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Spotlight

Thought leadership and policy

Healthcare: Designing a healthier future

Palliative reform

Predictive prevention

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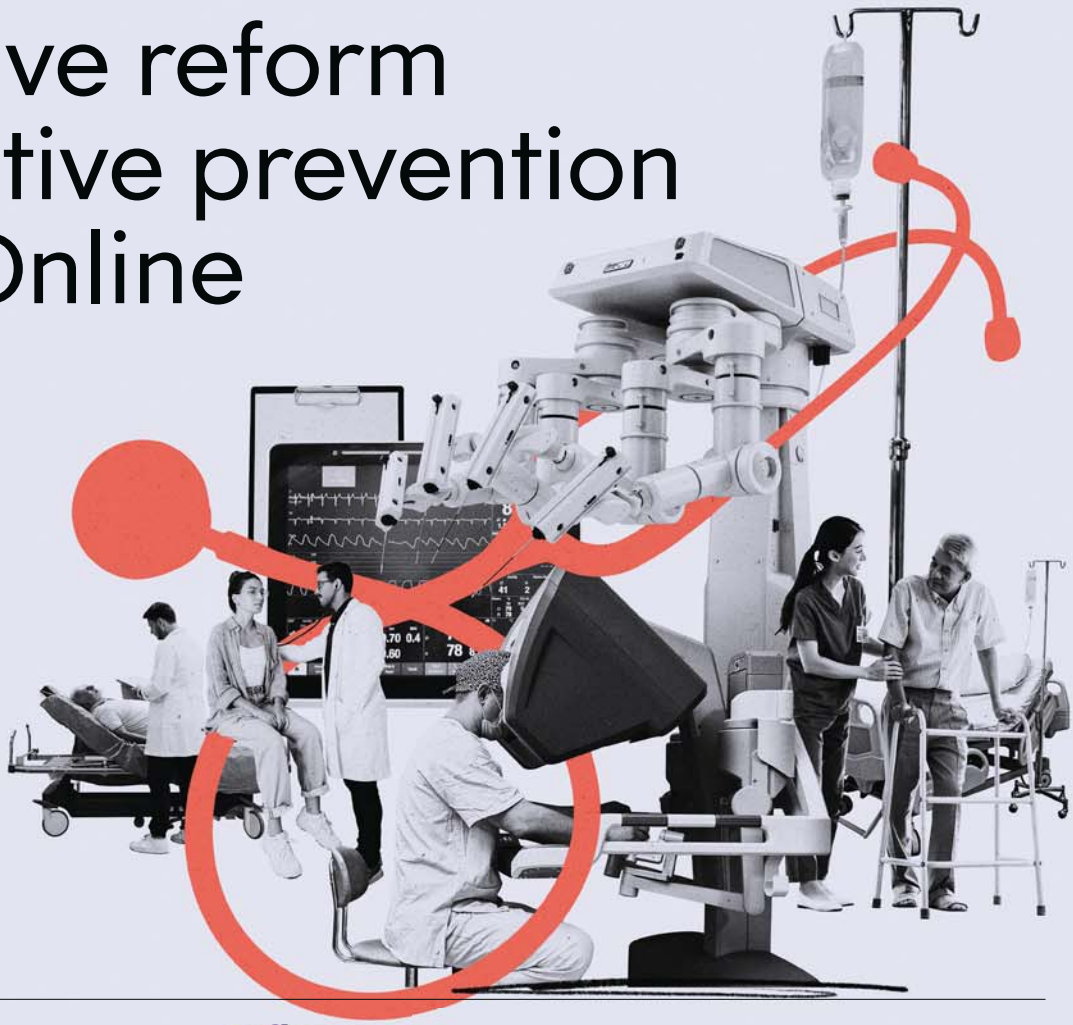

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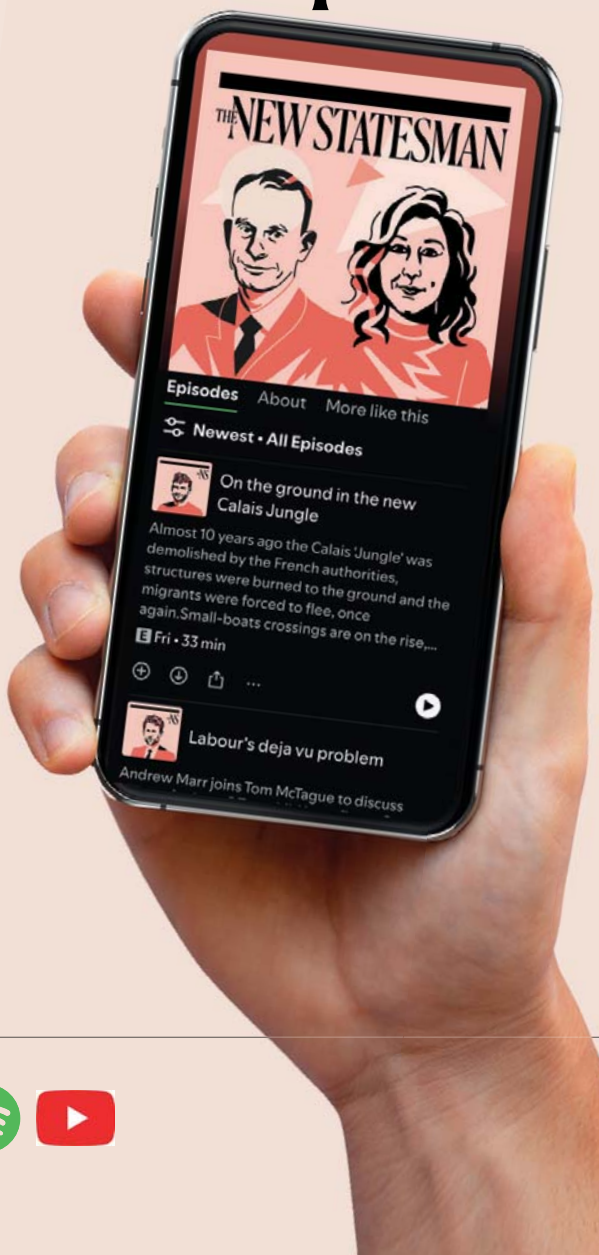

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The Future of Healthcare

The healthcare debate has long centred on how to fund and staff a system built to treat illness. Today, that conversation has shifted. *Fit for the Future: The Ten-Year Health Plan for England* aims to move from a treatment- to prevention-first model – from a reactive service to one that anticipates disease and keeps people healthy for longer. It is an ambition born of necessity: record waiting lists, rising rates of long-term sickness and the recognition that health and prosperity are inseparable.

But prevention is easier to promise than to deliver. A truly preventive system cannot be built by the NHS alone. It demands alignment across myriad departments and policy areas – housing, employment, food policy, education – the wider social and economic forces that determine health outcomes long before one reaches a GP or hospital ward. Success will depend as much on infrastructure and governance as on clinical innovation: connecting data systems, investing in communities and winning public trust and engagement.

This new model of healthcare – proactive, collaborative, community-based – will shape the next decade of reform. It will also test whether a mission-led approach to government can turn aspiration into practice.

In this issue, two MPs, Danny Chambers (page 6) and Dr Beccy Cooper (page 7) outline areas where they feel burden could be taken off front-line healthcare, if only for the right policies and support: mental health and diet. Harry Clarke-Ezzidio also looks at the economic benefits of getting mental health reform right (page 24), as a lack of adequate provision forces a growing number of young people out of work.

On page 10, Sarah Dawood explores how a struggling palliative care system could be the ideal testbed for anchoring non-urgent services in communities; we examine the potential of predictive prevention to identify and address illness before more serious medical intervention is required (page 18); and unpick the potential impact of launching virtual hospitals at scale (page 28).

The ten-year plan's message is clear: Britain's health framework must be built around prevention, not just treatment.

As this issue aims to highlight, doing so will demand investment and imagination – but also long-term political courage, cross-sector coordination and a willingness to see health not as the preserve of the NHS, but as a shared national endeavour. ●

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Advertorial

Now is the time to move from pilot to practice

To realise its Ten-Year Health Plan, the NHS must focus on digital adoption, not just innovation

By Rebecca Nash

In association with Baxter

On some shifts, working on the ward feels like swimming against a current.

Devices push information in different directions, and staff stitch it together. That effort costs time at the bedside and risks delayed response.

The NHS ten-year plan[1] envisions digital flow – and when adoption is done well, the current carries clinicians forward, enabling seamless, safe and human care.

The plan places digital adoption at the heart of reform, promising a shift from analogue to digital, with investment in AI, wearables, robotics, and an enhanced NHS App as the front door for patients. A single patient record is set to unify data across care.

Yet technology alone cannot deliver transformation. What I see as the real bottleneck is adoption – making sure tools are reliable, usable and embedded in daily practice.

From my perspective as both a frontline clinician and adoption and workflow manager, the hardest part of transformation is not the technology but aligning it with everyday workflows.

Devices may be capable of integration, but too often they are underused because they don't fit how staff actually work. Training can be rushed, digital fatigue sets in, and what was designed as a solution becomes "just another system".[2,3]

Adoption depends on trust and usability. Uptake only grows when staff see connectivity saving steps, improving outcomes and freeing time for care. In practice, adoption falters when technology ignores frontline realities. Tools may add steps instead of removing them, and interoperability gaps trap data in silos.

Clinicians are also cautious of accuracy and wary of being monitored rather than supported, and after years of pilots and rollouts, change fatigue is real.[4]

Each barrier erodes confidence. Implementation is not about switching a product on, but about whether staff can trust, rely on and value it in daily care.

When adoption succeeds, it transforms care. I've seen this in projects connecting smart beds and vital monitors, not only to electronic records but also to dashboards and alarm management systems.

In fall-prevention workflows, this meant staff were alerted if a patient at risk attempted to leave bed, enabling proactive prevention rather than reacting after the fall.[5] Vital signs updated automatically across systems, reducing duplication and allowing real-time response.[6]

The lesson is clear: adoption succeeds when technology is co-designed with staff, saves tangible time, and builds trust through reliability and safety.

One of the most powerful accelerators of adoption I've seen is true co-design of the digital pathway. When staff are involved early – before procurement or training decisions – their insights shape solutions that work in practice, not just theory.

At Baxter, our therapy specialists partner with clinicians to identify barriers to adoption and mitigate them, ensuring digital connectivity delivers maximum value.

The NHS plan recognises that delivering on its promise requires more than procuring technology. The challenge is embedding it into the way care is delivered.

Connected smart beds and vital sign monitors illustrate the potential: integrated not only with records but also with alert systems, they can transform wards. Connectivity among devices creates safer, more responsive environments by improving safety, reducing duplication and streamlining workflows, thereby driving efficiency.[7]

But these benefits only appear when adoption is prioritised. That means national standards for interoperability, investment in training, and measuring success by impact at the bedside – not just device counts. Adoption is the bridge between bold strategy and real-world change.

