DAC BEACHCROFT

Issue 25

Health adviser

Fresh thinking for healthcare leaders

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Foreword

Why fresh thinking is what we need now

Health systems evolve when leaders are willing to think differently - not just for the sake of change, but because the world around them demands it. The challenges facing health and social care today are well documented, from demographic pressures and widening health inequalities to workforce constraints and financial strain. But within and beyond the NHS, there is an increasing recognition that fresh thinking is not a luxury, but a necessity. With this recognition comes a growing appetite for new ideas and innovative solutions that can reshape healthcare.

As healthcare systems face many challenges, three key shifts are driving significant improvements in care delivery. The transition to digital systems, a move towards community-based care, and a stronger focus on prevention over treatment are reshaping how healthcare is provided and experienced. This issue of *Health Adviser* explores these critical themes and more, delving into how healthcare leaders can respond to the pressures and opportunities presented by our changing landscape.

This magazine brings fresh thinking from a range of perspectives. Amongst the articles in this latest issue, we explore the growing role of AI in the NHS and how it is transforming early diagnosis and care delivery in Manchester. We look at innovative new schemes that are helping the NHS to shift from a reactive healthcare model to one that prioritises prevention, with a focus on collaboration and equity of access. We also take a journey around the world with global leaders to understand how overseas healthcare models can inspire new ways of working within the UK.

Leaders in healthcare must be bold in their approach, embracing innovation not just in technology, but in the very structures of care. *Health Adviser* aims to provide insights into how the healthcare sector can evolve and respond to the need for greater flexibility, efficiency and patient-centred solutions. The road ahead will require collaboration across sectors, a willingness to challenge long-standing practices and a commitment to finding practical solutions to some of the most pressing challenges in healthcare.

Through *Health Adviser*, we hope to inspire the fresh thinking that will drive meaningful change, helping to create a healthcare landscape that is not only sustainable but also equipped to meet the needs of future generations.

Hamza Drabu
Head of Health, DAC Beachcroft

What can the NHS learn from global models of care?

Healthcare systems worldwide are under increasing pressure, grappling with ageing populations, rising costs and growing inequalities. Financial strain, workforce shortages and evolving patient needs, as well as the long-term impact of COVID-19, are other major issues.

However, at the same time, fresh thinking, digital advancements and unique collaborations are reshaping how care is delivered.

In the UK, the government has acknowledged these challenges, with Health Secretary of State for Health and Social Care Wes Streeting stating that the NHS is broken. But the question is, what part is broken? Is it funding, the workforce, the reliance on a hospital-first approach, inequalities in access, or something else entirely?

The reality is that the NHS, with its continued emphasis on acute, hospital-based care, is under increasing strain and in need of transformation to meet today's healthcare challenges.

To create more sustainable and resilient healthcare systems, leaders must address inefficiencies and explore new models of care.

Mark Britnell, professor and global healthcare expert, points out in his book *In Search of the Perfect Health System* that **"The perfect health system doesn't reside in one country, but there are fantastic examples of great health and healthcare all over the world."**

Adopting ideas from overseas is not just a matter of copying and pasting – it requires a deeper understanding of how healthcare fits into the societal and cultural fabric of peoples lives.

Hamza Drabu, Head of Health at DAC Beachcroft notes, **"When we talk about international models of care, the cultural understanding of healthcare – and how it fits into someone's life – is absolutely crucial. That will vary massively from country to country. Whether you're looking at Brazil, India or anywhere else, the cultural context shapes how any model works in practice."**

Effective adaptation also depends on governance structures, funding mechanisms, technology infrastructure and workforce models. By examining how these international models could be adapted to the UK, we can uncover opportunites for more effective, patient-centred healthcare solutions that meet the needs of today's evolving healthcare landscape.

People power leads the way in Brazil

A very different kind of healthcare system is making waves in rural Brazil. Often described as one of the most ambitious in the world, the country's approach does not rely on innovative technology or expanded hospital infrastructure. Instead, it places its trust in individuals through community-led, people-powered, frugal models.

