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Bold thinking for better health

The role of the workforce in the shift to prevention

Perspectives of nurses, midwives, allied health professionals and NHS managers

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Key messages

In 2025, we conducted five focus groups with health care professionals, including nurses, midwives, allied health professionals and NHS managers, to explore the role of the workforce in the shift from treatment to prevention outlined in the 10 Year Health Plan.

- We found that the shift to prevention intuitively made sense to participants and there was both an openness to, and enthusiasm for, its potential. In addition, the majority of participants could point to examples of where their roles already contribute to prevention.

- However, participants often experienced prevention as hard to prioritise, and as an add-on to their roles and the care they deliver. Participants found it hard to conceive of how the shift could be achieved without addressing pressures in the current context of care, including high demand and workforce shortages. There are concerns that prevention may be positioned as another thing the workforce is being asked to do.

- Participants' descriptions of the shift were largely framed as an expansion of what they currently do, with a focus on secondary prevention. The ambition for the shift to support radical reform to reinvent the health care model, as set out in the 10 Year Health Plan, is not clear to frontline staff. Further work is needed to create a vision for the role of the NHS in a shift to prevention to facilitate that change.

Our research found that to implement that vision and support the role of the workforce in the shift to prevention, government will need to address four key policy areas that shape and define practice.

How health care systems are designed and operate to prioritise prevention

- Prevention needs to be built into service pathways, and prioritised as part of commissioning, including in the development of new models such as neighbourhood care. Particular attention should be paid to access to services and the interface between services, ensuring timely and effective access to support. Sustainability of projects to enable prevention should be considered from the outset, with opportunities to share learning embedded as part of this.

- System targets and incentives need to be aligned with the shift to prevention. This includes targets within the National Oversight Framework and the use of key performance indicators at a local level. The balance of targets focused on prevention compared with those focused on treatment is an important measure of the government's prioritisation of prevention.

- The shift to prevention is dependent on partnership working with multiple stakeholders, including local authorities, voluntary, community, faith and social enterprise (VCFSE) organisations, and communities. Opportunities should be sought to facilitate cross-organisational working, which enables skills and information to be shared among staff. However, the shift to prevention should not be conflated with the shift from hospital to community, and acute trusts and hospital-based services in other sectors should be equally accountable for prevention.

What a system focused on prevention rather than treatment means for the role of staff in the delivery of care and the individuals they support

- The shift from treatment to prevention has the potential to change expectations and the balance of roles and responsibilities for staff and patients. Participants highlighted the need for an honest conversation with professions and the public about the rationale for the shift and the vision for care, including the roles and responsibilities of staff and members of the public.

- Person-centred care is core to supporting people in managing their health. Government needs to ensure that staff have access to training and education to develop workforce capability. Consistent infrastructure and national leadership for person-centred care should be developed alongside appropriate monitoring of implementation and outcomes.

- Staff are concerned that the shift to prevention could increase existing health inequalities. Implementation of policy and approaches to enable the shift should seek to address health inequalities from the outset. This is more likely to be successful if changes are informed by and co-designed with the people and communities most at risk of poor health outcomes.

How workforce design and capability can be optimised to facilitate prevention

- Workforce planning should consider how the shape and scale of the workforce can facilitate the skills and capabilities to support the shift to prevention. Key considerations include differential investment in roles where skills have potential to be of wider benefit to staff and patients beyond clinical treatment services, and development of multidisciplinary working, which supports holistic utilisation of skills and knowledge. Professional bodies should also consider the skills and competencies needed to deliver preventative care.

- Staff need access to a range of tools and resources to support prevention. However, responsibility for the development of and access to such resources is often fragmented, and there are notable issues with availability, quality and consistency. Government should

consider how best resources (including information and guidance) can be curated, and the most appropriate means for validating the quality of resources available.

The leadership and organisational development support necessary for prevention

- Responsibility for issues that participants identify as important in the shift to prevention sit across multiple areas of policy and practice. It is important that any vision for prevention aligns system leadership and accountability for prevention across relevant areas. This should also consider leadership and governance for areas of policy identified as being important in the shift, but where current arrangements are unclear and fragmented.

- The health and growth accelerators, the prevention demonstrator in Greater Manchester and prevention accelerators provide a picture of emerging leadership for prevention at a regional and local level. Government can play an important role in facilitating learning on the emerging role of the workforce, addressing systemic barriers to prevention, and providing clarity on prevention spending.

- The role of the NHS workforce in prevention can be greatly enhanced through the contribution of other areas of government, most notably through local government, including its relationship with the VCFSE sector and responsibility for public health. To deliver the government's health mission and the shift from sickness to prevention, government should strengthen cross-departmental action on the wider determinants of health.

01 Introduction

‘Everybody knows that prevention is better than cure.’ So said Lord Darzi in his 2024 investigation of the NHS in England, commissioned by the incoming government (Department of Health and Social Care 2024). As Lord Darzi put it, interventions that protect people’s health are far less costly than the treatment of illness – calling for greater investment in preventative services and redressing how funding and resources are currently directed.

In 2025, the government published the 10 Year Health Plan, setting out its ambitions for the NHS (Department of Health and Social Care 2025a). Alongside a shift in the delivery of care from hospital to the community and from analogue to digital, the government outlined a third radical shift – from the treatment of sickness to prevention – by reaching people earlier and empowering people to ‘make the healthy choice’.

There are currently around 1.5 million people working in the NHS in England (NHS England 2026a). Engagement with staff in the development of the 10 Year Health Plan found that they were strongly in favour of a shift from treating illness to prevention, believing it will allow the NHS to move from its current reactive model to one that supports people to live longer, healthier lives (Department of Health and Social Care 2025b). However, they raised concerns about the scale of shift at this point in time, notably within the context of workforce shortages and a perceived lack of financial resources to make the shift happen.

The plan indicates that not only will the NHS workforce be key to delivering the three shifts in care, but that a very different kind of workforce strategy will be needed to deliver a different approach to health care. Research studies with professionals involved in public health and prevention activities have identified a range of factors that can impact on the delivery of preventative care. These include systemic factors such as access to training and education, the availability of funding and time to set up and engage in prevention activities, and support for implementation; as well as factors that influence staff individually, including confidence, incentives, and attitudes and beliefs around health conditions and prevention. However, there is limited evidence on: what a shift to prevention means for health care staff in their day-to-day jobs; the existing capability and capacity of the workforce to support prevention that could be built on to support the shift; and the perceived challenges and gaps in evidence that future policy and practice need to address to make the shift to prevention a reality.

Framing prevention

Although it is widely agreed that prevention is important, there can be differences in how people understand its meaning (Arnold and Holden 2025). For example, within the NHS, health promotion and health protection often fall under the umbrella of prevention. In this research, we

have adopted the following understanding of prevention commonly used by public health professionals and academics:

- primordial prevention – action to prevent exposure to risk factors (for example, designing environments that support walking or ensuring access to healthy food)
- primary prevention – action to reduce exposure to risk factors (for example, vaccinations or supporting people to stop smoking)
- secondary prevention – emphasises early disease detection by identifying disease before symptoms have progressed, and stopping the disease worsening, if possible (for example, screening or routine health checks)
- tertiary prevention – action to help people manage symptoms and prevent further disease progression once the disease has already developed (for example, rehabilitation or management of long-term conditions).

About this research

In late 2024, the Department of Health and Social Care (DHSC) commissioned The King's Fund to explore the workforce implications of a health care system that puts prevention first. The Chief Public Health Nurse Office (CPHNO) had already undertaken a scoping review to explore barriers and enablers for a greater focus on prevention work for the health and care workforce, alongside a series of engagement events that aimed to identify potential policy ideas for strengthening the public health impact of the health care workforce. This research sought to build on that knowledge, with a focus on the perspectives of frontline health care professionals in the NHS, and their teams.

The research aimed to address the following questions:

1. How do health care professionals understand prevention in the context of their roles?
2. What do health care professionals think an increased focus on prevention could look like? What could the potential advantages or disadvantages be?
3. What do health care professionals think are the main challenges to increasing their focus on prevention?
4. What support do they need to enable their role in a shift to prevention?

Due to the breadth of the scope and timescale for delivery, it was agreed the research would focus on the perspectives of nurses, midwives and allied health professionals (AHPs) who make up approximately a third of the frontline health care workforce. Perceived commonalities in training and practice across these roles also provided opportunities to identify generalisable insights. The research also sought to obtain a diversity of perspectives that represented both type of care/care setting and staff providing direct care as well as NHS managers.

A subsequent piece of research explores the implications of the prevention shift for the adult social care workforce (Ross *et al* 2026).

Patient and public involvement

Development of the research and focus group questions was supported by Involvement@York. This enabled us to share our proposed focus group schedule and approach with a group of four public contributors for review. Feedback from the group highlighted the value of exploring any perceived impact on patients and communities as a result of staff's role in the shift to prevention, including perceived impact on health inequalities. The topic guide was amended as a result to incorporate additional questions relating to these topics.

Focus groups

Information about our research was circulated to various networks of professionals such as the Royal College of Nursing, regional chief nurses and regional chief allied health professionals, and was posted on NHS Futures, an online platform accessible to many people working in the NHS. Prospective focus group participants were asked to submit an expression of interest to the research team. The team then purposively sampled potential participants, seeking representation across a range of characteristics, including service area, job title, Agenda for Change pay band, and area in England where they were employed. Those selected were then invited to participate in a focus group relevant to their role and setting. Participation was subject to confirming their informed consent. Focus groups comprised the following categories:

- mental health care
- children and young people's services, including paediatric services in acute, community or mental health settings
- acute and secondary care, including acute hospitals, tertiary centres and emergency care
- community health services, including community health trusts, primary care or intermediate care
- managers and senior leaders working across health care settings/organisations.

Between August and September 2025, we carried out 5 focus groups with 34 participants. All focus groups took place online and followed a semi-structured topic guide. This included outlining the framing of prevention at the outset, to set a common understanding of prevention within the context of the research. Participants were offered £50 in accordance with our policy for remuneration of research participants. Focus groups were recorded and transcripts were coded using MAXQDA software, and the research team then carried out descriptive analysis of several high-level topics.

