitment in the upcoming digital, data and technology profession to fund expansion of these roles to meet future demand and the training needed to upskill the workforce, including through apprenticeships

b. working with ICB leaders to remove the barriers to accessing key data sources to enable a connected infrastructure to track and target improvement.

5. Promote a culture of learning and best practice by:

a. supporting and funding peer processes, which focus on both short- and longer-term issues including prevention.

b. ensuring any national improvement programmes such as NHS IMPACT provide support for longer-term priorities including scaling prevention within ICSs.

Appendix 1: Methodology

The research was undertaken on a relatively rapid timeframe in order to provide timely insights for policymakers and practitioners. Here, we outline what this meant in practice for project design, recruitment, data collection, analysis and write-up.

Design: Given our aim to understand how actors within ICSs have been experiencing the new arrangements in their efforts to promote prevention, our design was informed by an interpretive orientation. This style of research, common in policy studies, foregrounds the experiences and perceptions of policy actors and privileges rich qualitative insight. Given the rapid timeframe of the project, we opted for focus groups rather than one-to-one interviews. Using focus groups meant we could speak to many more people in a shorter space of time and enabled the whole research team to attend most of the focus groups to accelerate analysis. Most focus groups were arranged around a common 'level' or 'role type', with representatives across a diversity of systems. The logic of this was that participants would feel freer to reflect on obstacles and blockages across the system, and that they might usefully learn and reflect on each other's insights and experiences to deliver higher level insight. We finished with a final focus group that featured actors across a single system – Nottingham and Nottinghamshire – chosen because it had been earmarked as a system that has made progress on prevention and from which we might learn more about means of overcoming obstacles and making use of enablers of prevention.

Recruitment: The NHS Confederation team led on recruitment, drawing on their relationships and convening power to accelerate the process. An open call for participants was placed in February, drawing 80 responses. The project team then helped to select the best mix of participants for each focus group. In practice, diary coordination meant some changes and adjustments along the way. We were able to speak with 60 participants across 22 different systems, and all seven NHS regions in England. The focus groups took place during March 2024 (with one later in April). We ran seven focus groups in total, with between six and 12 participants on each call. Each lasted an hour and a half.

Data collection: To ensure that discussion in focus groups was suitably focused, Boswell and Cairney provided a short framing discussion. The Three Cs framework (clarity, congruity and capacity) is based around the wider lessons of trying to instigate prevention in public policy, and draws on previously published research in this field. The purpose was to open up a detailed discussion on 'what might be different this time?' with respect to integrated care arrangements. In practice, this framing helped to prompt spontaneous reflections, but also to foreshadow the topic guide (or list of questions) for the focus group discussions (see below)

Clarity

- What do we mean by prevention?
- What interventions sit within this definition?
- Is there an agreed definition of prevention in your ICS?
- Would it be helpful to have nationally defined set of preventative interventions?

Congruity

- Do you have a vision or aspiration for your prevention work? Is this formalised in a plan or strategy?
- How does your prevention work align with other priorities?
- Can you provide any examples of how to embed prevention across all system partners, making it routine business?
- Who holds responsibility/accountability for aligning prevention work across your system?

Capacity

- Are ICSs able to unlock the required resources for prevention?
- How can central government support prevention?
- Who leads prevention work in your ICS? How do all leaders across system partners enable the shift towards prevention?
- Can you provide an example of/from a local area or system where effective leadership is unlocking or augmenting capacity for preventive action?

We encouraged participants to ask additional questions, prompt debate and identify aspects of prevention that we did not address fully. For example, with reference to suggestions from our advisory group and reflections on previous focus group discussions. On balance, we think this approach successfully toed the line between keeping discussions open and the risk of a freewheeling and unfocused discussion that would make for tricky comparison and analysis. Some participants challenged aspects of our framing. Others accepted it wholesale and built on it. Either way, it led to useful interaction on the key themes we wanted to probe.

Each focus group used the Chatham House rule to record but anonymise responses and encourage frank discussion among groups. We took this approach into the report, largely generating key themes and constructing storylines that combine insights from one or more participants rather than providing direct quotations (unless they encapsulate a point perfectly). Discussion lasted around an hour and half and was transcribed using MS teams software. To comply with the ethical approval received from the Universities of Southampton and Stirling, only Boswell and Cairney had access to the transcripts.

Analysis and write-up: The themes that we focused on inevitably reflected a process of moving between the 3Cs framework derived from policy theory and patterns that emerged more organically in the discussions. This iterative process is known as abductive reasoning and is core to the interpretive approach to policy analysis. We began by focusing on key barriers, then enablers; the latter mostly informed by discussion of best practices that we probed for in focus groups.

We tested emerging findings in multiple ways:

1. 'storyboarding' the report with the project team, NHS Confederation and Newton

2. sharing findings with latter focus groups

3. engaging with NHS Confederation members.

Cairney led an initial write up, which then went through multiple rounds of feedback from the wider research team, and finally in dialogue with our expert advisory group.

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