At the heart of this approach is a nationwide network of Community Health and Wellbeing Workers (CHWWs) - non-clinical professionals employed and funded as part of general practice teams. Operating within small micro-areas of roughly 150 households, CHWWs conduct monthly home visits, identify health and social risks early and guide residents to the support they need. This proactive, preventative model has improved public health outcomes, reduced pressure on overstretched hospitals and addressed social determinants of health in ways that traditional systems often fail to do.

Over the years, CHWWs have become a trusted presence in some of Brazil's most deprived areas. Their work has contributed to significant outcomes - including a 34% reduction in cardiovascular deaths - and played a vital role in public health emergencies like the Zika virus outbreak. Although the model has faced challenges such as underfunding, recent initiatives have bolstered CHWWs' capacity through better training, stronger grassroots partnerships and a growing focus on empowering communities to claim their health rights and shape local policy.

Inspired by Brazil's success, UK-based health leaders have started to explore how this model could be adapted for the NHS. Dr Matthew Harris, Clinical Senior Lecturer in Public Health Medicine, who worked as a family doctor in Brazil, has championed the CHWW approach for years. In 2021, a pilot in Pimlico, London, led by Dr Connie Junghans, employed CHWWs to conduct regular household visits. The results were striking: immunisation rates rose by 47% and cancer screening uptake increased by 82%.

Another pilot programme in London - this time in Westminster - involving door-to-door visits by CHWWs led to a 10% drop in hospital admissions and a 7% reduction in A&E visits in only one year. Backed by Streeting, who called the results **"really encouraging"**, the initiative is now being rolled out to 25 areas across England, with ambitions to scale up further as part of the government's 10 Year Health Plan.

Dr Nav Chana, Senior Partner at Cricket Green Medical Practice and Non-Executive Director at Lewisham and Greenwich NHS Trust, has long championed the integration of community-led healthcare within primary care networks. **"As a GP in Mitcham, covering some of the most deprived areas in Merton, I have followed the expertise of Dr Harris, who first introduced me to the model in 2019,"** he says.

"The key principles of the CHWW' initiative are that it is comprehensive, dealing with all stages of the life course, proportionately universal, serving the entire population within the attached micro-area, and integrated within the primary care team." What seems to set the model apart, he notes, is its proactive approach. **"CHWWs aren't accessed by referral – they visit all residents in their area regularly and offer support as needed."**

Drawing on his own practice's experience, Dr Chana highlights a CHWW who worked with him. She has helped identify vulnerable patients – including some at risk of hypothermia – and arranged heating vouchers. "She has also improved monitoring of patients with long-term conditions, particularly those who weren't responding to existing care or were missing hospital appointments," he says.

Beyond clinical care, the CHWW has supported young people at risk of domestic violence, guided patients through benefit claims and contributed to daily clinical meetings with up-to-date knowledge of local support services. "She's become a highly valued member of the team," Dr Chana adds.

The wider rippled effects are becoming clear too. "Uptake of screening and immunisation has improved, and time-consuming GP requests – like letters for housing support – have reduced. Overall, the experience after 10 months is very positive," says Dr Chana. "We're now looking at how we can make the initiative even more effective over the coming years."

Crucially, the model goes beyond medical care. CHWWs are addressing broader determinants of health - tackling issues like housing, debt, loneliness and unemployment that, if left untreated, can often spiral into complex healthcare needs. As Dr Harris puts it, "It's knocking on doors and you might be forgiven for thinking it's interference, but it's giving control back to the resident." Scaling up this approach across the NHS could ease pressure on overstretched hospitals and GP services, while fostering a more equitable and resilient healthcare system.

However, for it to succeed, it requires a fundamental shift in:
- workforce planning
- funding structures
- how primary care integrates with community services.

This approach has the potential to transform the NHS, making it more adaptable to the evolving needs of the population and ensuring healthcare reaches those who need it most before they become acutely unwell. As we look to the future, Brazil's experience - and its growing resonance in the UK - highlights the pivotal role community-driven initiatives could play in shaping a sustainable, patient-centred healthcare system.