Ethical considerations

We obtained ethical approval for this research project from the University of York Health Services Research Governance Committee in July 2025. Participants were anonymised and are not identifiable in any quotations published.

02 What does prevention mean to health care professionals?

Across the focus groups, participants shared how they understood prevention, experienced it in their everyday roles, and were motivated to do more. Furthermore, a shift towards a more preventative approach in health and care was described as intuitively the right thing to do.

At the same time, participants shared both frustration with constraints in how they are currently able to work in a more preventative way, and concern around what a shift to prevention would mean for them within the current context of health and care.

The following section outlines how staff understand the shift to prevention, narratives that underpin why the shift is important, different ways in which staff perceive how the health and care system could be more preventative, and how the current context influences their readiness for the shift to prevention.

Why prevention is important

Participants described the value of prevention through three distinct but often overlapping narratives:

1. Improving health at an individual and population level – eg, screening for issues.
2. Improving health outcomes for those with health conditions – eg, preventing development of complications.
3. Reducing pressure on health and care services and systems. Within this, there is an additional narrative focused on reducing pressure in relation to A&E (accident and emergency), hospital and secondary/tertiary care services, with an expectation that prevention would result in more support in the community and within primary care.

Narratives relating to individual, population and condition-specific outcomes were often reflected within a wider narrative of reducing pressure on health and care systems. This may reflect the context in which participants work and how the outcomes of prevention relate to those, as well as the resonance and potential dominance of narratives around prevention that relate to NHS pressures.

> **… stopping people coming through the front door in the first place because they're living healthier lives.**
>
> (Managers and senior leaders focus group)

Staff are already doing prevention

The majority of participants were able to share examples of how their roles support prevention. This was regardless of roles or the case setting in which they work. Examples ranged from screening, giving patients information and advice about nutrition or smoking, preventing complications from existing health conditions, to supporting patients with non-clinical needs such as social isolation, which may impact negatively on their ability to manage their health. The multiple examples demonstrate how staff see activities they currently engage in as contributing to prevention. Furthermore, the examples reflect the breadth of upstream and downstream interventions.

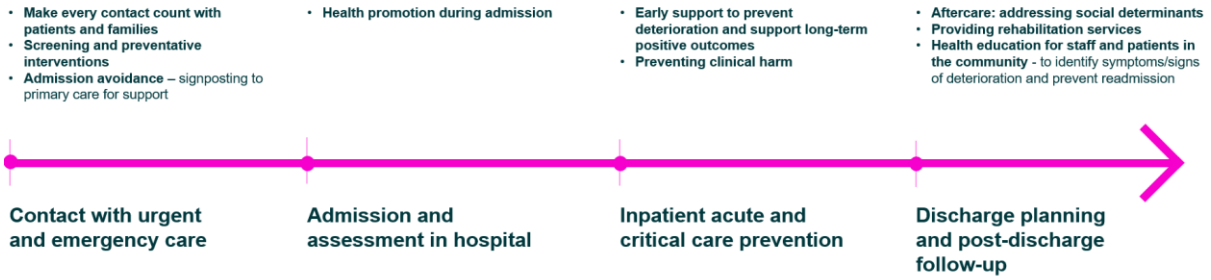
Timing of prevention

In the context of current practice as well as the shift to prevention, participants repeatedly referred to 'when' prevention activities felt meaningful. Participants consistently recognise 'opportunities' to intervene, both taking advantage of points of contact for preventative purposes and identifying opportunities to intervene at an earlier stage. Within the context of the shift to prevention, participants positioned preventative activities as occurring both at earlier stages in care pathways as well as being more consistently embedded as a routine part of care.

We identified three ways in which participants framed the timing of preventative activities. Each highlights examples of activities that participants describe as preventative within that context, drawn from across the focus groups. As a result, the examples may represent different areas of care within the same presenting context.

The first framing was in relation to urgent and emergency care and hospital admission (see Figure 1). Some activities, such as health promotion, are referred to at multiple time points. Participants noted the importance of considering opportunities for intervention, but also the context, which may have a positive or negative impact on health behaviours. For example, the shock of admission or assessment could provide an opportunity for messages around health promotion, particularly if they relate to the reason for the patient's admission. Many of the opportunities are also framed around defined processes in the delivery or management of care, indicating the potential to embed prevention as part of these. Participants shared a desire to provide greater outreach in the community, including to support health promotion, advice and education, and in response to patients at risk of deterioration post-discharge.

Figure 1 Prevention along care pathways – urgent and emergency care and hospital admission



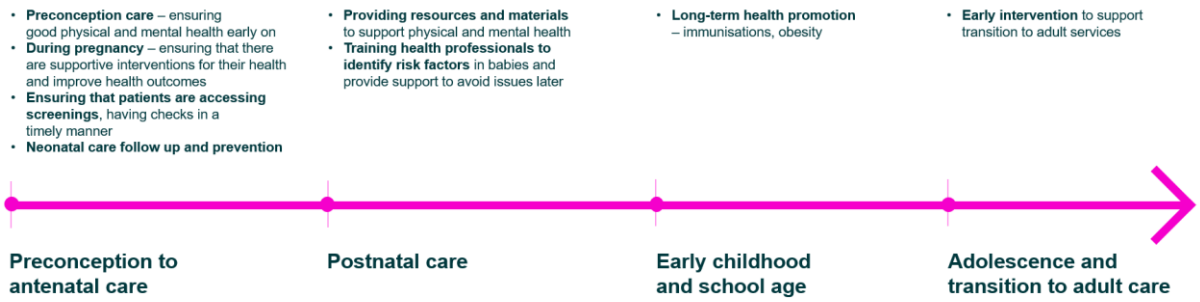
Participants also spoke about prevention within the context of care pathways in relation to long-term conditions (see Figure 2). Within this, participants noted timeliness of interventions such as screening, tests and reviews as a mechanism for identifying and preventing poor outcomes early on. Like the previous example, participants also highlighted the importance of care pathways providing flexibility, particularly around access for those living with and managing long-term conditions, to facilitate timely and preventative support.

Figure 2 Prevention along care pathways for long-term conditions



Finally, participants in the focus groups on children and community services in particular spoke about prevention within the context of a continuum of care (see Figure 3). Participants noted the value of health education and promotion right from the start, and the importance of building trust to enable ongoing prevention. Beyond this, participants highlighted the potential for identifying critical periods for interventions as well as opportunities for multi-stage health interventions at key points. Support for prevention across the continuum could be maximised by having a multi-sector approach, in particular across schools, local authorities, the VCFSE sector and communities.

Figure 3 Prevention as part of a continuum of care



How staff feel about prevention in the current context

Although participants shared multiple examples of how they see and engage in prevention and an openness to doing more, they also expressed frustration and concern when talking about the government's ambition of a shift from treatment to prevention. Participants described their role in prevention as being able to offer a wider range of support and responding to people's needs when the opportunity presented. Yet, they reported having limited capacity to do this as a result of high levels of demand, workforce shortages and a lack of time. They also shared how systemic factors – such as targets and performance measures that act to prioritise what care is delivered and how – can constrain their role, resulting in prevention being experienced as an add-on to existing care. Together, these contributed to concerns about how a shift to prevention could be realised.

> **There is a thirst out there, certainly I work with a lot of midwives, health visitors, etc, for preventative messages and support. But in terms of actually having the capacity to do that, obviously it's a different matter. The firefighting takes priority.**
>
> (Managers and senior leaders focus group)
>
> **… it's quite demoralising when you can't make a change. Like, I became a nurse because I want to make a change to people's lives, and influence their lives, and I have so many barriers that I can't make a greater change. So I can just do a short thing, and it just doesn't feel like the reward that you work for, and you just feel like you're not giving the best chance for people.**
>
> (Children and young people's services focus group)

03 The role of staff in supporting patients, families and communities

Throughout the focus groups, participants consistently referred to their role in relation to that of patients, families and communities. That role reflects activities that staff engage in which they identify as supportive of prevention, which they may do more of, or which might change in a system oriented toward prevention.

In parallel, participants described how they see the role of patients, families and communities that they serve, their readiness for changes in the role of staff and services, and their perceived capability and willingness to engage in what staff see as the characteristics of a shift from treatment to prevention.

Empowering and equipping patients and families

Across the focus groups, participants spoke about their role in the shift to prevention as one of 'empowering' and 'equipping' patients and families. One of the most common activities described as part of this was the sharing and use of information. Providing information, including options where relevant, sought to share knowledge to enable people to make healthier choices and better manage aspects of their health, including when and how to access support in a timely manner. Examples highlight how the type of information shared and purpose varied according to context. For example, one participant noted the value of informal and opportunistic routes to providing information, such as in a waiting room; another participant described capitalising on the existing expertise of families of children with complex conditions:

> **So, prevention in my team is a lot about being proactive and seeing children in a timely manner, when we've said we've got to review them in X amount of months, we do that, and are there to assess the child before any issues arise. Also, about education and empowering families to be able to know how to treat the child, and know what to do, and know who to contact if they see anything, any deterioration, and what deterioration looks like.**
>
> (Children and young people's services focus group)

In addition to information, participants described their role in identifying and sharing available resources, tools and support. Some participants also noted the importance of helping people to discriminate between different sources of information. The latter was particularly noted in relation to information that could be obtained via digital and non-professional channels.

Alongside providing information, participants described their role in providing advice, education and training to patients and families. Descriptions of giving advice within the context of the shift to prevention commonly went beyond the specific complaint to identify and address wider risk factors. Furthermore, while giving advice was often framed as an informal and opportunistic activity led by individual clinicians, participants also shared examples of more systematic interventions such as the use of brief advice for smoking and alcohol consumption. In providing advice, education and training, participants noted the importance of supporting people to utilise knowledge and information, to develop skills and apply it within a context relevant to their own lives.

Referring and signposting to services

Participants described referring or signposting patients to other services that were able to provide specific types of care in response to the identification of potential clinical risk or need, and to services that could provide support to address wider needs. Referral and signposting often aimed to facilitate access to services best placed to intervene early, as well as address issues that may adversely impact on or compound health issues in the long term.

> **… so there's a third sector charity called [name of organisation], and they'll do an assessment of what they might need. And then they'll refer them on for like, mental health support, if they need help with housing, finance, they sort of, signpost them.**
>
> (Community health care focus group)

However, some examples indicate that referral and signposting were also used when an individual service did not have capacity to address identified needs, or to services that were perceived to be more 'appropriate' to address needs.