From wards where devices once worked in isolation and staff carried the burden of stitching information together, I have seen adoption shift the reality: smart beds and monitors updating records in real time, dashboards flagging risks instantly, and clinicians freed to focus on the patient.[6]

That is the future the NHS 10 Year Health Plan aspires to – and it is within reach. The NHS doesn't just need more digital products; it needs adoption, because only then will technology move from fragmented parts to a seamless system of care. The next decade must prioritise digital confidence as much as capability. Procurement teams, policymakers and developers all play a role – but it is clinicians who adopt or abandon tools.

Listening to their experience is not optional; it is the key to unlocking digital transformation's full promise. ●

BAXTER

It is clinicians who will ultimately decide which digital tools take hold

Rebecca Nash is a NHS practising emergency nurse practitioner and paramedic, and clinical manager, adoption and workflows, connected care for western Europe at Baxter
UKI-CS417-250006 v2.0 09/2025

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A view from the opposition

Danny Chambers MP
Mental health spokesperson for the Liberal Democrats

"Reform means nothing if we ignore prevention – patients deserve more than crisis care"

The Mental Health Bill marks the biggest update to mental health law in more than 40 years. The bill strengthens patient autonomy, updates detention procedures and removes police stations as "places of safety". These are vital reforms. But its focus is so narrow that it risks being washed away by the unfolding crisis in our wider mental health system. A crisis that has pushed countless families to breaking point, delivered rising hospitalisations and failed to prevent a 25-year high in suicide rates.

The bill deals almost entirely with what happens once someone has been admitted to hospital – the rights, safeguards and treatment of patients in crisis. Prevention and community support are nearly entirely ignored. Without investment in those areas, even the most carefully written law will fall short of what people need. The rights created by this bill will mean little if the mental health system still lets people deteriorate until crisis is the only door open to them.

Nearly a million people in England are waiting for mental health treatment. More than 340,000 are children, many waiting over a year. Behind each statistic is a life on hold: young people missing school, parents unable to work, families holding on by their fingertips. Many patients are treated in wards built as Victorian asylums, or left in prison cells awaiting transfer to hospital.

The Liberal Democrats support this bill because it recognises that mental health law should be fairer and more compassionate. But reforming the rules that apply once someone is detained is only half the job. Without proper community care, early intervention and investment in local services, this legislation will end up managing failure rather than preventing it.

That's why we've tabled amendments to embed prevention and community care into the mental health system – not as an optional extra, but as its foundation. We believe mental health check-ups should become routine – ensuring people are supported at key points in life, such as bereavement, redundancy, parenthood or leaving the armed forces. We've highlighted the value that could be brought by guaranteeing a dedicated mental health professional in every school, creating walk-in hubs in every community, and providing better dedicated support for mothers' mental health during pregnancy and after miscarriage.

We must recognise that mental ill health is often intrinsically rooted in social and financial stressors – from debt and housing to domestic abuse – and we cannot meaningfully support someone with poor mental health without addressing these stressors. We must take a holistic approach.

We're pushing for a statutory, independent Mental Health Commissioner to speak up for patients, families and carers, and for better perinatal mental health support – including automatic referral after every miscarriage. One in five women experiences mental health problems during or after pregnancy; we must do better.

Care plans must address social and financial pressures, including debt, housing and insecure work, so people aren't discharged back into the same conditions that made them unwell.

These reforms are achievable, but they require coordination and investment. Preventative care involves education, housing, employment and community services. If those building blocks aren't in place, the best hospital care in the world cannot succeed.

Ministers must accept that prevention and community support are essential partners to hospital care, not separate conversations.

We can build a system that acts early, supports families locally and treats prevention as a core part of care. If it doesn't, this bill will be a well-intentioned reform that leaves the same painful gaps untouched.

We should not have to wait another 40 years for parliament to get this right. ●

MARTA SIGNORI

A view from parliament

Dr Beccy Cooper MP
Member of the Health and Social Care Committee

"Building a healthier nation starts with our food system"

Poor diet and excess weight are now leading causes of preventable illness in the UK. They drive cardiovascular disease, diabetes and cancer, shorten healthy life expectancy by up to nine years and cost the NHS around £6.5bn each year in direct costs.

We know empirically that obesity is a systemic problem, not a matter of personal failing. More than 80 per cent of the variation between communities is explained by environmental and socioeconomic factors rather than individual behaviour. Where healthy produce is unaffordable or inaccessible, and foods high in fat, sugar and salt (HFSS) are marketed aggressively, poor health follows. Policy must act on these structural determinants of health rather than relying on appeals to individual responsibility.

Past obesity strategies fell short because they targeted behaviour change rather than the structural and commercial drivers of diet. Many lacked delivery plans, timelines or evaluation frameworks, leading to fragmented progress and limited long-term impact. Now, stronger structures are emerging to embed food policy as a health priority and support the shift towards prevention.

The food environment is shaped by the economic, political and cultural context in which people make choices. It is dominated by HFSS foods, which are widely available and heavily marketed.

Britain's food system is among the most advanced in the world, with efficient supply chains, high safety standards and technological innovation. Yet that system is not serving us well, with farmers facing fragile margins and too many families struggling to access nutritious food.

The government's new Good Food Cycle sets out ten outcomes to create a healthier, more sustainable and resilient food system. It builds on the Dimbleby National Food Strategy, mapping well against its vision but omitting some of its stronger fiscal and legislative levers. It reflects the wider shift towards prevention, recognising that a healthy food system underpins a healthy population.

The Soft Drinks Industry Levy has reduced sugar content in soft drinks by more than 35 per cent since its introduction. Standards for public-sector food procurement have improved, setting clearer expectations for healthier and more sustainable food in schools, hospitals and other institutions. Compliance varies, but the direction of travel is positive. The Good Food Cycle embeds these principles across government, linking nutrition, environmental sustainability and local economic resilience. It commits to developing metrics and implementation plans for each outcome, ensuring that decisions are evidence-based and measurable.

The next challenge is execution. If obesity is driven by structural and commercial determinants, then only structural and commercial levers will change it. Fiscal incentives, advertising regulation and local empowerment must now work together to rebalance the food environment.

To meet the ambitions of the Good Food Cycle, we should extend the levy model to high-sugar and high-salt foods; enforce the 9pm watershed for HFSS advertising and close brand-mark loopholes; provide stable funding for local food partnerships so councils can act on local needs; and build evaluation frameworks into all food and health interventions to ensure measurable outcomes. Delivering the Good Food Cycle will require alignment between government, business and communities. To shift a system that drives ill health, policy must be systemic too. Transparent metrics, accountability and consistent incentives must drive progress.

Access to good food is one of the most powerful tools we have to reduce health inequality. Continued alignment across departments and sustained focus on delivery will ensure we can embed food policy as a national health priority. ●

MARTA SIGNORI

Advertorial

Podiatry's pivotal role

The practice will be key in delivering the NHS's Ten-Year Plan

By Professor Jane McAdam

In association with

ROYAL COLLEGE of PODIATRY

The NHS Ten-Year Health Plan for England lays out an ambitious agenda for the transformation of public health services. It aims to shift focus from the treatment of illness to prevention; from delivering care in hospitals to increasing services and accessibility within communities, and from relying on analogue systems to harnessing the potential of digital technology. Podiatry, the specialism of all aspects of foot and lower limb health, is central to achieving these goals.

Foot and lower limb health may not be the first thing that comes to mind when considering the NHS's biggest challenges, but it holds tremendous potential to transform lives and ease pressures across the system. Diabetes-related foot complications alone cost the NHS an estimated £1bn annually, mainly through preventable admissions, prolonged hospital stays, surgical interventions, and long-term disability from amputations. More than 80 per cent of foot and lower limb amputations could be prevented with timely, coordinated foot care. Podiatrists are vital in these prevention efforts: they diagnose, treat, and, critically, help people avoid complications from foot ulceration and lower limb musculoskeletal disorders. As the NHS pivots to a prevention-first model, podiatrists' expertise in early intervention, patient education, and long-term management will be crucial in reducing pressure on acute services and improving patient outcomes.

In addition, podiatrists play a central role in the integrated care of patients with long-term conditions. They manage complications associated with diabetes, peripheral arterial disease, rheumatoid arthritis, musculoskeletal conditions, and neurological disorders. Through their specialised care, podiatrists help keep thousands of people active, pain free and in work, improving overall health outcomes and quality of life for patients of all ages.

Care closer to home

A recent trial by Somerset NHS Foundation Trust exemplifies the benefits of bringing care closer to home. They found that integrating a consultant podiatric surgeon into community clinics significantly reduced waiting times, enhanced patient outcomes, and upskilled staff. Surgeries performed at

community hospitals were more cost-effective than using acute sites, and the model freed up GPs' time by shifting antibiotic prescribing to podiatry clinics. This approach demonstrates how strategic collaboration within community settings can improve efficiency and satisfaction across the board.

One major shift outlined in the NHS ten-year plan is moving care from hospitals into community settings. Podiatrists predominantly work in local communities; they detect early signs of complications before they escalate, and provide ongoing management for chronic long-term conditions. Intermediate care provided by podiatry services plays an important role in rehabilitation following surgery, injury, or infection. These services help people regain their strength and independence, and avoid the need for institutional care – which not only supports patient well-being but enhances NHS efficiency and reduces social care costs.

Addressing inequalities in foot health is critical, as poor foot health is strongly linked to deprivation and limited access to care. Expanding community podiatry, particularly in underserved areas, is essential to reducing health disparities and fulfilling the goals set out in the ten-year plan.

Strengthening the workforce

The podiatry profession faces critical shortages caused by more than a decade of underinvestment, a drop in new graduates, and high attrition rates as older podiatrists retire. As of today, there is only one NHS podiatrist for every 5,000 residents in England.

The Royal College of Podiatry has launched its career campaign, *Inspire Movement, Choose Podiatry*, to attract people into the profession. But we cannot do it alone. For such a campaign to have longevity and a chance of real change we need the help of UK governments to increase funding for podiatry undergraduate programmes and for clinical placements. Workforce planning must become a core element of the NHS transformation agenda. This involves expanding education pathways by providing fully-funded bursaries, apprenticeships, and paid placements to attract new talent and promote diversity in recruitment. Additionally, targeted support for underserved areas is essential, including retention bonuses and incentives for clinicians working in high-need communities.

Digitisation and innovation

Digital transformation is at the heart of the NHS's future. Here, podiatry can be a launchpad for the adoption of AI-enabled diagnostics, remote monitoring devices, telemedicine, and data-driven care pathways. Remote monitoring through new wearable technology enables real-time tracking of foot ulcers, allowing rapid intervention when deterioration is detected. This proactive approach often prevents severe infections and reduces the need for hospital admissions.

Expanding these telemedicine approaches can ensure continuity of care, especially for people who are immobile or living in rural or coastal areas. However, many NHS podiatry clinics lack the digital infrastructure to make this promise a reality. Investment in equipment, training and interoperable systems must be prioritised to avoid deepening inequalities that risk leaving certain groups further behind. Inclusive digital design, with analogue options for those unable to access or navigate technology, is essential.