Dementia village model thriving in Scandinavia

Scandinavian countries have become a beacon for healthcare reform, blending innovation, efficiency and community-based care. Nations like Denmark, Sweden, Norway, and Finland consistently rank among the happiest in the world and their healthcare systems reflect this through their emphasis on accessibility, patient-centered care and overall efficiency. While not without challenges, these countries have laid a strong foundation for future reform and offer valuable lessons for health systems worldwide.

The focus on integrating healthcare within the fabric of everyday life is particularly evident in the approach to dementia care. Today, almost 50 million people worldwide are living with dementia – a number expected to triple by 2050. As the global population ages, and dementia diagnoses rise sharply, innovative approaches to dementia care are becoming increasingly urgent with the need to meet the growing desire for sustainable and humanised services.

The concept of dementia villages was pioneered in the Netherlands, but countries like Denmark and Sweden have adapted and enhanced it. These villages are designed to replicate real-life neighbourhoods, offering a safe and stimulating environment where elderly patients can live independently while receiving the care and support they need. Dementia villages aim to break away from the institutionalised nature of traditional care facilities. They offer a more integrated, dignified approach to care and residents can engage in daily activities, interact with each other and experience a sense of normality and belonging, as if they were in their own communities.

This concept is groundbreaking and the UK has already started to take inspiration from it. Warwick's Woodside Care Village is in the town centre and encourages autonomy by providing residents with opportunities to perform familiar activities like shopping or working in a launderette.

However, there is still much to be done to fully integrate such models across the UK. The NHS faces challenges in fully implementing continuous, long-term care relationships that prioritise prevention, while within the progressive Scandinavian framework, Norway's healthcare system stands out for its unwavering commitment to equitable access and long-term stability. Professor Andreas Terje Eikemo, Director of the Centre for Global Health Inequalities Research, explains, "Every citizen is assigned a dedicated general practitioner, who not only addresses immediate health concerns, but also concentrates on preventive care throughout the individual's life. This stable, trusted relationship between patients and healthcare providers ensures that issues are managed proactively, reducing the need for reactive interventions.

"Furthermore, Norway's robust public-private partnership harnesses the benefits of technological innovation and private sector efficiencies, yet steadfastly maintains public health at its core. This model ensures that healthcare remains accessible to all, regardless of socio-economic status, and that the distribution of care resources actively targets those with higher healthcare needs."