> **We probably spend maybe about 25%–30% of the working week providing health promotion to prevent reattendances to ED [emergency department] with unnecessary issues, like signposting people on to primary care services.**
>
> (Acute and secondary care focus group)

Supporting engagement and providing advocacy

Participants noted how prevention is dependent on the engagement of patients, families and communities in activities that support prevention, from adopting positive health behaviours to engaging in treatment. Participants were aware of a range of barriers that could impact negatively on engagement. Examples shared by participants highlighted their role in mediating these barriers to facilitate engagement in preventative interventions.

> **… we've done lots of community engagement around vaccinations for example, and it's only when we've gone out to local communities and really asked what are their anxieties around it that we've started to make inroads.**
>
> (Managers and senior leaders focus group)

Community-based opportunities framed as 'outreach' were noted to be of particular value in being able to reach and influence the behaviour of large groups of people. These can provide opportunities for people to meet staff in services and teams who, in turn, could communicate about how they could help, and build trust, hearing about what people's anxieties are and addressing misinformation.

Participants also spoke about their role in preventing poor outcomes by providing effective and supportive outreach to address factors that may limit patients accessing the treatment they need. In addition, participants described acting as advocates to chase up services and provide access to wider support for issues that may impact people's health, including addressing health behaviours and social factors such as housing and benefits. Participants described this role as enabling patients to actually get what support they need, and negotiating how the NHS works – which can be challenging to understand even for those who work in it.

> **… I actually would take particular patients to appointments because the thought of them trying to do that themselves was impossible. So, I found that a really effective way of working.**
>
> (Acute and secondary care focus group)

Building trust

Trust was noted to be vital in the process of prevention. Participants highlighted their role in building trust as part of sharing knowledge and information, and to support patients to subsequently act on that. Participants reflected that they were sometimes operating in a context in which trust had been undermined – by negative media or reports on services, previous poor experiences of services, or a lack of integration of services, which led to people receiving fragmented and inconsistent care. Importantly, there was a risk that activities described as supporting prevention (such as signposting to information, resources and support) could also erode trust if they are experienced, or perceived, as staff handing them off at the expense of building a relationship.

> **This work of signposting, where there's a lack of capacity within the service, that managers have very much, for quite a long time, encouraged us to kind of, signpost people. And to be honest, for the families, if you've had a relationship with them, or if you're trying to establish a relationship in the first place, that can often feel like being fobbed off.**
>
> (Community health care focus group)

Finally, participants noted that in some circumstances, particularly when working with communities who may already be poorly served by NHS organisations or where there may be issues in relation to trust, their role in prevention was best served by working with trusted organisations, such as local community groups who have relationships with those populations.

Staff roles and the perceived role of patients

Participants used the language of empowerment and spoke about the role of self-management as part of a shift to prevention. However, while participants shared examples of how their role could support this, there were notable tensions about the perceived balance of roles and responsibilities between health care professionals and patients. In this context, participants shared judgements, assumptions and generalisations about the readiness and motivations of people to positively engage in activities and behaviours they identify as characteristic of a shift to prevention.

As part of this, participants reflected on their role in the shift to prevention within the context of wider societal expectations. This included public expectations around speed of access and perceptions that the NHS is there to ‘fix’ people. Participants noted examples of how the shift to prevention had already begun, pointing to how people have largely got used to expectations of booking GP appointments on their phone; at the same time, they noted a shift in patients doing their own research and obtaining information from alternative and online sources. Participants shared how this could direct interactions towards clinical pathways and treatment, narrowing the scope of staff to explore a broader range of options, including opportunities to understand and change factors underpinning the issue, which might have a potential long-term benefit.

While participants shared frustration with perceived behaviours that they describe as challenging their role in the shift to prevention, some were also sympathetic to this, reflecting how the system contributes to shaping behaviours. Participants pointed to challenges people face in accessing care in a timely manner, poor experiences of care, as well as requirements services make of people (such as having to take time out of work or attend multiple services at different times to receive care). This was described as contributing towards a preference for specialist and medical treatment options, and in some cases resulting in delayed access to support.

Participants shared examples that highlighted an ambivalence or uncertainties around their role in the shift to prevention. For example, all participants were able to recognise barriers to engagement that could preclude or delay access to preventative support, but fewer identified a

role for staff in addressing those barriers as part of a shift to prevention. Similarly, participants recognised a role for staff in working with people who were receptive to prevention, but raised questions about their ability to support those who do not ask for help and people who are not proactive or perceived to be self-motivated around their health and self-management; or provide access to the right intensity of support for people whose health behaviours were perceived to be 'habitual'.

Communities at risk of inequalities

In considering their role in the shift to prevention, participants consistently referred to communities and groups who they perceive to be at higher risk of inequalities during implementation of this shift. Many of the groups identified are those who are already at risk of greater health inequalities in the current system of care. In this, participants reflected on existing challenges these groups face with access to, and their perceived engagement with, health and care services – factors that they identified as vital to providing timely and preventative support.

Participants highlighted limitations in tools and ways of framing inequalities that impacted on an understanding of need and ability to identify opportunities to engage those most at risk and at an early stage. For example, participants shared how Core20PLUS, a national approach to focus efforts on reducing health inequalities (NHS England 2022), was used to identify inequalities at a population level, but did not necessarily translate to the populations who have the worst outcomes at a service level, or in relation to individual conditions. Similarly, participants noted that some populations are poorly captured by existing data, limiting knowledge and visibility of the barriers they face or the support they need, and the ability to intervene at an early stage, or provide holistic support to prevent poor health outcomes.

Participants also recognised that some people face many more barriers to accessing care and prevention due to the complexity of their health and life conditions. Some participants also reported seeing growing complexity within their services, most notably through new presentations of issues. Participants noted the importance of being clear about responsibilities for prevention, particularly where people may be in contact with multiple services.

Participants shared examples of how social and cultural factors could influence their role in prevention. For example, they described the social and cultural environments of some populations as shaping health behaviours, the impact of social isolation on poor health outcomes, and the importance of the wider support available to patients as part of adopting healthy behaviours and managing health conditions.

Finally, participants' perceptions of what the shift to prevention meant also influenced who they saw as at risk of inequalities. For example, many participants shared expectations that the shift to prevention would lead to an increase in digital delivery of care and services. Participants also gave examples of how some recommendations that staff make as part of a preventative approach (such as use of nicotine cessation products, or adopting a mediterranean diet) can incur additional costs for patients. In both cases, the perceived impact of a shift to prevention was noted as likely to have a disproportionate impact on some groups.

Many of the activities that participants shared as part of their role in addressing potential inequalities, within the context of a shift to prevention, focus on providing more targeted support for groups based on risk factors and considering the holistic needs of an individual. This includes spending time to understand people's health and social care needs, and adopting approaches such as trauma-informed care. Practically, participants highlighted examples of delivering services or care for specific populations, providing direct support to people (such as in the navigation and use of digital platforms), and offering access to resources or referral to additional forms of support.

Participants noted the value of outreach approaches to mediate issues that may impact negatively on engagement, such as stigma, and to support the opportunistic delivery of prevention activities. Participants also described their role as advocates in prevention, largely within the context of working with people who may require high levels of support, including across multiple connected areas of life and those who are most at risk of health inequalities.

Although some participants identified and shared examples of how they could mediate the impact of inequalities, other staff described factors such as poverty and the impact of deprivation as being beyond their control.

04 Delivering prevention – skills, capabilities and resources

Participants consistently referred to the importance of having the right skills, capabilities and resources to support their role in the shift to prevention. This included having the right knowledge and awareness of resources and tools, skills and capabilities in relation to prevention, and the confidence and competence to support people effectively with prevention. Finally, participants shared the importance of having resources to support them in their role and that they can use to support patients, families and communities, and the factors that influence the effectiveness of their delivery. The following section explores each of these areas.

Knowledge and awareness

Participants talked about having the right knowledge and awareness of, as well as access to, resources to support prevention. This included knowing where they themselves could go for information, resources or specialist support in the first place, as well as knowing where to signpost or refer patients to. Part of this was being able to identify opportunities to support prevention that may go beyond a narrower professional remit – for example, to capitalise on opportunities to ask patients about and provide associated support for broader issues around their health than the presenting issue. Participants pointed towards knowledge of relevant screening tools or factors that may impact on or confound specific health conditions, which, if they had greater awareness of, could facilitate opportunities to identify potential risk factors, thereby supporting early preventative action and preventing deterioration. In addition to staff sharing resources and skills (as noted in the following section), some participants suggested that knowledge and awareness could be built through placements across different services and shared learning:

> **We have GPs rotate and have a placement on the ward to upskill them about conditions. But even then, it's just everybody has a different experience, different knowledge…**
>
> (Children and young people's services focus group)

Skills and capabilities

Participants noted the importance of, and a desire for, education and training to support their role in the shift to prevention, as well as supporting the development of skills in the workforce more widely. Particular areas of focus included building a shared understanding of the value

and importance of prevention, as well as use of screening tools and delivery of preventative approaches, such as brief interventions.

Participants identified opportunities to embed training and education as part of the professional curricula for roles, so that people began their careers with prevention being seen as part of everyday care. In addition, participants identified opportunities for the development of skills and capabilities through the reciprocal sharing of skills and knowledge, including through mentorship, or within the context of teaching roles. Delivery of education and training was described as providing opportunities to strengthen trust across organisations and support consistency of the delivery of prevention, including a common understanding of evidence-based practice.

Participants particularly valued training when it had clear aims and outcomes, and specifically, set out how it would have a positive impact on prevention. Training was also valued when delivery was tailored or flexible to individuals or service need. Finally, participants shared the importance of follow-up and ongoing support with education and training, rather than attending one-off events.

> **I think being flexible around what the different needs are… So in the level two unit I work in, micro-teaching really, really works to help with prevention among staff. But in the level three unit, actually getting them on their away days, and their training days, actually works better.**
>
> (Children and young people's services focus group)

Confidence and competence

Some staff expressed concern that they lacked the confidence and competence to engage in conversations and more holistic approaches supportive of prevention as this took them beyond their training and perceived professional role boundaries. Efforts to build knowledge, and access to education and training, enabled health care professionals to build confidence and competence in their work. Confidence could also come from creating a team approach where people feel able to promote good practice and share challenges they faced.