Harnessing potential

To harness the full potential of podiatry and deliver the NHS's ten-year vision, several urgent policy measures are necessary. First, there must be a systematic integration of podiatry services into new neighbourhood health centres and digital care pathways. This integration will ensure that routine foot screening becomes standard practice for at-risk populations, enabling earlier detection and management of foot and lower limb complications.

Additionally, the development of a national foot health mobility strategy is critical for the health of the nation. Such a strategy would coordinate efforts around prevention, early intervention, and rapid referral for serious complications, streamlining care, and improving patient outcomes across the UK. Finally, ensuring equity of access to podiatry services, regardless of postcodes, must be recognised as a crucial measure in addressing health inequalities. Embedding foot health metrics within Integrated Care Boards will help track progress and promote equity in care delivery, ensuring that populations most in need receive appropriate support.

The NHS's future depends on its ability to keep people healthy, independent, and active for as long as possible. Podiatrists are essential to this effort, providing expertise that saves limbs, reduces pain, increases mobility, and supports the shift towards prevention and community-based care while delivering significant cost savings.

ROYAL COLLEGE OF PODIATRY

There is only one NHS podiatrist for every 5,000 residents in England

Dying with dignity

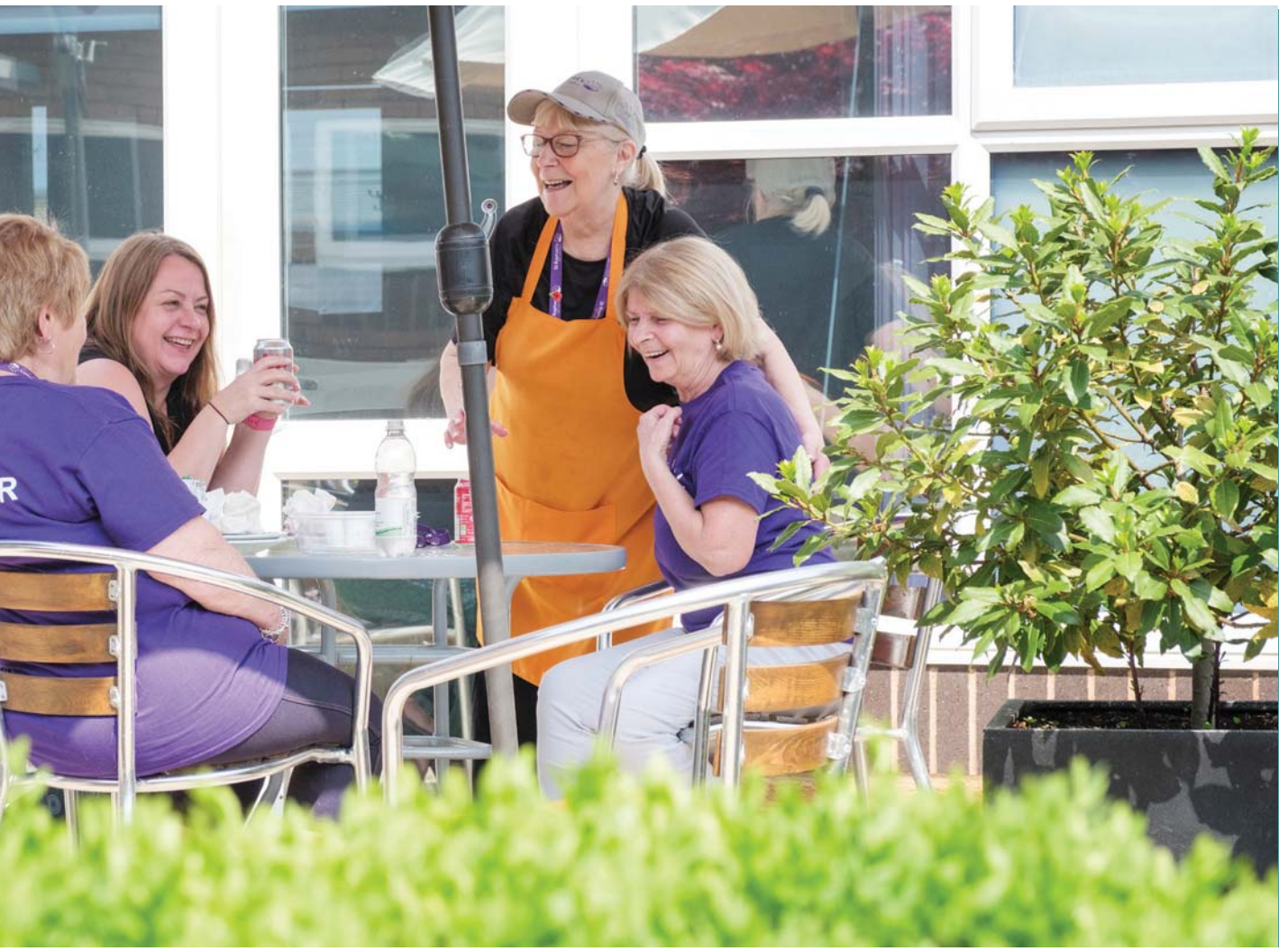
Investment in palliative care is crucial to both easing the burden on hospitals and ensuring terminally ill people can have a good death

By Sarah Dawood

Walking around the leafy grounds of St Raphael's Hospice in Sutton, south London, on a sunny day feels incredibly tranquil. All on ground level, several buildings offer a range of services that move far beyond the realms of clinical care.

An in-patients section with 13 private rooms feels like the much calmer cousin of a small hospital ward, without the trolleys in corridors and panicked bustling. Rooms for outpatient appointments service those in better health, and a lavender-scented reflection space hosts a chapel and a worship room for people of all faiths.

A secluded, quiet building is dedicated to psychotherapy and bereavement counselling, while a livelier well-being centre offers games, yoga, music and complementary



St Raphael's Hospice in Sutton, south London

ST RAPHAEL'S HOSPICE

therapies such as reiki, massage and hypnotherapy. In a central garden, tended to by volunteers, custom copper leaves hang from a tree sculpture, engraved with the names of people who have died under the hospice's care.

I visit the room of one patient, a 79-year-old woman named Marie, who is receiving end-of-life care for cancer. Her husband Ken and son Tony are also there. Marie was in hospital for two weeks before being transferred to St Raphael's. "It's such a relief being here," Marie says. "They've made me comfortable. They've given me purpose. And even though you might not ask for it, they give you humour. All those little things combine."

"The difference between this and the hospital is the dignity," Tony adds. "We turned up in A&E, and we were literally on the side of a ward in a bed with people walking past you the whole time. Here, you've got your own room, you can have conversations with the nurses, the doctors are always available if you need them. It's like chalk and cheese."

St Raphael's offers both in-patient care and community care in people's homes and care homes. All of its services are free, although it does encourage donations. "It's a huge part of the community," Becca Trower, joint CEO and clinical director at St Raphael's, tells *Spotlight*. "If we're not caring for somebody, then it's their loved one or their friend. It's not just the patient, it's all of those people around them."

"People are frightened to have conversations about death and dying, partly because they don't know what it might look like," she adds.

"There's a fear around the end of life. And I think one of our really important roles is to allay that fear."

Indeed, death is a topic that is often avoided, seen as depressing, awkward or undignified. But it doesn't have to be this way. Dr Gabrielle Tamura-Rose is a consultant in palliative medicine who works at St Raphael's and a local hospital. She has a friendly, relaxed demeanour as she informs me that she always wears pink scrubs on her Monday ward rounds, and forbids her team from wearing black.

"I want to demystify that we are all 'doom and gloom'," she says. "When I was training in palliative care, people would treat me like the grim reaper. But it's not just about death and dying, it's not just symptom control – we do so much more to help people."

Despite the holistic work St Raphael's does enabling people to ▸

◂ have a good death, it has had to scale back its services. Like all hospices, it is only partially funded by the NHS – it receives roughly 25 per cent of its funding from the local integrated care board (ICB), and the rest is funded by charity, which includes donations, gifts in people's wills, fundraising activities such as marathon runs, and profits from its charity shops.

Last year, it had to make £1m worth of cuts. The hospice's operating costs – such as salaries, IT costs, energy and food bills – have risen by £1.4m, but its NHS funding has not kept pace with inflation, and it has only received an additional £140,000.

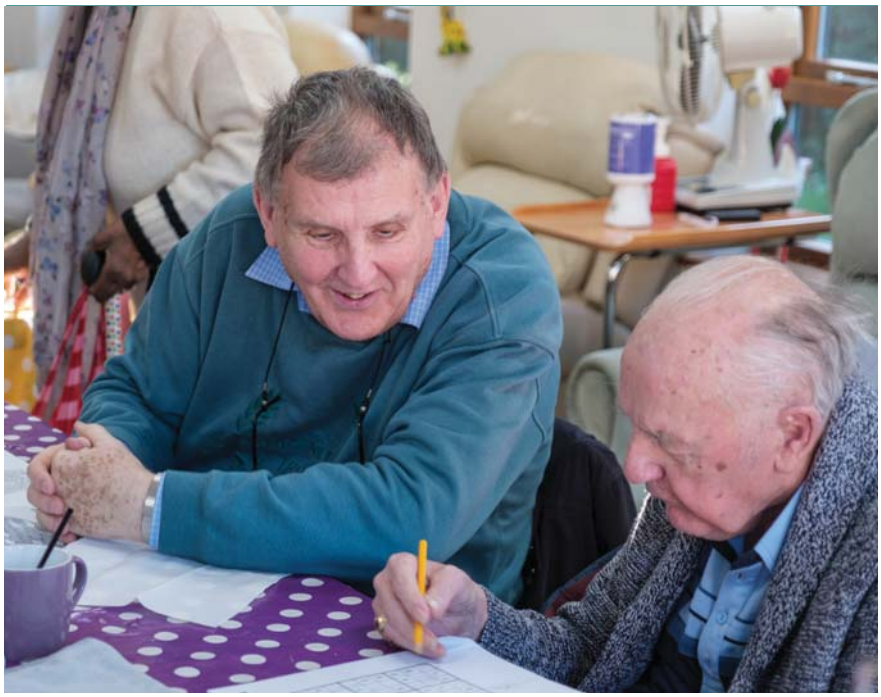
It has been forced to make redundancies and reduce its at-home care, psychological support and occupational therapy. The staff are "tired", "burnt out" and "stretched", Trower says. Some support, such as bereavement therapy for families, has been passed back to GPs, who are already under immense pressure: "It's so short-sighted, because we save the NHS money."

St Raphael's situation is not unique – hospices across England are being forced to cut services as others close entirely, placing the burden of care back onto GPs and hospitals.

In most cases, community palliative care services are commissioned by the ICB, which receives government funding to deliver various healthcare services in their area. While ICBs do have a legal duty within the Health and Care Act 2022 to commission palliative care for their local populations, funding is not ringfenced, which has led to inequitable provision of services.