Image by wcs-care.co.uk

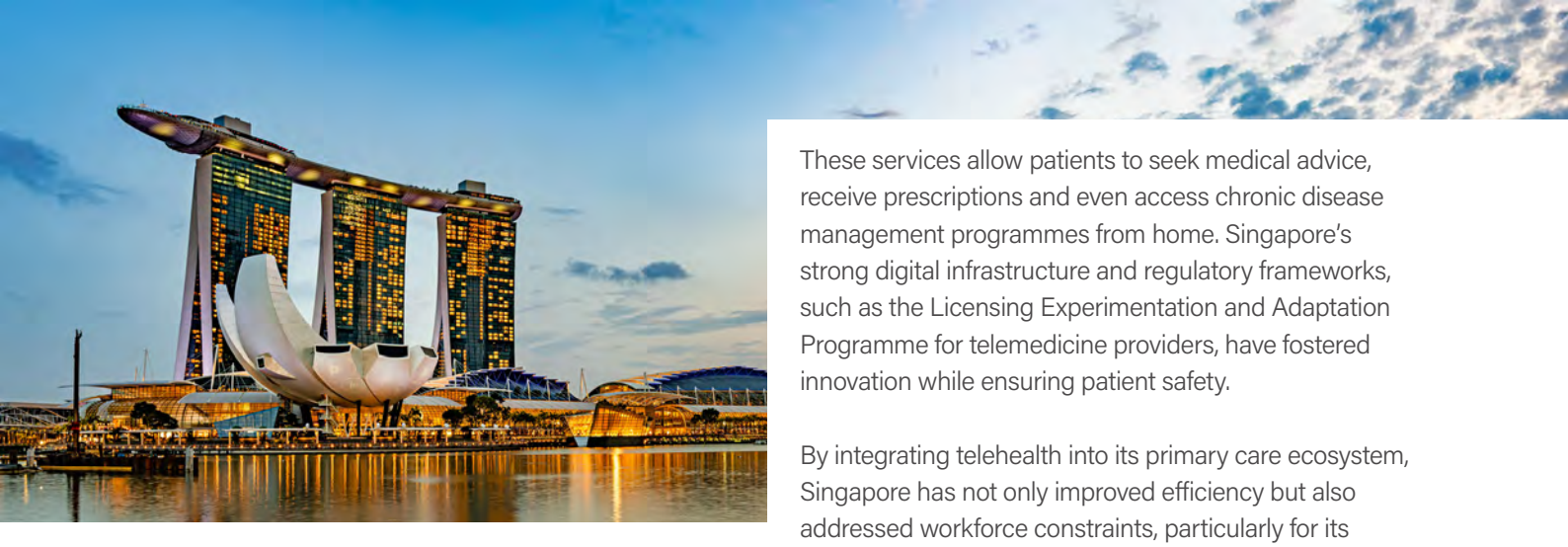
While GPs in the UK play a central role in patient care, the system's capacity to emphasise long-term, proactive health management is often hindered by funding pressures and an overburdened primary care network. As a result, the NHS tends to adopt a more reactive approach to healthcare, addressing issues as they arise rather than preventing them in the first place.

Hamza Drabu says, "The contracting and funding landscape across the NHS does not incentivise or reward prevention as currently framed. It is typically very difficult to reward a provider for something not happening, and most NHS contracts are based on input specifications of requirements. We have advised on a number of contractual models that can be used to reward providers for prevention – linked to indicators such as better patient outcomes or a decrease in the need for particular healthcare interventions. This often reduces costs for a healthcare system, but requires a long-term commitment from commissioners to realise this, coupled with an appetite to innovate, which often goes missing when the NHS is under pressure and strain."

Norway also provides valuable lessons through its integration of public-private partnerships in healthcare. By harnessing the efficiencies of the private sector without compromising public health values, it has created a model that maintains universal access to care. This stands in contrast to the NHS, which is grappling with increasing privatisation and concerns about its impact on accessibility and equity. Norway's approach demonstrates that technological innovation and operational efficiencies can be integrated into public healthcare systems without undermining key NHS core principles such as universalism and social equity.

Both systems, however, face common challenges, such as the inverse care law, where individuals with more resources are able to access specialist care more easily than those from lower socio-economic backgrounds. While Norway has made strides to address these disparities early on, the NHS continues to struggle with inequalities, particularly in the transition from primary to specialist care. This is an area where the NHS could learn from Norway's approach, ensuring that vulnerable populations receive the support they need throughout their healthcare journey.

Ultimately, the lessons from Norway's healthcare system offer valuable guidance for the NHS. By addressing the growing challenges of healthcare disparities, increasing privatisation, and integrating more community-centred models, the NHS could enhance its approach to care, ensuring that it remains accessible, equitable and effective for all.



Singapore harnesses the power of digital systems

Singapore offers an intriguing example of how a healthcare system can achieve impressive outcomes at a fraction of the cost of many Western nations, including the UK. The country's success is not only down to the design of its healthcare system, but also the fact that cultural factions, population health and societal values help keep costs low – particularly by focusing on efficiency, technology and patient-centred design. But what exactly makes Singapore's system so effective and how might elements of it be integrated into a potential new care model in the UK?

Streeting pointed out in *The Critic*, a British cultural and political magazine, that "[Singapore] is a system designed around patients", a principle reflected in the country's network of polyclinics, which serve as the cornerstone of primary care. They offer a wide range of services including general consultations, preventive health screenings, vaccinations and care for mothers and children all under one roof. The system is built around the idea that healthcare should be accessible and affordable, yet also designed to encourage personal responsibility. This structure reduces reliance on hospital-based care, ensuring patients receive timely treatment in community settings.