In building confidence and competence, participants valued having clear structures for prevention work; guidance and clear outcomes were also noted to support staff to gain confidence in adopting a preventive approach. The confidence of leaders to make decisions in support of prevention, and their subsequent role in motivating and encouraging staff when the gains may not be immediately noticeable, was also valued.

> **I think clear structure and guidance around how to actually… not necessarily how to achieve the prevention, but what are we hoping to achieve. And then actually our services can have the freedom to explore how are we going to achieve that prevention.**
>
> (Managers and senior leaders focus group)

Resources

Participants highlighted a wider range of resources that they see as integral to their role in supporting a shift to prevention. Many of these reflect access to information, education and training for patients, families and communities. Participants noted the importance of resources being available in multiple accessible formats, to address a wide range of needs, or tailored to specific needs within the context of their practice. In addition, participants pointed towards the importance of resources that are informed by evidence and quality assured. Understanding the context in which resources were developed, and by whom, was noted to influence professional trust in resources, their quality and perceived applicability within the context of different services. Participants reflected on how, just like their patients, they experienced challenges in navigating the range of information and guidance available. A lack of consistency of information and common understandings of what good practice looks like across different professions and settings could result in patients receiving conflicting messaging, which could create confusion and undermine trust.

A minority of participants shared how facilitating access to equipment could better support their role in prevention. For example, one participant shared how they could better support people at home with access to specific equipment, while another shared how providing wider and earlier access to glucose monitors could help staff to address issues at an early stage. This could support positive engagement in health behaviours by providing real-time feedback, rather than waiting until risk of disease was higher or when their actions to address risk were identified as failing.

Delivery

A final element that participants spoke about related to the delivery of resources within the context of prevention, and to ensure that actions to support prevention were effective. Participants highlighted the role of communication and language, including how information was framed, as influencing the acceptability and likelihood of taking positive action. Who delivers the information, advice or education was also identified as important. Participants noted that for some communities, particularly those who are poorly served by NHS services or are from marginalised communities, the sharing of information and associated resources may land better when it is delivered by ‘trusted’ organisations. Finally, participants shared examples of how the timing and location of delivery could have a differential impact. Different approaches, including identifying when people were receptive to information, or utilising opportunities through use of

Making Every Contact Count (Public Health England 2016) or as part outreach activities, may be more effective depending on context.

> **Our message used to be, 'well, if you don't do this, you'll lose your leg,' because that was reality, and we realised actually that that negative message did not go down well with the public. And giving multiple messages in one treatment, so 'stop smoking, lose weight, eat better, more healthily, and you'll prevent losing your leg' – that message wasn't heard. When we audited later, the patients had only remembered one of those messages. So, we went down to just one message per treatment rather than multiple, overloading of the patients.**
>
> (Managers and senior leaders focus group)

Across the care pathway, some participants highlighted how professionals who provide the first point of contact may be best placed to provide education, while others felt that the role should be across multiple professionals that people may interact with, including staff beyond health and care services.

05 Workforce design and roles in prevention

In considering their role in prevention, participants shared lots of examples of ways of working that they saw as supporting a shift to prevention. They also raised questions about the size and shape of the workforce required for a shift to prevention and what it meant for professional role identities and skills.

Ways of staff working together

A key way that participants saw their role in supporting the shift to prevention was through more collaborative working. This particularly focused on recognising and making full use of the knowledge and skills in the existing workforce.

Specialists supporting other staff

Participants representing allied health professions in particular shared how their knowledge and training inherently spanned a broad spectrum of intervention, from prevention through to treatment. Participants described this breadth as being beneficial in the shift to prevention by:

- being able to address issues at a lower level of need – for example, by dieticians providing support to people around healthy diet or dietary adaptations
- having knowledge of and being able to identify potential risk factors warranting early referral for specialist support, or where proactive care could prevent someone deteriorating
- working alongside colleagues to address the specific needs of patients holistically. In the example below, a speech and language therapist shared how they ensure that preventative advice was accessible to those with specific speech and language needs.

> **Obviously we see our patients from stroke as they come through the ED [emergency department]. We'll speak with our consultants if we can provide aphasia-friendly materials for some of that preventative advice in TIA [transient ischaemic attack] clinics.**
>
> (Acute and secondary care focus group)

A common characteristic among the examples shared is a perceived benefit of bringing in the unique knowledge and skills of specific professions and services earlier to enable health promotion or early intervention; or, in a more timely way, where there may be gaps in access to that care.

To support this, participants described contributing to a range of activities. These included developing and sharing resources beyond their immediate service, which enabled them to provide support for patients who may be seen in the context of other services and ensure the information they receive is appropriate.

Participants also highlighted their role in providing training for staff in other services and settings. In many of the examples shared, participants sought to spread messages about prevention and health promotion, and provide skills and confidence for staff to work more effectively with the people they see. As one participant shared:

> **... implementing and delivering training to the maternity colleagues, to GPs, primary care – that can go an awful long way to preventing trauma related to the perinatal journey.**
>
> (Mental health care focus group)

Participants also highlighted the benefits of training staff in other agencies, including those who contribute to a person's health needs, such as parents and school governors. This expanded capabilities more widely meaning that health care professionals were not necessarily leading all care and could contribute to reciprocal learning by upskilling health professionals in community needs. It also allowed health care staff to tap into other resources, without the need for additional funding.

> **We're now tapping into, like, after-school clubs that already exist, going in and providing those people with more training from our physios. So therefore we then can recommend, actually they've had that training, they're more inclusive for children with complex needs.**
>
> (Children and young people's services focus group)

Participants also shared examples where specialists directly supported other teams or services. In one example, allied health professionals within hospitals were sharing ideas and resources to provide 'wraparound' support to community teams; in a second, an emotional support service was working with carers in residential units providing support to young people. While both sought to optimise care, the former was described as also seeking to negate subsequent referral to a specialist team, or providing a foundation that specialist services could then build on if required.

In sharing these examples, one of the underlying challenges that allied health professionals in particular noted was a lack of recognition more widely of their skills and capabilities. This resulted in missed opportunities to provide quality support at an early stage. At the same time, while their roles inherently required them to work holistically, there were concerns that providing these skills more widely risked them ending up being stretched too thin and diluting what they do. A further concern was that the transfer of additional knowledge and skills supportive of prevention to other staff could inadvertently add extra work pressure onto those staff, if they are responsible for this in addition to their existing roles.

Multidisciplinary team working

Multidisciplinary team (MDT) working was consistently raised across the focus groups as supporting the shift to prevention. Examples of MDT working were all within the context of treatment and could be conceived as ways of managing risk. However, participants described MDTs as providing a means of bringing different skills and teams together to share information and develop a shared understanding or plan across services. Doing this at an early stage could help pick up on things that might get missed and could lead to intervention at an earlier stage. In some circumstances, this could be enhanced by including other agencies, such as social work, education and school nursing.

Participants shared three approaches to MDT working:

- One service acting as a conduit, referring or getting other services involved as necessary. A benefit of this was that the conduit held sole focus and knowledge of the population while utilising all available resources to support them.

> **We tend to act as that conduit, referring onto other services but also getting other services involved where we'll get those MDTs in with mental health services, different community services… So we can all be that team around the child or team around that vulnerable adult to ensure that person doesn't fall through the gaps and see who can do what to support that person on their journey.**
>
> (Mental health care focus group)

- Developing a shared awareness among staff of each other's roles as part of an informal network and utilising that to access the right support.

> **So we have a family hub system now within our [county] locality area, and one of the key things is that different disciplines are involved, so therefore we've created more of an awareness within the resources in primary, secondary and tertiary sectors.**
>
> (Mental health care focus group)

- Processes that brought different professionals together to develop a wider understanding of an issue and identify and share potential solutions and resources.

> **So if there is a family with whom there's concern, then there's a professional involved, then there is… a weekly hub meeting that we can be invited to, and therefore with consent we can anonymously discuss a case, and within an MDT get resources that others have used in the past… So knowing where we could refer to and then going back to the family and consenting for a referral.**
>
> (Mental health care focus group)

MDTs also faced challenges to their effectiveness. Participants identified under-representation of professionals in some settings, such as schools and education, which could limit breadth of capability. The also identified the importance of having the right systems in place to take forward actions within respective services.

Workforce capacity

Across all focus groups, participants raised staffing as a barrier to prevention. Within their own roles, participants highlighted having sufficient time as being integral to prevention work. In part, this reflected a conceptualisation of prevention as additional to their role. However, staff also described the delivery of prevention activities as requiring an investment of time, particularly in relation to building trust and supporting the role of patients in managing their health.

Participants described how shortages of staff, recruitment freezes and staff sickness, coupled with increased demand for services, had led to increased workload and large caseloads of patients. The also described how this restricted the amount of time they could spend with each patient, leading to a narrow prioritisation of the care focused on delivery of specific clinical treatments, which limited their ability to focus on prevention.

> **… everyone doesn't have the time to sit down and go through details, a lot of care is a bit more rushed now.**
>
> (Children and young people's services focus group)

Despite this, when pushed, some participants noted activities within their current role that led to an inefficient use of their time, which, if addressed, could free up time for prevention. These activities included:

- administrative tasks, including managing referrals, booking appointments, typing notes
- processes that generate a high administrative burden, such as assessments and regulatory requirements
- meetings, some of which have value, whereas others do not
- having to source required tools and equipment to do the job, which are not on hand.

In some examples, staff capacity was noted to have a differential impact on the shift to prevention, depending on the role. Roles including social workers, care co-ordinators and allied health professionals were highlighted. These roles were perceived as providing key functions for staff in providing preventative care, such as access to support with housing and wider social issues, and specific types of support. Vacancies among roles with a specific remit, such as community dieticians, were noted to have a disproportionate impact in being able to provide wider support to patients and staff in other services, given their small number. Finally, in responding to staffing gaps, service managers were increasingly having to step into clinical work, reducing time available to take forward and lead on projects to support prevention, from putting together a grant application to being able to implement planned activities effectively.