Hospices are just one part of the palliative care landscape, which overall is a neglected and misunderstood part of England's health ecosystem, medical experts tell *Spotlight*. It is delivered across a range of settings, including by specialists in hospices and hospitals, and generalists such as GPs and community nurses.

There is a common misconception that it is solely for people who are close to death, but the specialism is actually focused on improving quality of life for anyone with a life-limiting illness – an incurable condition that shortens life span – from the point of diagnosis. It includes symptom management, but also psychological, social and spiritual support for patients and their loved ones. End-of-life care is specifically the care that people receive in the final year of their life.



Cuts have forced hospices to cut back on services

Palliative care doctors work with other specialists, such as cancer and respiratory doctors, to assess and treat patients holistically. "Palliative care works best and is most effective when it's provided early and collaboratively," says Katherine Sleeman, a professor of palliative care at King's College London.

She describes palliative care as a "high-value intervention" – providing benefits to patients, their loved ones and carers and the NHS. People who are terminally ill frequently end up in busy A&E departments and intensive care units (ICUs) for issues such as pain management.

Palliative care is a "high-value intervention" for society

"When people receive high-quality palliative care, they stay longer in their own homes, they bounce in and out of hospital less in their last months of life, and they're more likely to die in their own homes – all of which are things that people approaching the end of life generally want," Sleeman says. "The main message to policymakers is: investment in palliative care is not just the morally right thing to do – it's fiscally prudent."

Over the past year, death has received renewed attention due to the Terminally Ill Adults (End of Life) Bill, otherwise known as the Assisted Dying Bill – brought forward in November 2024 by Labour MP Kim Leadbeater. The legislation, which is expected to become law by 2029, would allow adults in England and Wales with fewer than six months to live to apply for an assisted death, subject to approval by two doctors and a panel of specialists.

The bill has been a source of much debate, inciting strong feelings on both sides. But it has also brought conversations about palliative care to the forefront.

Specialists such as Sleeman have expressed concerns that people may choose an assisted death simply because they cannot access the care

ST RAPHAEL'S HOSPICE

and pain management they need – it is estimated that 100,000 people in the UK who could benefit from palliative care die without receiving it each year. Many specialists are adamant that investment into palliative care is an essential prerequisite to the incoming law.

Dr Jamilla Hussain, a palliative care consultant and academic working in Bradford, is currently conducting research into inequalities at the end of life. Similar to other healthcare areas, those from disadvantaged groups, including poorer, disabled and ethnic minority people, are less likely to receive specialist palliative care.

"We know that certain groups systematically get less palliative care, which ensures you have good symptom control, psychological support and spiritual support," says Hussain. "We need to have better palliative care so people have a genuine choice."

One major barrier, particularly for ethnic minorities, is awareness of and preconceptions around the specialism. Public health messaging is urgently needed, she says, to tackle misinformation and make clear the difference between palliative care and assisted dying.

"These communities don't know about these services," she says. "And if they do access them, the biggest fear they have is of not being cared for in the same way [as others]."

Through its ten-year health plan for England, the government has recognised the vital role of moving some healthcare away from hospitals and into the community. Palliative care is a model example for this approach: research from the National Institute for Health and Care Research (NIHR) has found that 78 per cent of healthcare costs in the final year of life are spent on hospital care, at nearly £19,000 per person. Investing in community services could reduce expensive hospital admissions while freeing up beds for those who need life-saving treatment.

But without investment, specialist services such as hospices will struggle to meet demand. According to Hospice UK, in England, on average, the NHS only funds around 40 per cent of the care that hospices provide, and two in five UK hospices are planning service cuts this year.

"What we're asking is: how is it acceptable to have a state-funded assisted dying service, yet end-of-life care is reliant on charity?" says Charlie King, director of external affairs at Hospice UK.

"Our concern for a long time is that palliative and end-of-life care has been seen as a sort of 'second-class citizen' within the health and social care space," he adds. "There are signs this is changing under this government, but we need them to commit to long-term funding reform."

Last December, the government announced a £100m funding boost for England's 170 adult hospices, and £26m for its 40 children's and young people's hospices. The grant was for capital investment, so improving and modernising buildings, equipment and IT rather than daily running costs such as salaries.

The hospice sector broadly welcomed this, but it is calling for multi-year financial contracts rather than one-off packages, and for specific funding for salaries so that hospices can match NHS pay, vital for recruiting and retaining staff.

Hospice UK has laid out both of these asks in a plan it published earlier this month, alongside calling for specialist palliative care to be fully funded by the NHS (complementary support would remain charity-funded), and for the government to commit to equitable provision of palliative care services across England.

Others are calling for investment into out-of-hours support – a national 24/7 palliative care helpline would ease pressure on emergency services, says Sam Royston, executive director of policy and research at end-of-life charity Marie Curie. "When somebody has agonising pain in the middle of the night, their response is often to call 999," he continues. "If paramedics aren't carrying the end-of-life medications needed to support that person, they then get conveyed back to hospital – this should be entirely avoidable."

78%

Proportion of healthcare costs for the final year of life spent on hospital care.

40%

Cost of hospice care funded by the NHS.

100,000

People in the UK who could benefit from palliative care who die each year without it.

On visiting St Raphael's, it was apparent that palliative care is about so much more than medical intervention or pain relief. That broader range of services – from physiotherapy to family support and alternative therapies like massage – are what make people's final months, weeks or days feel worth living. And experts agree that they are essential components in ensuring someone has a dignified, good death.

"I think that we've medicalised death and dying in the UK," says Hussain. "Unlike diabetes or even cancer, they are social events rather than medical events. It's about people and families and communities. I think part of us addressing inequalities in access to palliative care is: how do we [doctors] stop getting in the way of that? How do we support that to flourish?"

Demand for palliative care is only set to increase – the UK's ageing population and projected rise in major diseases mean that 160,000 more people in England and Wales will need palliative care by 2040, according to research published in *BMC Medicine*.

With the Assisted Dying Act on the horizon, it is imperative that people have the freedom to choose how they wish to die on their own terms. The government has placed emphasis on shifting the NHS from sickness to prevention – but to truly ease pressure on an overburdened healthcare system, it clearly needs to invest not only in helping people live well but helping them die well too.

Advertorial

Prevention is better than cure – but are we there yet?

Consistent policy frameworks, timelines and accountability are needed to shift to a healthier food system and turn the tide on diet-related illnesses

By Richard Hall

In association with

When I last wrote for the *New Statesman*, the new government had just taken office, and the UK was in the grip of a growing health crisis. Increased prevalence of obesity and malnutrition wasn't new, but bold and systemic change was urgently needed. We were promised a prevention-first NHS and decisive action on obesity. One year on, what have they delivered?

The simple answer is: not enough. The UK remains embroiled in a health crisis fuelled by poor diet and limited understanding of nutrition. But some inroads have been made. We recently saw the launch of the NHS 10 Year Health Plan and the government has signalled its intent for the long-awaited National Food Strategy through its Good Food Cycle framework.

We are on the cusp of change, but with government floating its latest proposals before summer – without timelines or consultation – clearer direction is still needed.

A shifting landscape

As a health-focused company, and leading supplier of medical nutrition to the NHS, Danone has long championed the role of nutrition within preventative healthcare, so people avoid illness, recover faster and stay healthy for longer. It was welcome news that the NHS 10 Year Health Plan recognised the pivotal role that a good diet plays in relieving pressure on the NHS.

Last year, I called for the government to champion the production, sale and consumption of healthier food, and agree on what constitutes "healthy". A promising fulfilment of this ask is the government's new Healthy Food Standard, a policy designed to ensure big businesses promote healthier food. Large food and drink businesses, retailers, manufacturers and out-of-home providers (for example, takeaways and meal delivery services) will have to report on their sales of healthy food and drink based on levels of fat, sugar and salt.

The link between poor diet and negative health outcomes is well established; reducing consumption of foods that are high in fat, sugar or salt (HFSS) is necessary. Mandatory reporting matters because it drives accountability, creates a level playing field and rewards companies already

doing the right thing. It also provides government and civil society with reliable data to inform policy and track progress, which has been, until now, sorely lacking.

At Danone UK & Ireland, we already report on the healthiness of our food sales and set firm health commitments in 2023 to never produce a product for children which is HFSS and that at least 90 per cent of our product portfolio by sales volume would not be HFSS. Today, we've exceeded that target. More than 90 per cent of our portfolio is non-HFSS, down to incremental innovation and consistent investment in reformulation.

Consistent policy is crucial for success

Currently, HFSS legislation is underpinned by the 2004/5 Nutrient Profiling Model (NPM), a system that measures the healthiness of a product based on its ingredients. Retailers and manufacturers spend considerable time, resource and investment adapting to this model, and progress has been made.

Now, the government is considering moving to a new version – a model that has been called out by experts, including Professor Morris and Dr Jenneson at the University of Leeds, as too theoretical and impractical for industry. Since current HFSS legislation is not even fully implemented, a change in model would move the goalposts significantly and risk compromising the investment and reformulation already made.

Industry needs a clear and consistent policy framework. We recognise that models like this must evolve as science progresses and we're open to working with government on what a revised, practical approach could look like. But the current model is working and consumer behaviour changes – as Nesta notes – take time. A consistent framework is absolutely key to maintaining momentum. If a company like ours, with health at its core, is concerned about the feasibility of a new model, government should be too.

Prevention must drive policy

If we want to reduce diet-related disease and relieve pressure on the NHS, consistent policies are essential, and healthy and accessible food needs to be part of everyday life. Mandatory reporting is tangible progress, but it must be backed by a National Food Strategy with prevention at the core.

Food and drink companies with a genuine interest in nutrition, like ours, should be treated as partners. Industry has the scale, innovation and expertise to deliver practical and lasting solutions, but only if government provides stable, long-term parameters.

Although the government has set out a broad ambition for a generational shift in how we relate to food through its Good Food Cycle framework, ambition needs structure, and the framework is too vague. With nearly 700 policies to tackle obesity proposed over the last 30 years, to little success, the Good Food Cycle has an opportunity to deliver where others have not. But only if it has clear timelines and accountability. To succeed, government must work alongside industry and, for example, appoint a named individual – such as a minister for healthy and sustainable diets – to ensure policies are not just announced but implemented, tracked, enforced and improved.

Keeping up momentum

As we await further detail, we can't lose sight of the immediate interventions needed to tackle diet-related health issues. The health repercussions of malnutrition and obesity both place increased pressure on the NHS and carry a high cost. Yet these repercussions are preventable if addressed urgently through a focus on better nutrition.

We need to see obesity and malnutrition rates reduce year-on-year, with access to malnutrition screenings expanded to support early intervention, such as medical nutrition that can aid recovery and reduce hospital stays. Again, it would be beneficial to see clear ministerial accountability to drive progress.

The anticipated NHS workforce plan would also benefit from a joined-up approach, considering how a focus on nutrition can help ease pressures on frontline teams. For example, additional dietitian and community-based care roles could enable earlier identification of diet-related issues, leading to improved health outcomes.