Singapore also excels in leveraging telemedicine and digital health solutions to enhance accessibility and reduce unnecessary visits to healthcare facilities. This aligns with broader global trends towards virtual healthcare.

The country has embraced telemedicine as a key pillar of its healthcare strategy, with initiatives such as HealthHub and platforms like MyDoc and Doctor Anywhere making virtual consultations widely accessible.

These services allow patients to seek medical advice, receive prescriptions and even access chronic disease management programmes from home. Singapore's strong digital infrastructure and regulatory frameworks, such as the Licensing Experimentation and Adaptation Programme for telemedicine providers, have fostered innovation while ensuring patient safety.

By integrating telehealth into its primary care ecosystem, Singapore has not only improved efficiency but also addressed workforce constraints, particularly for its ageing population. The success of its telemedicine model offers valuable insights for other healthcare systems looking to expand virtual care solutions in a sustainable and scalable way.

Unlike the NHS, which provides healthcare services free at the point of use, Singapore operates on a system where patients contribute towards their care – the financial incentives structure. This is often through mandatory health savings accounts like Medisave or co-payments. This creates a patient-as-customer dynamic, where providers are incentivised to deliver timely and high-quality care.

While such models may be difficult to implement entirely in the UK, they raise important questions about how financial structures influence efficiency and patient outcomes. Singapore has built a system that balances cost control with strong healthcare outcomes. The challenge for the UK lies in determining which elements can be adapted within the NHS framework.

Singapore's healthcare model presents compelling lessons for the NHS as it navigates rising demand and financial pressures. While direct replication may not be feasible because of differences in funding structures and societal expectations, elements such as polyclinics, telemedicine expansion and a stronger emphasis on preventive care could help create a more sustainable and patient-centric system. By integrating these approaches, the NHS could improve efficiency, reduce hospital dependency and enhance accessibility, especially for managing long-term conditions.

The key challenge will be adapting these innovations while preserving the NHS's core principle of free and equitable care. Singapore's success demonstrates that strategic investments in primary care, digital health and financial incentives can drive better health outcomes at lower costs, offering valuable insights as the UK seeks to modernise its own healthcare system.

Achieving equity in healthcare for Indigenous people in British Columbia

As we explore healthcare systems around the world, the last powerful example of system transformation comes from British Columbia, Canada – where efforts are under way to deliver more equitable, culturally safe care for Indigenous people.

The story of Indigenous healthcare in British Columbia is one of resilience in the face of adversity. For generations, First Nations communities have faced disproportionate barriers to health and wellbeing, shaped by the legacy of colonisation, land displacement, and limited access to culturally appropriate care. Today, Indigenous peoples in the province continue to experience higher rates of chronic illness, mental health challenges, and difficulties in accessing timely services. These challenges are compounded by a historic mistrust of mainstream health institutions, which stems from lived experiences of exclusion and cultural insensitivity.

A turning point came nearly a decade ago, when concerns about discriminatory treatment of Indigenous patients in emergency departments sparked a province-wide conversation about equity in healthcare. Although the most high-profile allegation - a so-called "game" involving staff guesses about patients' blood alcohol levels - was not substantiated by a government-commissioned review, the investigation uncovered systemic issues and highlighted the urgent need for change. For many Indigenous communities, it was a moment of validation: their concerns about inequity were finally being acknowledged at the highest level.

Since then, the province has taken important steps toward addressing these disparities and rebuilding trust.

The Provincial Health Services Authority (PHSA), which provides specialised health services across British Columbia, has increasingly prioritised the delivery of culturally safe care. Its Indigenous Health Program supports a range of initiatives - from cultural safety training for healthcare workers to Indigenous representation in leadership and the integration of traditional knowledge into policy and service design.

These efforts form part of a broader provincial commitment to health equity. Rather than a top-down approach, British Columbia is embracing co-designed, community-informed solutions that aim to transform care in both urban and remote settings.