Role scope and boundaries

Many participants described their training and passion for the job as being holistic and prevention-focused. However, over time they had experienced constraints to the breadth of this role by requirements to deliver clinical and task-focused care, and limitations on the number of contacts they can have with people. This limited professional autonomy to respond to individual needs and the scope of their role more widely, the latter being associated with developing a better understanding of community needs.

For other participants, working more holistically and engaging in a person-centred approach, to focus on what matters to the patient, was described as taking staff into territory not specific to their job role, or what people traditionally think of as their job role.

> **And I think some of the barriers around that then, when we're asking people to work even more holistically, are confidence and competence in having some of those conversations that maybe they weren't trained in or are not so skilled in, or they perceive it to be that way. But there's also a fear of professional identity. I hear that a lot – people saying 'that's not my job, that's a nurse's job', and if we're doing that, we're the same as that. I think you definitely get two camps of people – [those] who are quite probing and holistic and others that are nervous about it because if we're adding in a new thing, am I what I qualified to be? And if everybody's doing those roles, where does that leave me? Which then impacts obviously staff satisfaction.**
>
> (Managers and senior leaders focus group)

Although role boundaries could be beneficial in establishing clear remits for action, they could also constrain the ability to do things differently:

> **So, particularly in a neonatal unit, there's a lot that we [speech and language therapy] do that OTs [occupational therapists] also do, and that can be a bit of a barrier in terms of, we don't want to step on everybody else's toes. And so we're being very careful and, kind of, tip-toeing around. And that actually takes more time…**
>
> (Children and young people's services focus group)
>
> **Historically, nursing, midwifery, AHP [allied health profession], medical roles, they're predominantly very disciplined roles with very clear responsibilities, and rightly so. But I think therein lies the barrier, because there's not always that scope for creativity or an innovative mindset perhaps, and maybe that is also a barrier.**
>
> (Managers and senior leaders focus group)

06 Service and operational factors influencing prevention

Participants' understanding of their role in the shift to prevention was consistently framed within the services and systems in which they work. In considering their role, they identified a number of services or approaches that are important in supporting their role, or which they saw, and in some cases have experienced, as demonstrative of a preventative approach.

They also highlighted key aspects of current service provision that they see as integral to being able to take a preventative approach, as well as how this influences their role in prevention, and the factors that either limit or could enable the workforce to play a more powerful role in achieving the shift to prevention.

Services and approaches to support prevention

Participants identified three types of services that were important in supporting the shift to prevention. The first were services or interventions that help to build knowledge, skills and confidence of patients and the public to adopt and implement positive health behaviours and self-management of health conditions. Participants referred to these as complementing their own role in prevention, setting people up with core capabilities, and providing them with the practical skills to implement advice on prevention. Examples included antenatal classes and community cooking classes. A strength of these was the ability to provide timely practical support in the context of people's lives.

> **We've spoken in the past to the team about how things like community cooking classes would be really helpful, so somewhere where people can go to have that experience of what does that actually mean in real terms, what are meal examples that are easy to prepare in the context of busy family lives and work commitments and all that other stuff.**
>
> (Acute and secondary care focus group)

The second were services that provide information on what to do and where to go or provide routes to support. Examples included hospital discharge programmes, helplines, emotional support lines and places of sanctuary, and services that provide support for issues that compound people's health, such as bereavement support. Many of these services reflect the motivation of participants to obtain timely support for a specific need they had identified in relation to their own patients or service, or which the individual can access for further advice.

A final set of services were those providing support for people with a higher level of needs. Examples included rehabilitation and support services following hospital discharge, and services for children in care. Participants often framed these services as ensuring that there are sufficient skills in the community, preventing risk of further service use (including hospital admission). It was also noted that these services were not always available.

In addition to types of services, participants shared several examples of opportunistic screening for risk factors associated with poor health outcomes as demonstrative of the shift to prevention. These included examples within acute hospitals as well as community settings. A core feature of opportunistic screening was its location in a busy area or with high footfall, and a time when people are there – rather than having to navigate getting an appointment. In hospitals, this included capitalising on people attending for reasons not specifically related to the screening activity.

> **But if I was walking in, I don't know, [name of city], and there was a pop-up shop, nobody around to judge me, I'd be 'ooh, what do they do in there, oh some leaflets, I could take one of those.' It's that opportunity.**
>
> (Acute and secondary care focus group)

> **We do an alcohol screening tool, and as part of our preventative work and early intervention, it's not mandatory for patients but we offer it to every patient 16 and over that attend. And we screen approximately 7,000 patients a quarter that will actually complete the screening tools. And then we train all our staff with brief intervention, and then we complete the enhanced brief intervention.**
>
> (Acute and secondary care focus group)

Service thresholds for care

Participants shared how thresholds for access within their own services defined the populations they saw and the level of prevention they could engage in. In addition, service thresholds were reported to impact on staff's ability to make appropriate referrals, often where issues were identified at an early stage. Examples related to mental health services, and social services in relation to the care of children and young people.

Thresholds for care fell into two types: those based on severity of condition or presentation, and those based on a set of specific criteria that determine which individuals a service will work with.

> **At the moment we accept referrals for a BMI [body mass index] over a certain number, so if we could see them before then, that would mean we have less extreme cases.**
>
> (Mental health care focus group)

> **… children and social care will say the child has a mental health issue because they're constantly self-harming, and then CAMHS [Child and Adolescent Mental Health Services] will come back with 'no, it's not a mental health, it's a behaviour that challenges,' but there is not a service for behaviour that challenges, and then we get stuck. So they don't meet criteria for referral to CAMHS, but then they don't meet criteria for referral anywhere.**
>
> (Mental health care focus group)

Access to services

Participants highlighted timely access to services as a key feature of a preventative approach, by facilitating help-seeking behaviours (particularly when related to primary care services) and providing an opportunity to address issues at an early stage, with the potential to prevent further deterioration and referral to hospital.

However, participants highlighted concerns with access that fell into two groups. The first reflected practical barriers, such as being able to obtain an appointment (eg, having to ring multiple times in the morning), services in locations that are inconvenient or where travel is difficult or there is a lack of parking, and services that are only open during working hours, requiring people to take time out of work. These barriers, while pertaining to the current delivery of care, were perceived as also limiting the shift to prevention, with staff constrained by a paradigm of service delivery that was already not working for people.

> **[if] we were going to provide some kind of training and education sessions for reduction of risk of stroke, …that information would currently be available probably, [through] appointments in the hospital, [or] information available probably online. And that's not necessarily what's going to capture people, it's not necessarily that accessible for them.**
>
> (Acute and secondary care focus group)

Practical access barriers, alongside delays in being seen, were described as impacting on prevention by limiting the ability to address issues early on. Some participants shared how this led to them seeing people when they were more acutely unwell, or requiring referral to hospital, limiting opportunities to engage in approaches aligned with secondary rather than tertiary prevention.

Some participants shared alternative offers of support they had developed in response to barriers to access, particularly in relation to lack of access to GP appointments, which sought to mediate delays and prevent further deterioration. Examples primarily relate to mental health, and include signposting to emotional support lines, helplines and drop-in crisis services where people could go if they are at risk of suicide, and which would check in daily with them to provide support.

Waiting lists

Waiting lists were also highlighted as important in the timeliness of care. In a similar way to barriers and delays in access to care, participants described how long waiting lists increased the risk of people's conditions deteriorating. More extreme presentations had the impact of requiring greater levels of intervention and more staff time. Furthermore, it led to a focus on tertiary prevention – including potential admission to hospital – rather than opportunities to engage in secondary prevention activities.

> **We've got long waits for community speech therapy, so their wait for an urgent swallow, which is someone who's known to be at risk of aspiration, is the 4–6-week mark currently, which, by that time, that patient will have become unwell and admitted to hospital.**
>
> (Acute and secondary care focus group)

Descriptions of the shift to prevention in relation to waiting lists indicate an assumption among participants that preventative approaches are within the context of, and additional to, existing practice. For example, participants were concerned that a more preventative approach would require patients on waiting lists to be seen before they could accept less urgent referrals with whom they could engage in more upstream preventative activities. Another participant questioned whether a shift towards providing more upstream support would require some people to wait longer for care.

Despite their concerns, participants also shared examples of how waiting lists themselves could be a focus for preventative approaches. The of role of staff in signposting or providing people with resources while they wait was noted in being able to help people feel more equipped to manage their health/conditions at home, or in preparation for the service, while they wait to see the health professional or in between appointments. Participants also saw this as a way of preventing further deterioration or recurrence of issues, including addressing contributing factors and needs.

Some of these had been developed as part of specific service approaches commonly framed within the context of managing waiting lists, but with varying results. For example, one participant shared how the offer to attend a drop-in clinic rather than going through a referral process had been positively received, resulting in people with lower-level needs in particular having them met more effectively. However, in another example, an offer to attend a screening clinic while waiting had resulted in poor uptake, and staff questioned whether the purpose was clear, or if people felt they might not be getting a proper assessment.

Finally, waiting lists were also identified as an opportunity for wider prevention activities that could facilitate or optimise treatment outcomes. Both examples shared below relate to waiting lists for elective surgery.

> **So for them it's trying to prevent them waiting longer for surgery, because they've already got longer waiting times. But then also to sort of, improve their diabetes knowledge, get their blood sugars down, to prevent longer-term complications as well.**
>
> (Community health care focus group)
>
> **We're part of a thing called Waiting Well, so patients who are waiting for elective surgery, we're the diabetes arm of it. But then it's meant to be holistic, so there's a third sector charity called [name] and they'll do an assessment of what they might need. And then they'll refer them on for like, mental health support, if they need help with housing, finance… they sort of, signpost them.**
>
> (Community health care focus group)

Information-sharing

Participants drew attention to the importance of transparency of information across the care pathway, including timeliness of information-sharing and communication. Participants noted how their roles are often dependent on information generated and communicated by others across the health and care system, impacting on their ability to act in a timely manner. This was particularly notable in the transfer of care from hospitals to services in the community:

> **Our community team works in a different trust to our acute team, and we use two completely different electronic patient records, so they are unable to see what I have inputted on my system and I'm unable to see what they've inputted on their system. So, again, in terms of recognising those patients earlier and knowing what input they've had previously, is tricky work for us for community and community for us, which probably takes up quite a lot of time often.**
>
> (Acute and secondary care focus group)

Factors underlying this include: a reliance on referral forms and paperwork, which result in different systems of working between services; processes that rely on correspondence between professionals; and a lack of common electronic patient records or access to information. The latter was noted to have an impact in the context of local organisations as well as out-of-area care. Shared care records were described as an improvement, but did not address the timeliness of communication.