There's no denying the government is focused on delivering a healthier nation. A start has been made, but if it wants to have an impact within this parliamentary term, it needs to hold steady and let progress do its job. Meaningful outcomes require patience; if we want to really shift the dial on health, the government needs to focus on implementing and enforcing policies that are already working.

Richard Hall is vice president, general secretary, Danone UK & Ireland

DANONE UK & IRELAND

Danone has long championed the role of nutrition within preventative healthcare

Advertorial

Fit for the future or stuck in the past?

Type 1 diabetes screening is testing the government's health ambitions

By Ahmed Moussa

In association with sanofi

Anyone with type 1 diabetes (T1D) will remember when they first learned they had the condition. Many will have felt shocked. Genetics can play a part, but it can strike anyone at any time in their lives.

A late diagnosis can be life-changing. There are many examples of people presenting at the hospital for an emergency diagnosis triggered by a severe lack of insulin, resulting in diabetic ketoacidosis (DKA), a potentially life-threatening diabetes complication. Across England and Wales alone, nearly a quarter of all new T1D cases had a DKA diagnosis.

Troublingly, misdiagnosis is common. A retrospective study in 2019 suggested that up to 40 per cent of adults over 30 in England who had T1D are initially misdiagnosed with type 2 diabetes. This, combined with unequal access and uptake of life-changing technologies between ethnicities and socioeconomic groups (including insulin pumps and continuous glucose monitors), means a postcode lottery in diabetes care persists.

But it doesn't have to be this way. A blood test, which identifies risk before symptoms appear, can help patients prepare for disease progression and avoid late diagnosis leading to complications like DKA.

Other European countries, such as Italy, have begun to implement identification and care for people in the early stages of T1D. However, despite people already being diagnosed through research studies, the UK currently lacks NHS-funded and coordinated care pathways which involve nationwide screening for early-stage T1D, meaning people are potentially experiencing DKA that would otherwise be preventable.

The government has a golden opportunity to put this right. In *Fit for the Future*, the ten-year health plan for the NHS, ministers express enthusiasm about three interlinking shifts: leveraging technology, moving from reactive treatment to preventive healthcare, and transferring beyond hospitals to community-based services.

The design and implementation of comprehensive pre-symptomatic care pathways and targeted testing for those at high risk for T1D meet these criteria and deliver a win-win scenario for patients and taxpayers. T1D hospital

costs are six times higher than for those without the condition and require ten times more emergency care. By reducing DKA incidents, there's a possibility of reducing the pressure on emergency care from T1D, enabling access for UK patients to clinical trials.

This is a powerful illustration of how the government could deliver a virtuous circle when it comes to improving the nation's health. In this scenario, prioritising prevention and access to new technologies, treatments and medicines creates a healthier society. This supports a more sustainable NHS and drives national economic growth. A growing economy and a health system which promotes innovation make the UK a prime destination for global life sciences investment, fuelling the next wave of medical breakthroughs that will help British patients.

The alternative is the familiar vicious cycle in which rising health burdens drain the economy, stifling investment and promoting inequality. This would leave the UK trailing Europe, the US and China and let one of our growth-driving industries wither on the vine.

The reality is already knocking on our door. Foreign investment in the UK's life sciences sector declined by a staggering 58 per cent between 2021 and 2023. But it is the impact this vicious circle has on patient access to new medicines in the UK that is most concerning. Currently, the UK spends considerably less than most comparator countries on medicines – just 9 per cent compared with 15-18 per cent typically spent by our European counterparts. This is amplified by the context that the UK's evaluation models for determining patient access to new drugs and treatments, set by the National Institute for Health and Care Excellence (NICE), haven't kept pace with inflation since 2014. Inevitably, this has consequences. Consider this one, salient fact: UK patients on the NHS can access only 48 per cent of new medicines, compared with 85 per cent in the US.

If this is to change, we must ensure the systems that evaluate and approve new medicines are as advanced as the science that powers them. Only then can early detection pathways support access to new medicines.

This would see the government updating the threshold that NICE sets for its Quality Adjusted Life Year assessments, which estimate the health benefits of new medicines, from the current maximum. It would be a move that aligns them with inflation, annual growth rates and the cost of developing medicines over the last 11 years.

In tandem, reducing the current levies set by the voluntary scheme for branded medicines pricing, access and growth, currently set at 23 per cent and forecast to rise to 28 per cent by next year, would see more medicines reach UK patients.

With this approach, the government would clearly signal its commitment to the UK's life sciences sector, which it could underscore by setting out an ambitious target to make it the fastest-growing market in the G7.

This is what the NHS's ten-year plan should look like: a future where our health system identifies and manages T1D risk before symptoms develop, an example of a preventative healthcare model that reduces emergency care and positions the UK as a more competitive market for clinical trials. This is about more than the future of life sciences or even the NHS: it is a test of our national ambition and our appetite for implementing real change. We can't afford to fail it. ●

Ahmed Moussa is Sanofi UK&I general manager. Full references can be found in the online version of this article at https://tinyurl.com/4m8mtrmn

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DC STUDIO/SHUTTERSTOCK

Type 1 diabetes hospital costs are six times higher than for those without the condition

Joining the dots

Predictive prevention could transform healthcare – but only if data, trust and policy align

By Phin Foster

Britain's healthcare system is under strain from pressures it was never designed to handle at such scale. A service built in an era of short illnesses and early deaths now faces a population living longer with multiple chronic conditions – and deepening inequalities that medicine alone cannot fix.

And the case for reform is about much more than healthcare. Record levels of sickness-related inactivity have seen roughly one in five adults living with a condition impacting employment.

Prevention is framed as fundamental to the country's economic future; health and growth as part of the same project. As Andrew McCracken, assistant director for external affairs at the King's Fund, opined to the *New Statesman* during a panel discussion at this year's Labour Party conference: "You can't grow an economy if millions are too unwell to participate."

A combination of genetic data, blood tests and digital records can predict illness early

CAVAN IMAGES/SHUTTERSTOCK

Around eight million working-age people now report a long-term condition that limits their ability to work, and roughly three million are out of the labour market altogether.

The link between poor health and low productivity is well established. Places with the lowest healthy life expectancy also tend to have the weakest labour markets and the heaviest demand on NHS services. In the most deprived parts of the country, men live about a decade less than in the richest; for women, the gap in years lived in good health is closer to 18.

Labour's new ten-year plan for the NHS is meant to break this cycle. Its emphasis on screening, early intervention and community-based care marks a shift from a system that treats disease to one that tries to prevent it.

But ambition alone won't deliver results. Much of the NHS still relies on paper records; hospital and GP systems don't talk to each other; patients receive appointment letters after the date has passed. "There's a gulf between what's scientifically possible and what people experience day to day," McCracken says. "We've got to fix the boring stuff before we can deliver the exciting stuff."

That "exciting stuff" is the promise of a genuinely preventive NHS: one that uses genetic data, routine blood tests and digital records to identify risk years before symptoms appear. A push towards "predictive prevention" – spotting risk early through data, genomics and new technology – is central to reform. But making that work requires more than merely leveraging advancements in tech; it means building reliable data systems, clear rules on how they are used, and a culture that sees people before they are broken.

The ability to act before illness takes hold could save not only lives but vast sums of public money. Scaling such capabilities will remain a hypothetical without the mundane groundwork of shared databases, interoperable systems and basic administrative competence.

For Josh Fenton-Glynn, Labour MP for Halifax and a member of the Health and Social Care select committee, prevention is not just a clinical issue but an administrative one. A former councillor and social care lead, he has seen first-hand how poor coordination can waste money and weaken outcomes. "The NHS accounts for about 40 per cent of government spending," he says. "If we're trying to get growth, it has to be part of it."

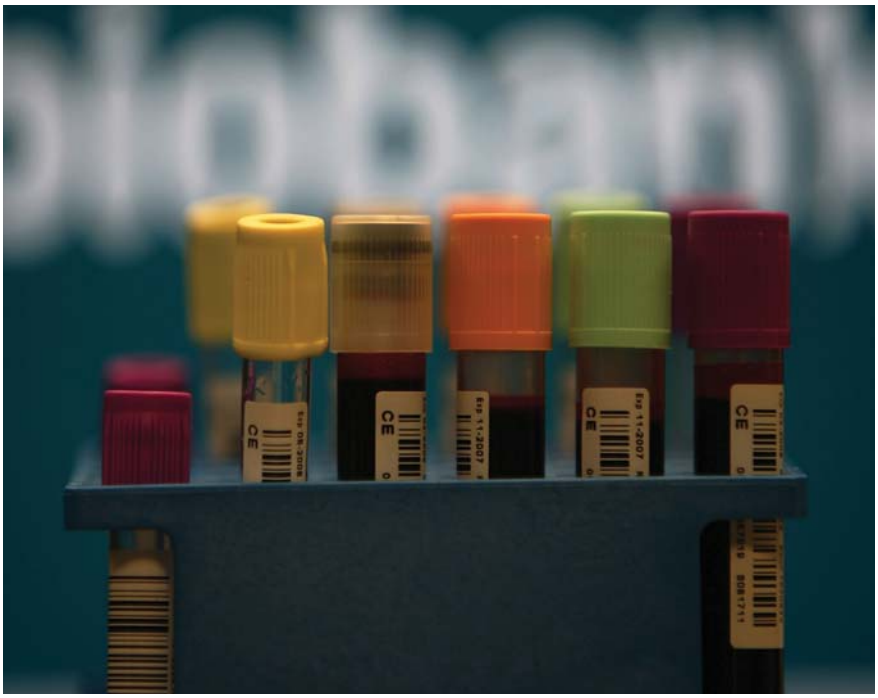
He argues that the NHS should be viewed not as a cost centre but as a platform for innovation – a single national system that, if joined up properly, could be the world's best test bed for early diagnosis. "We talk about AI, but a GP still needs numerous passwords to log in," Fenton-Glynn adds. "We've not managed large IT projects well. That has to change."

A government elected on promises of "a healthier Britain" must prove that technology and reform can work together without eroding trust. Digital modernisation should make the NHS fairer, not more fragmented. Pilot schemes and white papers mean little without shared standards, transparency and a clear public mandate.

Sir Rory Collins, professor of medicine and epidemiology at the University of Oxford and chief executive of UK Biobank, has spent decades turning population-level data into public benefit. "You can't prevent what you can't see," he says. "You can't work out whether you're implementing preventive strategies if you can't gauge what's being implemented."

At present, the NHS can see what happens in hospitals but not in GP surgeries, where records are held by commercial software suppliers. That, Collins argues, makes it impossible to know whether proven interventions – controlling blood pressure, managing cholesterol, screening for cancer – are reaching patients at required scale.

His solution is both straightforward and complex: data consolidation. A national health-data service combining primary and secondary care, registries ▸



UK Biobank has been following 500,000 volunteers across two decades

CHRISTOPHER FURLONG/GETTY IMAGES)

◂ and diagnostics, all under NHS control, would allow the system to track progress and apply new tools safely. "The data is already there," Collins says. "We just need to bring it together."