Since then, the province has taken important steps toward addressing these disparities and rebuilding trust. Joe Gallagher, Vice President of Indigenous Health and Cultural Safety at PHSA, reflects on this transformation, **"It's fundamentally important that we do this work in the right relationship with the First Nations peoples of the land and their laws and title.**

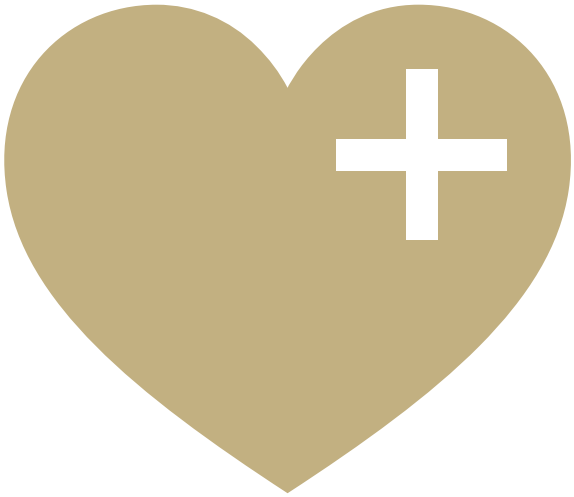
"Without that, we risk replicating colonial patterns that erase Indigenous identity and harm our own communities. We're not all the same - and equity means recognising and honouring those differences."

Gallagher's words highlight the importance of viewing Indigenous health through a lens of cultural safety and respect for the laws, title and traditions of Indigenous peoples. It is not enough to simply treat all patients the same; to truly achieve equity, the healthcare system must acknowledge and respond to the unique needs and experiences of Indigenous communities.

What stands out is the province's recognition that meaningful system change must be rooted in cultural understanding and shaped by the communities it serves. This reinforces Hamza Drabu's earlier point that the success of any healthcare model depends on how well it fits into the cultural and social context of people's lives. British Columbia demonstrates how listening to communities, respecting identity and embedding cultural safety into service design can build trust and drive equity. These lessons offer valuable perspectives that complement the NHS's existing strengths. With many community-led and co-designed initiatives already under way across the UK, there is growing momentum towards a more inclusive and responsive health system.

What does DAC Beachcroft want to see in the 10 Year Health Plan?

The much-anticipated 10 Year Health Plan is being published very soon and will set the direction for the NHS for the next decade. Here, DAC Beachcroft lawyers outline what they want to see in the plan.



For several months the government and a carefully selected panel of healthcare experts have been developing a 10 Year Health Plan.

It is structured around three key goals:

- moving from a system that primarily treats sickness to one that prioritises prevention
- shifting care from hospitals to community and primary care settings
- driving digital transformation to improve service delivery.

To truly deliver on these ambitions, the NHS must tackle long-standing barriers to innovation, workforce capacity, procurement and integration between health and social care.

DAC Beachcroft lawyers highlight the key areas where reform could make a tangible difference - whether through enabling innovation, improving access to mental health services, investing in NHS infrastructure, or ensuring greater collaboration between the NHS and independent health providers. Their recommendations provide a blueprint for how the NHS can not only evolve, but potentially thrive in the next decade.

Hamza Drabu, Head of Health, highlights the need for clear market signalling and better regulation for life sciences, MedTech and digital health

What we need from the 10 Year Health Plan is a clear pathway for the most impactful innovation to be adopted at scale across the NHS. This should include clarity of NHS priorities, in terms of the key problems it would like the life sciences, MedTech and digital health market to help address. This will enable the market to direct the genesis of innovation to tackle these issues.

We need better, not necessarily "more", regulation of software and AI as medical devices. Such regulations should be risk-based and contextual and allow companies to safely trial certain solutions in tandem with their application for registration. This would facilitate a pathway to quicker regulatory approvals, whilst retaining proper safeguards for patients. Recognising the various organisations and different IT systems used relating to health records, we would also like to see requirements for certain technology solutions to be interoperable before the NHS implements them, and to phase out those which are less flexible.