Integration of care and services

Participants described how their role in prevention is often dependent on other services and the integration of that care. Many of the examples highlight how staff identified opportunities for

prevention that require action beyond the context of the care they provide. However, processes in place that define who delivers specific tasks and responsibilities, and how they can be accessed by health care professionals, were experienced as constraining their effectiveness in addressing those needs. This could occur between services; however, participants in the acute sector shared how processes and a lack of integration between teams in the hospital created the same dynamic.

> **If you can intervene earlier, even down to… an example would be a community alcohol service requires blood tests for patients before they can actually get into detox, and they then put the onus on those blood tests, to actually go and get those blood tests done at their GPs. That can take weeks and weeks to put into place. It's just things that shouldn't really be happening because it makes the journey for the patient a lot more difficult than it should be.**
>
> (Acute and secondary care focus group)

Participants described how this could lead to delays and missed opportunities for earlier intervention and additional burden in terms of time and having unnecessary contacts, particularly where the delivery of care may require multiple referrals and re-referrals. Within the context of high levels of demand, participants were not always confident the action would be prioritised elsewhere in the system. Furthermore, it often placed responsibility on patients and families to engage with and navigate subsequent contacts, when in some cases participants felt they themselves would be more effective in getting it done if the appropriate access was available.

In other examples, the role of prevention, or a preventative 'offer', was described as being restricted to one service or part of the pathway; or services implementing approaches to prevention that only focus on their part of the pathway (such as hospital discharge). Participants highlighted how this could result in potential opportunities for prevention being missed, or limited opportunities to facilitate improved outcomes in the long term.

Participants highlighted the importance of addressing organisational boundaries to enable staff to work together in a more consistent way:

> **So when we were based in the GP surgeries, we were one team. We don't have those conversations anymore, because the midwifery service is managed by the acute trust, and we're based with the community trust.**
>
> (Community health care focus group)

This included addressing perceived 'red tape' and challenges with getting consistent messaging across multiple organisations. At the same time, participants also shared examples of where this was working well. In one example, the adoption of a common set of guidelines between hospitals caring for children with a specific set of needs was described as facilitating clear expectations and timely engagement.

Integration was particularly important for the implementation of prevention initiatives. One participant shared how the delivery of both community and hospital services in one trust had provided a mechanism to implement preventative initiatives across both settings. Participants attached similar levels of importance to establishing appropriate governance mechanisms at the level of neighbourhoods and primary care networks (PCNs) to enable initiatives to be implemented.

> **We have the skills to be ready for that approach. It's facilitating that approach, it's changing that culture.**
>
> (Managers and senior leaders focus group)

Examples also highlight the importance of facilitating the ability to network and share good practice. This included working with a range of professionals and organisations within the context of local systems, including the VCFSE sector, private sector providers and industry partners:

> **… it would be quite useful if we knew who our local public health team were and where they lie, because it was difficult to engage with them. And when I did engage with them they're actually brilliant.**
>
> (Managers and senior leaders focus group)

Finally, participants saw opportunities to facilitate the shift to prevention by looking at the organisation of the workforce itself, including how skills are distributed across services and organisations, and moving from individual prevention projects to a more systemic approach – creating a shared vision and collaboration to look at how services overlap. This could be facilitated by an understanding of population demand, opportunities for health improvement, identifying what is already being done and using evidence to drive things forward, and making joint impact. Within this, participants noted that integrated working to support prevention needed to reflect a cultural change from focusing on the acute sector to focusing on community-based care, while also ensuring that the acute sector is engaging with and contributing to prevention.

Geography

Participants working in or with services that covered large geographies highlighted specific challenges for the role of staff in the shift to prevention. The shift was perceived as staff being able to invest time in and provide more care within the communities in which people live. However, large geographies required additional time and resource to cover, which at the same time represented time not available to spend with patients. As a consequence, some services had centralised resources requiring patients to come into hospital, while others were reported to have increased thresholds for care, focusing on providing treatment for fewer people with the most need, rather than engaging in wider prevention activities.

07 Policy factors that influence prevention

Participants highlighted several issues that influence their ability to take a more preventative approach. These issues frame the context in which staff operate and often relate to wider policy and systemic factors.

Targets and key performance indicators (KPIs)

Participants described how targets and KPIs drive an understanding of what is important and the type of activity required. Existing targets and KPIs were described as focused on delivery of reactive treatments and numbers of people seen or contacts, resulting in pressure to do clinical work and on speed of delivery (ie, fewer contacts and of shorter duration). Participants identified this as limiting their time to engage in a wider range of activities supporting prevention and to build trusting relationships as the basis for actioning advice. Targets were described as subject to scrutiny at multiple levels from the commissioner and service managers, and at an individual level, precluding the ability to work differently. Activities that were not the focus of targets, including prevention, were described as undervalued, or could be perceived as a 'luxury service'.

> **We have to meet a lot of targets, not just even in terms of the trust, we all have our contacts scrutinised in our one-to-ones. And you have to bring how many people you've seen in that month, and if it's low you have to explain why. There's a lot of pressure to do clinical work, because you will get scrutinised if you do something different.**
>
> (Community health care focus group)
>
> **We've developed this [preventative] service, it doesn't really align to things like KPIs, and that's a battle I'm going through at the moment, to try to get more sustainable funding to continue the work.**
>
> (Community health care focus group)

One manager noted that if there were a target for prevention, staff would be happy to take that on. Yet they noted the risk that overburdening staff with too many targets in relation to public health could lead to burnout, and questions about whether this was their role or the role of public health professionals.

Participants gave some examples of targets in relation to preventative activities such as addressing health issues around smoking and obesity. However, targets did not always align with the services in which people were seen, or the support they needed.

> **We have KPIs that we should be booking them into our service [maternity] by the time they are nine weeks, which is exceptionally early, when some of our clients aren't finding out they're pregnant until maybe eight weeks, often more.**
>
> (Community health care focus group)

Quality of care

Participants highlighted a few examples of where measures that focus on the quality of care can support or hinder the shift to prevention.

Requirements including national guidance, quality standards for care and, in one case, statutory requirements in relation to education, health and care plans were noted as prioritising what and how care should be delivered. However, these could also constrain taking a more preventative approach and sometimes precluded the adoption of preventative activities.

> **I was just thinking, in terms of neonatal work, that things that are supposed to support in one area, and do support in one area, end up causing barriers and preventing the prevention in the other areas. So, I'm thinking particularly of the UNICEF Baby Friendly initiative, which supports breastfeeding, and means that we can't promote bottle-feeding. But obviously, some families make an informed decision to bottle-feed, and so we're stymied. So for instance, we're trying to introduce reusable bottles and teats, because we know that the ones that we are supposed to use cause issues with the babies, and cause issues with the families. And so, a really good preventative thing to do would be to use better ones, but we can't, because it goes against the Baby Friendly initiative.**
>
> (Children and young people's services focus group)

Participants also shared examples of how quality of care has influenced prevention at a practical level. For example, several participants noted the impact that clinical environments could have on recovery. This extended to also consider the environment in which people live.

> **…in A&E we talk about pressure sore prevention. I'm currently presenting into our safety board about 'are you sitting comfortably', people sitting 24, 36 hours, probably on chairs like we're sat on, limited drink, dehydration, then they're a bit confused.**
>
> (Acute and secondary care focus group)

> **… and the environment [neonatal unit] to be protective of our babies. Things like it not being too noisy, that kind of thing, so that we don't get to the babies having problems.**
>
> (Community health care focus group)

A final example highlights how processes to support quality of care can also contribute positively to prevention within the clinical environment.

> **When I'm reviewing patients' notes and I can see things have been written incorrectly or medication not prescribed, I could prevent an incident… So, I do a lot of preventative errors, stopping and troubleshooting and having safe conversations with teams who may have done something that could have been detrimental, and preventing an adverse event.**
>
> (Acute and secondary care focus group)

Risk management

Participants identified a number of challenges to prevention that relate to the management of risk. Particular note was given to statutory duties for safeguarding in the context of care for children and young people. A need to prioritise safeguarding could limit capacity to engage in preventative activities, particularly when staffing was limited. However, staff were also concerned that a shift to prevention – where there is greater emphasis on self-management and the role of parents or individuals to seek support when required, or a shift towards online engagement – created a context in which safeguarding risks could be missed, particularly where there may be a lack of contact with services, including schools.

More generally, management of risk was described as taking priority in care with the purpose of keeping patients safe, but also motivated by aims to avoid potential litigation. This was particularly notable among staff working in mental health settings where additional processes were implemented to manage risk, including assessments and development of 'safety plans' for those at risk. This was accompanied by additional paperwork and an emphasis on 'documenting everything' – limiting available time for staff to engage in prevention approaches.

Risk aversion also had the potential to negatively impact on prevention. In one example, a participant shared how they used to go with patients to appointments. However, a focus on risk assessment, alongside stigmatising views about specific client groups, had led to this practice being stopped.

Funding

Funding was highlighted as underlying the case for prevention as well as being core to delivering it. Participants saw current delivery of care as leading to people receiving care late, having more interventions, and thus incurring further costs. It could also lead to a perception of waste, including doing things that are not necessary or where things get missed, providing an opportunity to improve how existing funding is spent. Participants also shared the notion that if the NHS were to invest in prevention, it would probably save money in the future by avoiding the need for higher-cost interventions.