UK Biobank, which has followed half a million volunteers over two decades, shows what's possible: long-term genetic and lifestyle data that have already reshaped understanding of disease development and prevention.

But public trust is questionable. Britain's experience with the care.data programme – an NHS England attempt a decade ago to link GP and hospital records that collapsed after a backlash over privacy – still casts a shadow.

McCracken believes any new system must be open about what's being shared, why it matters and how patients benefit. Within the NHS, there is still uncertainty about working with private technology partners. "If we want innovation, we need governance frameworks that protect patients but give professionals confidence to collaborate," he says. "Right now, Government hasn't quite done that work."

The ethics of predictive prevention reach beyond privacy. Questions of consent, accountability and fairness loom large: who gets flagged for screening, who decides what risk means, and what support follows? Without openness, data-driven care could deepen inequalities. Fenton-Glynn argues that innovation should start where the need is greatest. "Too many pilots happen in affluent suburbs," he says. "We need to make sure the most deprived areas are where new models of care are tested first."

Every prevented case of diabetes or earlier cancer diagnosis delivers value to both individuals and the public purse. Labour's "missions" agenda links those goals directly: better health as a driver of growth. But investment will be essential – in data platforms, digital literacy and local services that keep people well rather than waiting for them to fall ill. "We've got the science and technology," McCracken says. "What we lack is consistency and coordination."

Collins sees prevention as part of a wider social contract. Medicine alone has never delivered the biggest health gains. "What got people to stop smoking wasn't their GP saying 'don't smoke'," he says. "It was taxation. And what will change obesity? The same." Predictive tools can identify risk, but society still has to decide what to do with that – through housing, food policy, education and local government as much as through the NHS.

> We have the data – we just need to bring it together

And a blend of science and policy will define whether predictive prevention works. A purely biomedical approach could turn ordinary life into a clinical risk map; an entirely social one wastes the potential of technology. The next phase of reform must leverage systems that flag danger early, and public policy that makes healthy living achievable.

Despite the scale of that challenge, Fenton-Glynn is cautiously optimistic. "Technology is moving fast," he says. "The NHS is the biggest healthcare system in the world – if we get this right, we can lead globally." Prevention, he adds, should not be an add-on but "the organising principle" of reform. "It's better for industry and for patients. It means parents spending more time with their kids because their cancer was caught early. That's what it's about."

Collins shares that sense of opportunity. During the pandemic, he recalls, Britain proved it could join data quickly and use it safely to guide national decisions. "Then we stopped. We need to be less afraid of sins of commission and more afraid of sins of omission."

McCracken's benchmark is simpler: a health system that no longer spends most of its time treating what could have been prevented. "The science is there, the technology is there. Surely we can do the implementation bit now."

Predictive prevention isn't a slogan, miracle cure, or Philip K Dick-inspired fantasy. Rather, it's a fundamental feature in delivering a change in posture – treating the NHS as part of Britain's economic and civic infrastructure rather than an emergency service of last resort.

If the next decade brings steady investment in data, trust and equity, the UK could yet show how a universal health service becomes a preventive one. The hard part will be staying the course: joining the systems, earning confidence, and proving that early intervention can be humane, sustainable and genuinely transformative. ●

Advertorial

Break down barriers to save lives

The UK must cut through bureaucracy if it is to remain a leader in life sciences

By Clare Pelham

In association with epilepsy society

You only have to look across the Atlantic to appreciate the impact that politics can have on scientific research. The threats made by the Trump administration to freeze grants and funding for many of the most respected research institutes and universities has had a chilling effect.

Researchers, fearful for the future, have been packing up their microscopes and mothballing their laboratories – and the impact has not only been felt in the US but here in the UK, too. Many international collaborations have been frozen or ended, with projects at many top universities finding the fiscal rug pulled from under their feet.

Of course, political fragility is nothing new. But perhaps over recent decades we had felt that this was a relic of our less enlightened past – that it was a battle that had been won. We all know that for scientific endeavour to succeed and flourish it must be firmly rooted in the fertile ground of intellectual freedom.

But in these turbulent times I make no apology for saying again that the first requirement for scientific creativity is intellectual freedom.

The second requirement is a truly diverse team. Research is a global affair, now more than ever. And it is no longer – if it ever truly was – the preserve of supremely gifted individuals.

Research is a team sport. A fully international laboratory, with representation from Europe, Asia, Africa, the US and beyond, allows for a fertile exchange of skillsets and experiences that enriches the research landscape and benefits patients.

International collaborations are particularly key in the study of rare diseases, where pooled datasets increase statistical power and allow for the identification of rare genetic markers, leading to better diagnosis and greater treatment options. This is unquestionable in the field of epilepsy. But is the UK life sciences sector doing enough to create a fertile environment that supports global talent alongside home-grown talent? Could we do more to attract top researchers from overseas to our world-leading labs and encourage greater creativity and innovation on home soil?

The UK is undoubtedly a global leader in life sciences. It is home to

several of the world's top universities for life sciences and medicine. It has an enviable track record of scientific breakthroughs, including the discovery of penicillin, the structure of DNA and developments in IVF and stem cell research. The UK also became the first country to approve and roll-out vaccines against Covid-19.

But in spite of a widespread acknowledgement that international talent is needed in order to maintain our position at the forefront of science, our systems are beleaguered by red tape and bureaucracy. Yes, the UK's life sciences research is cutting edge, but we're also at the mercy of a filing-cabinet mindset, where processes move at a bygone pace.

The non-profit organisation Campaign for Science and Engineering recently published a report showing that one of the greatest barriers to recruitment in R&D is the complexity of the visa system with its accompanying high costs.

If the UK is to be welcoming to global talent, then the entry system needs improving, and fast.

The impressive £54m Global Talent Fund has been created to help attract top researchers from around the world. But competition is fierce. The EU has set aside €500m (£434m) to make Europe a magnet for researchers, and Japan has earmarked $700m (£493m) to capture some of the talent that is pouring out of the US. UK immigration or visa delays could see the country's laboratories losing out.

Barriers at the Home Office are not the only hurdle holding back research and potentially life-saving treatments of the future. Facilities are also essential. Unlike high achievers in some other fields, many – if not all – life scientists need cutting edge technology and premises to do their best work. These things cannot be provided at the drop of a hat.

Over in the Ministry of Housing, Communities and Local Government, reforms in the planning and infrastructure bill cannot come quickly enough – for decades, nimbyism has led to the blocking of essential housebuilding as well as other vital infrastructure. This has been a barrier for progress at my own charity, the Epilepsy Society, where we are desperate to develop a substantial part of our 300-acre site. This would raise £93m to accelerate research into the causes and treatment of epilepsy.

The development would be on green belt land and, understandably, there has been local opposition. It has become a tussle between the rights of people wanting to walk their dogs there versus the right of people with epilepsy to a seizure-free life. At what point does the green belt – and not a particularly luscious part of it – count as a greater priority than people's health?

One in 100 people has epilepsy. It is one of the most common serious neurological diseases. Every year, 1,200 people die of epilepsy-related causes, many of them young people on the cusp of adult life. In the three years since our planning application was submitted to the local authority, over 3,600 people will have died.

Reforms to the planning and infrastructure bill will speed up much-needed development. They will slash through the red tape that is holding up important planning applications such as our own. They could ensure faster progress towards 1.5 million new houses across the UK for those who desperately want a home of their own. And in our neck of the woods this could mean thousands more people with epilepsy will be able to enjoy a seizure-free life and contribute to the UK's economy.

Significantly, the scheme would enable us to attract up to 100 of the most talented researchers from around the world – visa dependent – to nurture alongside our own home-grown talent, generating economic activity and growth. Life sciences can be an engine for health-related economic growth. According to the consultancy Frontier Economics, there is £246bn to be gained in productivity growth from improving health outcomes in the UK. Big sums and big ideas. But at the heart of research is the patient and the difference it could make to their lives.

I hope the visa system gets sorted. I hope that planning is allowed to block the blockers. And, if so, that UK life sciences will thrive and develop. It could not be more important for hundreds of thousands of people, including those with epilepsy.

Because we must never lose sight of the human benefit of life sciences research. Of those whose lives will be saved or made so much easier as a consequence of our amazing life scientists. Doing exactly what it says on the tin. ●

EPILEPSY SOCIETY

We must never lose sight of the human benefit of life sciences research

Clare Pelham is chief executive of the Epilepsy Society

Breaking the bind

Britain is in a mental health productivity spiral. Will Labour be able to end it?

By Harry Clarke-Ezzidio

In 2013, "parity of esteem", the commitment to hold and treat physical and mental health in equal regard, was enshrined in the NHS constitution. This came following the passing of the 2012 Health and Social Care Act, which put the principle in law.

Thirteen years later, however, the consensus within health policymaking circles is that there is still a long, long way to go for mental health interventions – in terms of funding, resource and strategisation – to be on an equal-footing with physical ailments.

To many, the irony is that, even with this lopsided arrangement, the NHS isn't doing enough to deal with people's physical issues. The "NHS elective waiting list", standing at 7.4 million (as of August 2025), only accounts for those in need of physical treatment. Less attention is put towards the 1.7 million on the separate list for mental health. Of course, many of those facing physical ailments – through, for example, delays in accessing treatment – could go on to develop issues with their mental health, and vice versa.

There is one recurring word and policy intervention that has dominated discussions around health in recent years: prevention. Particularly in terms of preventing young people from falling ill at a young age, potentially condemning them to an unproductive, unfulfilling life.

The latest figures show that 948,000 people aged 16 to 24 are "Neet" – not in education, employment or training – which is equivalent to 12.5 per cent of all people in that cohort. Its causes are multiple and often overlapping: key among them being poor mental health. Over a quarter of Neet young people (26 per cent) identified poor mental health as being a key driver behind their status, a survey from the National Centre for Social Research (NCSR) found. Studies have shown that being Neet can have a detrimental effect on physical and mental health, and increase the likelihood of unemployment, low wages, or low quality of work later on in life.

Although Keir Starmer's party has, as one of its central tenets of government, pledged to build an NHS that's "fit for the future", there is still an underlying feeling that what has been put forward does not go far enough. The success (or otherwise) of the policy would have impacts far beyond the brief of the Department for Health and Social Care.

How is Labour meant to achieve its other missions for government – particularly the highest growth in the G7, and breaking down opportunity barriers for young people – if the current physical-mental-sickness bind persists?

"We've made such progress in pushing towards parity of esteem between physical and mental health," Danny Beales, the Labour MP for Uxbridge and South Ruislip and a member of the Health and Social Care select committee, told me during a panel discussion at the Labour Party Conference last month. Beales flagged the recent work his select committee has done on community-based mental health services. "Many people that we've spoken to in our review talk about only being able to access support when they're very acutely mentally unwell," he said. "And as soon as they feel better, there's almost a kind of punishment, [in that] the support that they receive is withdrawn, and suddenly they're back in the community, struggling to access support."

The consensus is clear: our current policy frameworks are not fit for purpose. It not only has a health-based impact for people but an economic one for the country. "We know, through our analysis, that [poor] mental health costs England around £300bn every year," Kadra Abdinasir of the Centre for Mental Health charity said during the same discussion. That cost "shockingly", Abdinasir continued, is nearly twice the total budget of the NHS. "If we want to take productivity seriously and improve it, we have to make use of the resources that we already have by shifting [policy] focus towards preventing mental ill-health, and intervening earlier."

The consensus is clear: our current policy frameworks are not fit for purpose

The scale, causes and effects are clear. But the government's plan to overcome the challenges of Neet individuals and, indeed, their older contemporaries, has had a mixed response.

In July, the government launched the NHS ten-year health plan. It aims to seize "the opportunities provided by new technologies, medicines and innovations to deliver better care for all patients – wherever they live and whatever they earn – and better value for taxpayers". Its headline pledges on mental health are to put £120m towards 85 dedicated mental health emergency departments; expand mental health teams in education settings; and roll out more, localised, neighbourhood health services.

The plan, while having some positive proposals, "falls far short of the transformative vision or commitment we need for the nation's mental health", in the view of Andy Bell, chief executive of the Centre for Mental Health. The plan says "very little" about how the gap between physical and mental health will be closed: "Mental health waiting lists are still given less importance than those for physical health care," added Bell. "There is little in this plan that will prevent mental ill health."

The most pressing request was for a holistic strategy on mental health. The government needs to "step-up", Bell argued, "and commit to a cross-government mental health plan".

Despite the numerous calls from politicians and the third sector in recent years, a cross-governmental plan to tackle the health-productivity spiral is yet to truly materialise.

Cross-departmental collaboration is acutely necessary if we are to tackle Neet young people, and productivity in particular. The top five "risk factors" for Neet status – from the aforementioned NCSR study – were: post-16 caring responsibilities (Health and Social Care); single-parent households, and social renting (Housing and Local Government); anti-social behaviours (Home Office); and parents having no qualifications (Education).

Beales said: "I hear all the time from parents in my constituency [about] their child with mental health issues, who may or may not be out of work, [or] applying for PIP, or struggling to get CAMHS [Children and Adolescent Mental Health Services] appointments for two or three years. That can't be an acceptable state of being if we want to get young people back into work or training to support them to live their best possible life and achieve their potential.

"It can't just be about tweaking the benefit system. It has to be about a more active benefit system; more active joined-up state system; health and mental health system, working with the welfare and job support system. At the moment, the state is far too siloed."

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Advertorial

Why prescription charges for IBD must end

The NHS can reduce hospital admissions and shift focus from sickness to prevention

By Jeremy Thorpe

In association with

A CHRONIC COST

Almost half a million people in the UK live with inflammatory bowel disease (IBD), which includes Crohn's disease and ulcerative colitis. Most are diagnosed between the ages of 15 and 40, meaning they face a lifetime of managing a serious, often invisible illness during their working years.

Chronic conditions like IBD place a huge strain on individuals and the NHS, with long-term illness costing health and care services an estimated £115.2bn annually. With 25,000 new IBD diagnoses each year, the case for better, more affordable management of the condition is not just a health issue, it is an economic and political imperative if Labour is to build an NHS that is fit for the future.

While Scotland, Wales, and Northern Ireland have rightly abolished prescription charges, England continues to impose the standard £9.90 fee, leaving many IBD patients to shoulder a recurring cost every few weeks. In the midst of a cost-of-living crisis, this is a financial burden that disproportionately affects those living with chronic illness at a time when the government is trying to get more people back to work.

Prescription charges are more than a financial inconvenience, they are a health risk. A 2023 survey by the Prescription Charges Coalition, involving 4,000 individuals with long-term conditions, found that nearly one in ten had skipped medication due to cost. Over half (53 percent) reported taking time off work due to deteriorating health. These figures highlight a troubling reality: when patients are forced to choose between medication and other essentials, their health – and productivity – suffers.

For employers, this also translates into lost productivity. The think tank Demos estimates that the annual cost to UK businesses from IBD-related absenteeism is around £600m annually. NHS hospital admissions related to IBD have surged by almost 27 per cent in recent years, rising from 282,335 in 2019-20 to 358,063 in 2023-24. These admissions are often preventable with proper medication adherence, which is undermined by financial barriers.

Most IBD patients are also diagnosed well before the age of 60, when they would become eligible for free prescriptions. This means they face the

burden of paying for essential medications throughout most, if not all, of their working lives. While Prescription Prepayment Certificates (PPCs) – which covers all NHS prescriptions for a set price – offer some relief, uptake remains low. In 2023-24, only one in three patients who could benefit used a 12-month PPC. More guidance and support are needed to help patients navigate these options and manage their condition effectively.

The government insists that 'extensive arrangements' exist to make prescriptions affordable in England. Yet one of its key mechanisms, the list of medical conditions eligible for free prescriptions, has barely changed since 1968. Back then, IBD was neither well understood nor as prevalent as it is today. This has resulted in thousands of patients being excluded from vital support due to an outdated framework that fails to reflect modern medical realities.

Community pharmacy teams also feel the strain. Their role should be focused on supporting patients and dispensing necessary treatments. Removing prescription charges would allow pharmacists to concentrate on care, not cost.

A change in policy directly aligns with the government's health priorities. The York Health Economics Consortium estimated that eliminating prescription charges for IBD patients could save the NHS approximately £20m annually. These savings would come from improved symptom management at home, fewer relapses and flares, reduced bowel cancer incidence, and fewer GP visits.

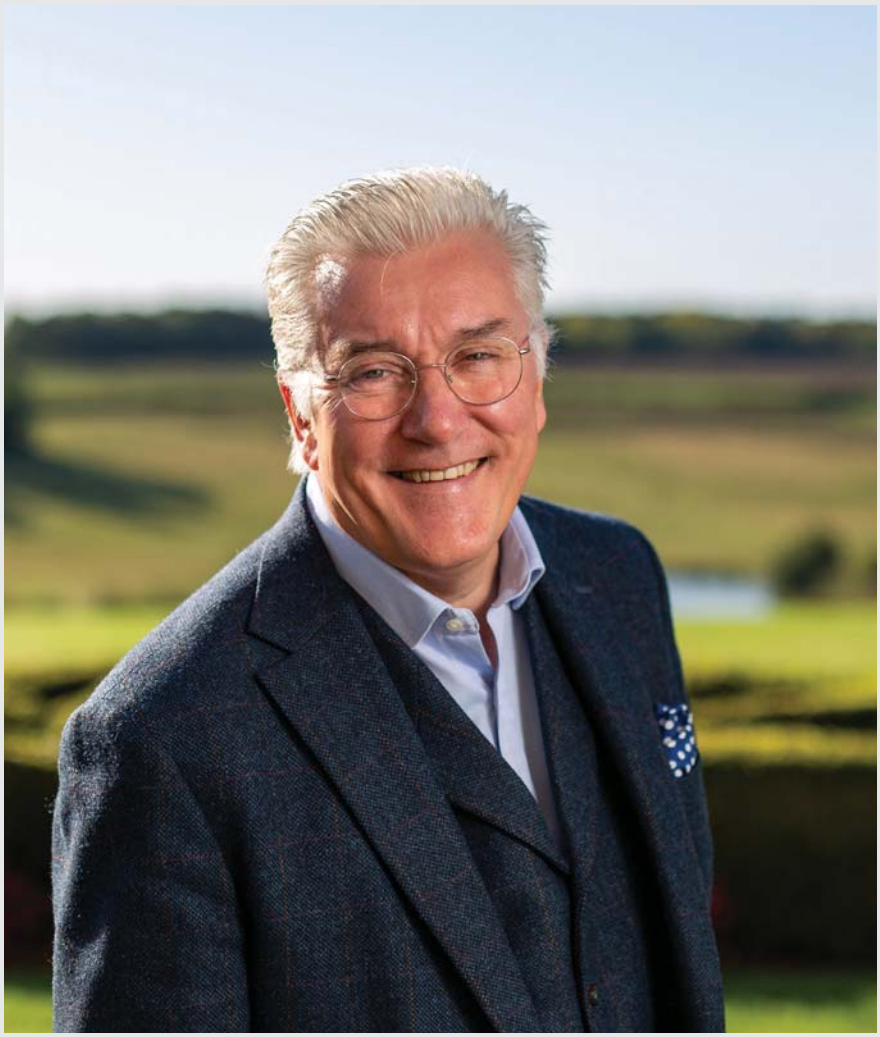
When patients are supported, the whole system benefits. Better access and adherence to medication leads to better health outcomes, reduced hospital admissions, and lower long-term costs for the NHS. This directly supports two key priorities outlined in the NHS's ten-year plan: shifting care from hospital to community, and from sickness to prevention. It also enables individuals to remain active in work and education, contributing to society.

In response to these challenges, Tillotts has launched the *A Chronic Cost* campaign, advocating for the abolition of prescription charges for IBD patients in England. The campaign recognises the complexity of achieving this goal, especially in light of the government's decision to freeze prescription charges at £9.90 earlier this year, a move positioned as a success, despite its limited impact on affordability. As interim steps, the campaign calls on the government to:

- Review the medical exemption list for prescription charges
- Assess the cost-effectiveness of scrapping charges for IBD patients

To support its cause, the campaign has developed an interactive heat map of IBD-related data by constituency across England, alongside a tool that enables users to email their local MP. A patient survey and report are also in development. A parliamentary reception is scheduled for 28 October 2025 to further raise awareness and drive policy change.

This campaign is not just for those living with IBD, it's for anyone who believes in fairness, equity, and a healthcare system that supports rather than penalises chronic illness. By removing prescription charges, we can empower patients to manage their condition effectively, reduce pressure on the NHS, and improve outcomes across the board. ●



Jeremy Thorpe: pharmacists should be able to focus on care and not costs

If you would like to learn more about the campaign A Chronic Cost, support our efforts, or attend the upcoming parliamentary reception on 28 October 2025, please contact us at: info@achroniccost.co.uk.

Jeremy Thorpe is managing director at Tillotts Pharma UK
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TILLOTTS

Opinion

The dawn of the virtual hospital

NHS Online promises to deliver virtual care at unprecedented scale

By Rosie Beacon

Picture a world where you can recover from major surgery without ever returning to hospital; doctors track your progress remotely while you rest at home. This isn't a distant concept, but a reality within reach.

It is a transformational concept worthy of the NHS's revolutionary roots – a universal, publicly funded health service, redefining how we deliver care and setting an example for the world. But a system built for 1940s Britain cannot meet the demands of 2025.

In the immediate term, hospitals are grappling with rising costs, worsening value for money, declining productivity and access, and deteriorating patient experience. In the longer term, they face shifting clinical demand: an ageing population, more conditions that are incurable but survivable, and relentlessly increasing costs of care.