However, participants also shared multiple examples of how constrained finances, particularly at the provider level (ie, trust finances), impacted negatively on prevention. This included barriers to accessing training and education, and not recruiting or filling vacancies. Cuts to funding also limited the capacity and capability of services and led to the further narrowing of care to focus on treatment rather than prevention. Funding pressures were also having an impact on existing efforts to support prevention, including greater scrutiny and constraints on use of time, resources and spending:

> **A colleague of mine had a business case declined for a service, which is a preventative service, if we can improve these people with lung conditions' fitness in theory and in the evidence base available, it will prevent hospital admissions for exacerbations of COPD [chronic obstructive pulmonary disease]. The funding wasn't approved for that because it doesn't bring any money in. It seems that the trust would rather have the admission from a financial point of view because they receive some money for someone presenting to ED, whereas there's no financial benefits of reduced numbers of people turning up in emergency departments.**
>
> (Acute and secondary care focus group)

Grant funding and national programmes were highlighted as being valuable in terms of getting projects going. However, these programmes were also seen as being too short term, and funding pressures among local organisations and bodies meant there was no guarantee of financial assurances for prevention work. This applied to both individual projects and to the scale and spread of projects that had proven to be successful. As a result, some participants saw prevention as dependent on national direction and funding – without which it is unlikely to get done.

A key challenge of funding programmes was the ability to evidence impact. This included within the context of a complex system, as well as the practicalities of securing resource and capacity for evaluation. One participant noted that the focus of some funding programmes (such as people with existing comorbidities) restricted opportunities for more upstream prevention.

Funding was particularly noted in relation to the vital role of the VCFSE sector in the shift to prevention. Its role was seen as being dependent on funding, which led to an insecure

relationship. It also meant that the support provided by the sector was really stretched and support may be there at one point, but the service ends when the funding stops.

08 Conditions to support the shift to prevention

Research to date on implementing prevention activities has often focused on the role of public health professionals and health and care professionals involved in the delivery of public health activities. In light of a planned shift from a system focused on treatment to one that orientates primarily around prevention, this research has explored how nurses, midwives, allied health professionals and NHS managers see and experience prevention within their everyday roles and what the shift means to them.

We found that the shift to prevention intuitively made sense to participants, and there was both an openness to and enthusiasm for its potential. Moreover, the majority of participants could point to examples of where their roles already contribute to prevention and how, with the right support and conditions, this could be built on. This represents a significant asset in the shift to prevention. At the same time, participants emphasised that the current context of care meant that it was often hard to prioritise prevention; that preventative activities were seen as an add-on to treatment and care; and with high demand and workforce shortages, staff often felt like they were firefighting, and found it hard to conceive of how the shift could be achieved without this changing.

A radical shift to prevention?

A notable feature of the focus groups is that what participants described around the shift to prevention is grounded in the current system of care and how it is designed. For example, participants commonly talked about opportunities for early intervention or to provide more holistic care within current pathways and delivery of care, and where the focus was primarily on secondary and tertiary prevention. Within this, staff conceived prevention as an extension of their existing role, or perceived different parts of the existing system as being allocated greater responsibility for prevention – most notably primary care and community services.

The government plays an important role in setting the vision for what the shift to prevention looks like and the narrative that supports it. The 10 Year Health Plan outlines the three shifts as radical approaches to reinventing the NHS. Yet the participants in our research described the shift largely in terms of a process of iterative change. Furthermore, while participants noted the value of prevention in supporting population health and wellbeing, the dominant narrative for the shift to prevention within the focus groups was based on reducing hospital and service demand, and cost-saving.

While it is recognised that there is a need to balance both short-term effectiveness of NHS services with long-term ambition, this should not preclude the development and articulation of a

clear vision for achieving the latter. Our research indicates that the vision for the shift to prevention in the NHS is not clear to frontline professionals. Furthermore, in the absence of a clear vision, efforts to support prevention will continue to be framed by the current context of care. Creating a vision for the role of the NHS in a shift to prevention, and the role of the workforce within this, is an important step to prepare the workforce for future change and provide a focus for existing approaches to support prevention on areas that will facilitate that vision.

Systems that enable prevention

The 10 Year Health Plan put in motion a number of significant changes, with corresponding policy and implementation guidance. Commitments made as part of the other two shifts, such as the development of the neighbourhood model and implementation of electronic patient records and the NHS App, provide clear mechanisms for making progress that are arguably less tangible than with the shift to prevention. Our research highlighted four areas that are important to consider in developing a future vision for prevention and plans to support its implementation.

Service design, development and commissioning

Our research highlights the role of service design, development and commissioning, and in particular, consideration of prevention within the context of pathways of care. The NHS England strategic commissioning framework aims to move towards a continuous and evidence-based approach to planning, purchasing, monitoring and evaluating services in the longer term (NHS England 2025a). This provides an opportunity to explore how pathways can be better designed to support prevention – for instance, by building whole-system approaches to prevention that account for the skills and capabilities of the workforce to deliver that care (Naylor *et al* 2025). It is also important that with the diversification of commissioning roles and responsibilities (including development of neighbourhood models, PCNs and provider collaboratives), the shift to prevention is accounted for within policy and guidance at each of these levels.

Within this process, our research highlights that particular attention should be paid to access and interfaces between services, including thresholds for care to facilitate prevention. In addition, service design and commissioning should consider how referral pathways contribute to delays to care, and additional work for staff and patients. Finally, our research suggests that providing a level of flexibility when defining service requirements and KPIs can facilitate professional autonomy to deliver preventative approaches to care in line with professional training.

Finally, we heard about the many ways in which health professionals are leading on prevention along with learning from individual projects. However, participants also noted challenges in obtaining funding and support for evaluation of projects, and in sharing examples and learning. There is a need to consider how best to facilitate learning from activities that support the shift to

prevention – including being able to test and evidence outcomes, and being able to network and share practice.

Aligning targets and creating incentives

Participants consistently shared how targets and incentives that are set for the system often drive activity counter to the shift towards prevention. The combination of targets and accountability mechanisms signal what is – and, by default, what is not – important in the performance of organisations. Participants shared how this, in turn, frames the scope of service delivery and limits professional autonomy.

The NHS Oversight Framework sets out NHS England's approach to assessing and overseeing integrated care boards (ICBs), NHS trusts and foundation trusts. Organisations are assessed against a set of scored delivery metrics, alongside wider contextual metrics, and are ranked according to performance (NHS England 2026b). In 2026/27, the number of scored prevention metrics was increased, although only addressing tobacco dependence is specific to NHS trusts. The targets also largely focus on secondary prevention, rather than addressing wider determinants. The government can support the shift to prevention by: considering whether the focus and balance of metrics are adequate to support the shift; ensuring that prevention metrics across ICBs and NHS trusts count towards overall ratings; and including metrics that contribute towards the breadth of prevention. The government should also consider how prioritisation of financial metrics in ranking of performance impacts on the ability to invest in upstream prevention. The shift to prevention should also be addressed within the development of Modern Service Frameworks which themselves will outline further priorities for the health and care system based on evidence-based interventions (Department of Health and Social Care 2025a).

One area of incentivisation with mixed impact is the availability of national funding programmes. Participants noted how these have enabled the development of individual projects, and in doing so signalled prevention as a national priority at a local level. At the same time, expectations that this would lead to subsequent commissioning at a local level were not necessarily realised. Further consideration therefore needs to be given to the mechanisms by which approaches to prevention are tested and adopted within health and care systems.

The shift from hospital to community

Participants frequently spoke about the shift from hospital to community within the context of the shift to prevention, and the importance of working in and with communities to enable prevention. One mechanism for this was the NHS working more effectively with staff and volunteers in non-NHS organisations, including other public sector, VCFSE and private organisations to deliver preventative interventions and facilitate behaviour change, utilising existing resources and within the context in which people live. Although this could be achieved through commissioning, there were also wider opportunities for skills and information-sharing between clinical and non-clinical staff across settings. For example, the Water Wellbeing accreditation supports leisure centre staff to demonstrate high standards and quality of support for people with long-term

conditions to access exercise (Swim England 2014). The scheme provides confidence for health care professionals to refer patients as part of an ongoing preventative approach.

Participants also highlighted particular benefits of working with VCFSE organisations in developing trust, extending reach into and working with communities who are at risk of health inequalities. In addition, they could support health care professionals to better understand the needs of communities.

One of the risks for framing the shift to prevention within the context of the shift from hospital to community was that staff perceived the role of prevention as lying within the context of particular settings and organisations – notably primary care and the VCFSE sector. This risks negating the important role that the workforce within acute and hospital settings can play, and placing disproportionate burden on areas of care and organisations to deliver the shift. It is important, therefore, that the shift to prevention is incorporated as part of the development of community-based models (such as the neighbourhood model), rather than forming a parallel and additional line of work. Equally, policy-makers need to ensure consistent prioritisation and investment in VCFSE leadership and capacity, not only to deliver services but as partners in the design and development of approaches that enable the shifts set out by the government to be achieved (Ross and Gilburt 2023).

Addressing the relationship between staff, the NHS and the public

Although many participants recognised the important role that patients and members of the public already play in managing their health and wellbeing, they also shared many examples where there is a clear gap in terms of the balance of roles and responsibilities. As such, participants called for government to lead on establishing an honest conversation that appropriately frames both the role of the NHS and the public as part of the shift to prevention.

The role of patients, families and the public in prevention

Calls for this type of honest conversation are not new and not restricted to the NHS (Lant 2023; Ham 2018). The NHS Long Term Plan called for a ‘fundamental shift’ in how the NHS works alongside patients and individuals as part of a broader cultural shift, moving towards ‘shared responsibility’ for health (NHS England 2019). Examples such as the Wigan Deal have also sought to address the role of communities in improving health and wellbeing (Naylor and Wellings 2019).

As part of developing the current 10 Year Health Plan, the DHSC conducted a substantial engagement exercise with members of the public and NHS staff on what the NHS should look like in the future (Department of Health and Social Care 2025b). Although the public agree they have a responsibility to the NHS and their health – in particular by not misusing or wasting NHS resources – they place greater emphasis on the role of government and the NHS. For example, the public said that education and signposting is required about the availability of NHS services, and the government has a responsibility to make it easier to be healthier. Furthermore, while

supportive of the shift to prevention, the public expressed the need to address the immediate challenges they experience in the NHS today.

Such exercises provide an understanding of how the public see that balance. Importantly, it highlights how a shift in the balance of roles between professionals and the public is not a one-way conversation, and comes with expectations of the NHS and staff. As participants in this research highlighted, they too would benefit from support about the rationale for the shift to prevention. They also pointed to the need to reconsider how different functions of the NHS set public expectations and how these align with aims around prevention, with an emphasis on actions that make it easier for patients and the public to engage effectively with the NHS to support prevention. Importantly, changes that support the shift to prevention should be informed by and codesigned with people and communities.

Supporting prevention through person-centred care

Many of the examples participants gave about how the NHS can support people in the shift to prevention (in particular, in managing their health and health conditions) reflect the core aims of person-centred care. Person-centred care aims to involve patients and families or carers in decision-making processes around their health, ensuring that care is planned and delivered to take account of individual needs, while developing people's knowledge, skills and confidence to better manage their health. These principles align closely with the vision set out in the 10 Year Health Plan, for empowering patients to self-manage and be seen as active partners as opposed to passive recipients (Department of Health and Social Care 2025a).

In recent years, the NHS has implemented national policies to support person-centred care, particularly focused on people living with long-term conditions. This has included the development of a core skills education and training framework for person-centred care, and training to develop workforce capability through the Personalised Care Institute (PCI). An independent evaluation found that the PCI delivered significant gains in understanding and confidence in the delivery of person-centred care, factors which participants in this study identified as important in the shift to prevention (Self-Care Academic Research Unit, Imperial College London School of Public Health 2025). However, impact is dependent on staff capacity and requires consistent infrastructure and leadership at a national level, which have been lost or decommissioned in recent years.

Learning from implementation of person-centred care in the NHS will be important in understanding how to enable the behavioural shift to prevention and the role of patients and the public. However, sustaining this progress to support the shift to prevention requires the continued reintegration of person-centred care into the NHS workforce strategy, and appropriate monitoring of implementation and outcomes, with consideration of delivery in other associated sectors.

Addressing the needs of communities at risk of health inequalities

The shift to prevention is particularly relevant to health inequalities by addressing behavioural risk factors and wider determinants that drive poor outcomes (Jefferies *et al* 2025). However, one of the risks with the shift to prevention highlighted by staff and members of the public (particularly from seldom-heard audiences) in the government engagement exercise was that it could worsen existing health inequalities and stigmatise people with health conditions. The government's equalities impact assessment for the 10 Year Health Plan identifies further populations and communities where potential risks associated with the implementation of approaches to support the shift to prevention need to be mitigated (Department of Health and Social Care 2026). For example, while the majority of policies to support the shift to prevention seek to benefit populations overall, the assessment identifies the risk of exacerbating inequalities as digital, genomic and predictive approaches are developed and implemented. This reflects some of the concerns identified by participants in this research.

Core to addressing the risk of worsening health inequalities as a result of actions to support prevention is effective engagement with communities and their involvement in the design and development of solutions. Examples drawn from the rollout of vaccinations during the Covid-19 pandemic, including the role of community-based organisations (Wills and Baird 2025) and community champions (Gilburt *et al* 2024), provide a basis for learning on how this can be successfully achieved.

Tensions were identified in how current approaches to address health inequalities support the shift to prevention. Approaches such as Core20PLUS5 and targets focused on specific public health risks associated with poor outcomes (including smoking and obesity) could be valuable in targeting risk factors at a population level, but were not always aligned with the health inequalities associated with specific health conditions or within the context of individual services. The shift to prevention is likely to benefit from a mix of approaches that combine targeting of populations that are meaningful to staff and patients in individual settings, as well as population-level approaches.

Participants also shared that wider social factors such as poverty and housing could both exacerbate health inequalities and impact negatively on people's health conditions and their ability to engage in preventative approaches. Social isolation was also highlighted as a mediator for changing health behaviours. Evidence indicates that the NHS plays a key role in tackling the wider determinants of health such as poverty (Fenney and Buck 2021). However, there is more that can be done to raise awareness of these issues among health care professionals and to articulate the role of the NHS and its staff in tackling them. The NHS can also take practical actions to address the social determinants through commissioning and procurement decisions that provide routes to support for health care professionals to address issues they identify. Finally, the NHS can advocate for change by enabling leaders and clinicians to speak out without fear of negative consequences.

A final area of inequality that participants highlighted was in relation to people living with complex health and social conditions, which create multiple barriers to care. Examples provided

by participants suggest that some communities may benefit from tailored approaches that seek to address their needs in the round and mediate the potential burden of complexity and individual capabilities to facilitate the shift to prevention.

Enabling the role of the workforce

Our research highlights key opportunities in relation to workforce design that could support the shift to prevention. This includes numbers and types of staff, the breadth of roles and how they relate to each other. For example, some roles (such as dieticians) were identified as enabling a shift to prevention by supporting both patients and staff to address issues related to diet, from healthy eating through to self-management of conditions. As such, workforce plans at a national as well as local level should consider not just the shape of the workforce to deliver care, but how the shape and scale of the workforce can facilitate the skills and capabilities needed to support the shift to prevention. This may result in differential investment in specific types of skills, particularly where they may enable multidisciplinary ways of working identified as being conducive of preventative approaches.

The forthcoming NHS workforce plan presents an important opportunity to outline both the expectations of the workforce in relation to the shift to prevention, and the workforce required to support future plans for delivery. Given the concerns raised by participants, it is important that workforce plans reflect a trajectory that accounts for implementation within the context of high demand – for example, by balancing the capacity of the workforce with the extent to which future plans are likely to change or shift patterns of demand in the health and care system.

It is clear from our research that prevention is already seen as a core feature of some professions. For other professions, their role in prevention is less well-defined, providing an opportunity for the relevant professional bodies to outline those roles, and how this can be embedded within training and professional competencies. For example, the Royal College of Psychiatrists has developed a certified public mental health leadership course in addition to a community of practice, which aims to develop and support the role of psychiatrists in prevention (Royal College of Psychiatrists 2024). This provides an opportunity to embed prevention in a way that is meaningful to clinical practice, as well as providing leadership capability at a local level.

Optimising access to tools and resources

Our research also highlights how the role of health care professionals can be enabled through access to the right resources and tools. These are wide-ranging, including information and equipment to manage health conditions, as well as tools for staff to identify opportunities for prevention. Responsibility for the development of and access to resources was often unclear. This provides flexibility for health professionals, particularly those with specialist skills and knowledge, to develop information that can be disseminated more widely. However, it also leads to duplication and a lack of consistency, creating challenges for both patients and staff in identifying information that is both trustworthy and accurate, while avoiding misguided and

conflicting information. Participants shared examples of online tools and websites that curate sources of relevant support at a local level which they could signpost people to, but which varied in quality, and require ongoing maintenance and updating.

There is no one single route for ensuring that staff and patients have access to the resources and tools to support prevention. Policy is fragmented around different functions and purposes, and there is an opportunity to review how effective the current architecture and future plans for providing such access, are in supporting the shift to prevention.

Our research identifies opportunities for exploring how standardised resources and available guidance on prevention could be curated at a national level. The NHS Knowledge and Library Services aims to support staff, patients and the public through education and by sharing knowledge, research evidence and best practice. The current strategic framework for the service is due to end in 2026 (Health Education England 2021) and represents an opportunity to align future strategy with the aims of the shift to prevention.

The diversity of organisations supporting the development of information and resources provides the opportunity for the NHS to also seek partnerships that capitalise on expertise and capability, while supporting access to and standardisation of resources. The government's announcement of Diagnosis Connect has the potential to improve the information and support available for people diagnosed with long-term conditions in primary care (Department of Health and Social Care *et al* 2025). Ensuring that the model is designed around the needs of individuals, including the timing and delivery of information, will be important in its role as a preventative intervention, supported by the development of appropriate measures and evaluation of outcomes. Collaboration between NHS England and organisations such as the Patient Information Forum (PIF) provides a further route to support access to trusted and evidence-based health information accredited with the PIF Trusted Information Creator certification.

Finally, the NHS accessible information standard sets out how providers and commissioners of NHS and publicly funded adult social care services should ensure that disabled people and people with impairments and sensory loss can access and understand information, and receive the communication support they need (NHS England 2025b). It aims to support organisations to meet their wider legal duties in relation to equality and accessibility, but is more limited in scope. Providers are required to have regard of the standard, and commissioners have a role in assuring that all the requirements of the standard are being met. Although the standard is not assured by the Care Quality Commission (CQC), it is considered as part of its assessment framework for providers.

Creating leadership and organisational development capability to deliver change

We identified a range of policy levers that play a role in supporting the shift to prevention within the workforce. Where there are existing mechanisms for influence, it is important that leaders

understand the impact of current approaches on the shift to prevention at a workforce level, and the changes that can influence this. However, it is less clear who currently owns policy responsible for public engagement on prevention and personalised care, while ownership of policy relating to information and resources is fragmented. Making progress in each of these areas will require consideration of appropriate leadership, and alignment of policies across different policy areas.

It is important to recognise how a greater focus on the role of regions through the English Devolution White Paper (Ministry of Housing, Communities and Local Government 2024), the health and growth accelerators (NHS England 2024), and announcement of the first prevention demonstrator in Greater Manchester and prevention accelerators (Department of Health and Social Care 2025a) are providing new leadership for prevention. This provides a means to fulfil some of the opportunities for utilising the skills and capabilities of the workforce across organisations to support prevention, as well as addressing some of the wider determinants that impact on health. At a national level, policy-makers can play an important role in this by facilitating these processes more widely, addressing barriers to prevention and providing clarity on prevention spending (Buck 2025).

Although the shift to prevention is a commitment within the 10 Year Health Plan, it is important to note that responsibility for health does not lie exclusively with the NHS. Local government plays a key role, including the role of the public health workforce, but was notably absent in our research. Its omission is a symptom of a lack of integration at a local level. Examples such as West Yorkshire demonstrate how public health leaders can serve as a vital resource for the health and care system, providing access to important skills and insights to support prevention (Smith 2025), but which require consideration within the context of the integrated care system's role in population health, and the emerging role of population health leaders as part of that (Buck *et al* 2024). The focus on work and health (Department for Work and Pensions 2025) is a further example of the role and contribution of other government departments to health. The government's health mission provides an important opportunity to strengthen cross-government action on prevention, but its role in driving policy change beyond the NHS has been lacking (Woolnough and Dixon 2025). Facilitating cross-government action should remain a priority if the outcomes of a shift to prevention are to be fully realised.

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