All of this points to one hard truth: if the NHS were to be designed from scratch in 2025, it would look nothing like the system we have today. If you took our current hospital model and placed it in 1948, the underlying model – patient in, treatment, patient out – supported by the familiar wards, clinics and A&E departments, would look basically the same. Yet healthcare demand looks profoundly different.

As the NHS faces a considerable generational test, it desperately needs to rediscover the reforming spirit that once made it a model for the world. For decades, politicians have promised to modernise the NHS. Now, this government has sought to turn slogans into substance, launching the UK's first entirely virtual hospital.

It is hard to overstate the sheer operational complexity of a hospital. Hospitals are unusual in combining constant emergency demand with a single site that houses multiple – and expensive – specialist departments. Subject to complex and ever-changing demand, it is a unique economic unit.

Redesigning the NHS today would yield a very different model. Technology would form the foundation of care delivery rather than being an add-on. Patients would be able to be inpatients from the comfort of their own home and receive hospital-level monitoring while going about their daily lives.

The hospital would be a service, not just a building, accessible anywhere at

any time without undermining the quality of care. Only those who need to be in the physical hospital building would be there – reserved for the most risky, complex care and little else.

This is what makes the Prime Minister's recent announcement to create an entirely virtual hospital – NHS Online – such a crucial innovation. Virtual secondary care has existed for many years in fragments, but never at scale. Much like the NHS was a world-first, so too is the shift to virtual secondary care.

What once seemed futuristic is now a growing reality – and essential for the hospital of the future. NHS Online does not, of course, have the same suite of services that a traditional hospital does and should not attempt to. But within its scope – providing faster, more convenient treatment across a range of specialisms – it can help to address several of the challenges that typically accompany efforts to expand NHS capacity.

Historically, increasing health system capacity has been complicated and prohibitively expensive. Up until now, "more capacity" meant hiring more people, buying more equipment and constructing more buildings. It essentially requires funnelling more money – billions of it – into a system we know is not working effectively.

Just one large hospital trust could cost as much as £1bn a year in running costs. This is roughly equivalent to the funding required by 130 comprehensive schools or an astonishing 600 GP practices. But a virtual hospital can be developed and scaled extremely quickly, with minimal overhead costs in comparison to a physical hospital.

Compare the New Hospitals Programme, costing a gargantuan £45bn over 15 years, and with the construction of one hospital alone taking 3.5 to seven years. From inception to delivery, it can take as long as 11. Then look to Moorfields Eye Hospital's virtual A&E: 32 different virtual waiting areas, with two of their large services seeing 40 to 50 patients a day, all set up within a month. Drop-in video consultations were launched less than 48 hours after the first UK Covid-19 lockdown was announced.

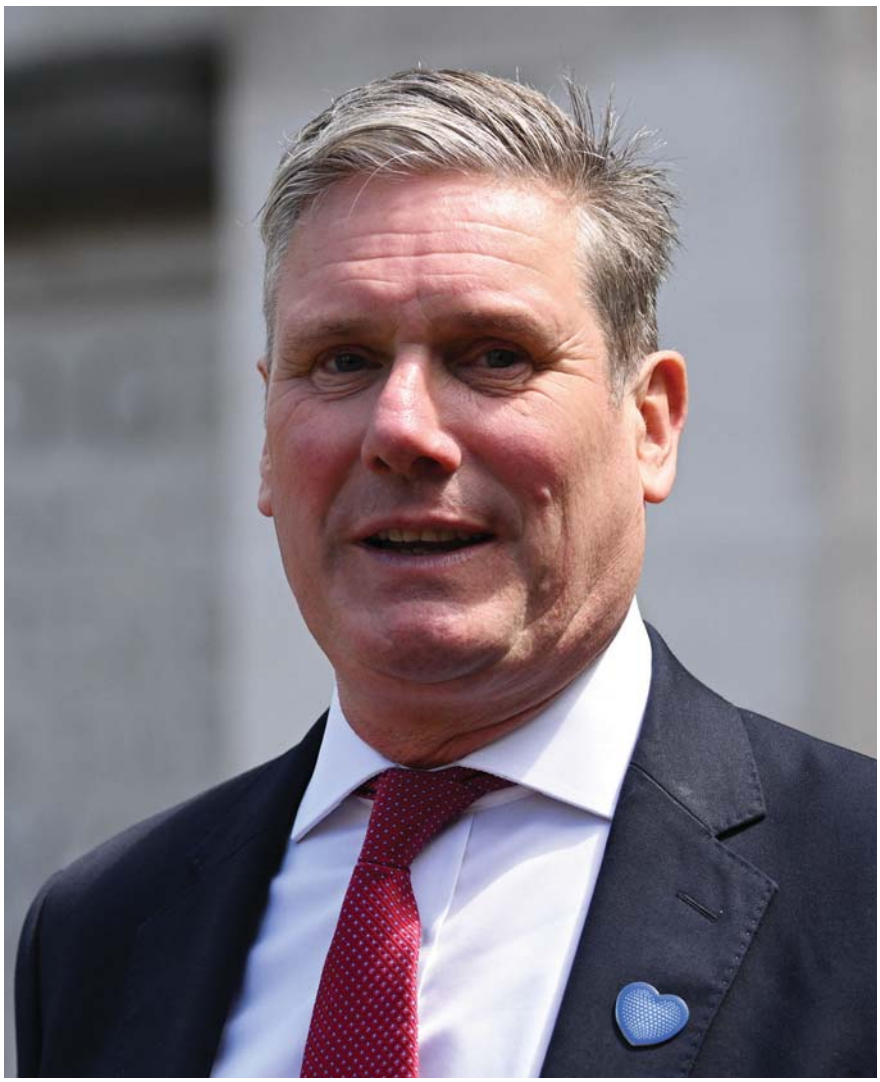
Since it would provide fewer services than a traditional bricks-and-mortar hospital, could move through appointments faster and have lower fixed costs, NHS Online can serve a much larger group at less expense. It will not be bound by physical capacity or local geography. Staff can work from home at times convenient to them.

Critics may argue that the NHS is about more than fiscal sustainability, that it exists first and foremost to provide critical healthcare to patients. Of course, this is true. But fiscal sustainability and efficiency are generally what make good care possible. And, irrespective, evidence from previous virtual initiatives suggests that the value patients get out of the speed and efficiency of the service counterbalances any reservations they may have had around virtual care. Indeed, many appreciate the convenience and comfort of being treated in their living room rather than a sterile hospital ward.

The shift to a virtual hospital marks the first decisive step towards a health system built for modern society, not the post-war era. As the Secretary of State put it, the NHS faces a choice: reform or die. This move reflects a clear commitment to pursuing the former. ●

Rosie Beacon is head of health at Re:State

Redesigning the NHS today would yield a very different model



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Keir Starmer set out plans for NHS Online at the Labour Party Conference

Ending the HIV epidemic by 2030

New modelling by Gilead Sciences shows we're at risk of missing current targets – but not all hope is lost

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In association with GILEAD

The HIV epidemic has changed beyond recognition. The UK government has made an ambitious pledge to end new HIV transmissions in England by the year 2030, and become the first country in the world to achieve a milestone that would have been unimaginable at the peak of the epidemic.[1] Recently, the government's commitment to achieving this goal was reaffirmed in the Ten-Year Health Plan.[2]

Yet new data shows we are further off-track to end the HIV epidemic by 2030 than previously believed. The modelling – developed by Aquarius Population Health and commissioned by Gilead Sciences – is the first to map new transmissions across the whole population; not just among gay, bisexual, and other men who have sex with men.[3] The modelling explores three possible scenarios based on how the number of new HIV transmissions (acquired in the UK) are projected to change as HIV interventions are scaled up, including prevention, testing and timely treatment.

Starting from a baseline of 947 new transmissions in 2024, in the current scenario there will still be 924 new transmissions in the year 2030 if nothing about the government's response to HIV were to change, the modelling suggests. In fact, new transmissions will begin to increase after the year 2030. In the moderate scenario with somewhat upscaled HIV interventions, this number falls to 750 new transmissions. In the optimal scenario, with significantly upscaled interventions, we can reach 411 new transmissions and get much closer to our goal.

The data tells a clear story about how the HIV epidemic is changing. Gay, bisexual and other men who have sex with men have been most significantly and disproportionately impacted by HIV, but we have seen a significant drop in new diagnoses among this group over time.[4] New diagnoses are now rising most steeply among heterosexual men and women.[5] Our modelling predicts that three quarters of new transmissions could be among heterosexual men and women in 50 years.[3]

Widening inequalities in HIV are putting the 2030 goal at risk. Gilead has recently spotlighted the experiences of women affected by HIV across England, who for too long have been systematically excluded and ignored.[6] As

the nature of the HIV epidemic evolves, we cannot simply do more of the same. The government believes that we will end new HIV transmissions by 2030,[2] and the whole HIV community stands behind this ambition. We hope that this new data can allow us to refocus our efforts and do things differently to get us back on track to 2030.

"By sharing this new modelling, Gilead hopes to inspire the government to act decisively, now," said Peter Wickersham, Vice and General Manager, UK and Ireland, of Gilead Sciences. "The data shows that there is still much work to be done. We need the same ambition, but new ideas as well."

We have the learnings. The effectiveness of the HIV response among gay, bisexual and other men who have sex with men shows us that the impossible is possible. But we cannot get complacent with a one-size-fits-all approach. The changing nature of the epidemic and widening inequalities requires a new strategy to target different groups.

We also have the momentum. In recent years, the emergency department opt-out blood-borne virus testing programme across England has helped to identify over one thousand people living with HIV who ay not otherwise have been diagnosed.[7] Building on this momentum and being willing to try new approaches will be vital.

Finally, we have the mechanism. The government has promised to publish a new HIV Action Plan this year to take us to 2030. This new HIV Action Plan must set out plans to upscale effective HIV interventions, in alignment with the government's wider shifts for the NHS: for example, widening access to the prevention tool Pre-exposure prophylaxis (PrEP) in local communities; establishing a new national programme to re-engage people in care; and rolling out digital innovations to support self-management. These interventions need to be implemented in parallel to be effective.[8]

"Without investing in new approaches to HIV prevention and care, we will miss the opportunity to end new HIV infections in England by 2030," commented Anne Aslett, CEO of the Elton John AIDS Foundation. "Put simply, many more people need to be using PrEP. A new digital prevention strategy that guarantees everyone in England online access to at-home HIV tests and postal delivery of PrEP would help drive down new infections, especially among harder-to-reach groups," she added. "The government should also provide PrEP outside of sexual health clinics, such as in women's health hubs and community health centres to engage the communities overlooked by the current system."

The next five years could change the course of the HIV epidemic forever and show the world what is possible. With bold leadership and increased focus as well as investment, the UK government can ensure we don't just slow down transmissions, but end the epidemic altogether. Let's get back on track and within touching distance of 2030. ●

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Bold leadership and investment could see the UK get back on track with its HIV goals

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