Once priorities are clear, a move to centralised procurement of key solutions at a national level would improve efficiency and help to realise benefits at scale. We also need to clear channels for suppliers to engage with local and regional Integrated Care Systems when seeking to bring products to market.

Lastly, we need a contracting and incentive system that crosses primary, secondary, tertiary, and social care, so that the benefits of life sciences, MedTech, and digital health interventions that support the prevention agenda can be assessed and rewarded. This will allow us to understand their impact both in terms of patient outcomes and cost savings.

Gill Weatherill, Partner, calls for investment in Child and Adolescent Mental Health Services (CAMHS) to bridge gaps and improve long-term mental health outcomes

We need investment across organisational boundaries in the areas that will save money, and lives, longer term. Perhaps the most obvious area for a long-term strategic focus is Child and Adolescent Mental Health Services (CAMHS) to fill the current gap for children and young people with mental health problems, whose needs often fall between health and social services. Enormous amounts of public money are expended across agencies, with costly care packages being put together which all too often fail. Waiting lists for mental health services mean children and young people are unwell and go untreated for longer, creating unnecessary suffering as well as the cost to society rising exponentially.

The 10 Year Health Plan should provide for, or impose, a joined-up approach, obliging health and social care to work together, rather than the child or young person "bouncing" between mental health services and local authority care on a "one step forward, two steps back" or "revolving door" basis. A holistic approach, based on meeting the young person's needs in one placement, rather than attempting to slot individuals into the current established care pathways, would ensure cash was focused on individuals. This would improve outcomes and avoid costly and ineffective arguments as to whether a child's needs are a mental health or behavioural social care issue.

The benefit to children and young people, the NHS and social care, and society more widely, would be significant in human and financial terms. It would result in well-supported young people having the chance to make a net contribution to the public good and purse in adulthood, rather than joining the growing numbers of adults unable to work because of mental health disability, who necessarily consume significant public resource.

Streamline purchasing and data policies to drive NHS innovation and consistency, says Charlotte Burnett, Partner

The NHS faces increasing pressure to deliver high-quality care efficiently, cost-effectively, and with less reliance on corporate services' spend, as evidenced by the government's recent announcements.

The 10 Year Health Plan should include a centralised commercial function for national significant scale purchasing projects, which have the ability to greatly enhance the NHS's ability to meet these demands. This would let it create national frameworks from which regional commissioners can deliver standardised, and interoperable, products and services, from a range of suppliers. This means the NHS could leverage economies of scale, negotiate better terms, and ensure consistency in the quality of products and services it purchases. This approach would reduce duplication of efforts, minimise administrative costs, and streamline processes, while continuing to enable local adoption and design into care pathways.

This could facilitate simpler data collection and analysis, supporting more informed decision-making and strategic planning. It would ensure that all parts of the NHS have access to the same resources, reducing disparities in care delivery, while driving innovation and implementing best practices.

Improvements in interoperability of products and services will, however, only go so far as current policy on data use within the NHS. This is arguably outdated when compared with the rate of technological change (in particular automation and other privacy-enhancing features which can be used to create linked but not directly identifiable datasets). The 10 Year Health Plan should therefore provide much clearer guidance on when it is likely to be permissible to use and share data for secondary purposes i.e. planning and optimising the delivery of health services as well as health research. This would shift the dial from an often default assumption that such activities are unnecessarily difficult to achieve within the applicable legal framework.

Corinne Slingo, Partner at DAC Beachcroft adds, "Better use of data may in turn remove a barrier to enabling better access to better quality, and ultimately safer, patient care. Linked to both data and quality, is regulation across the health and social care sector – where 'scaling up' to a single regulator of quality and safety in the sector via the Care Quality Commission (CQC) has reached an all time low in terms of confidence. Any 10-year plan which ultimately focuses on improving patient safety and access to healthcare, will be set to fail unless a truly fit-for-purpose regulator exists which has oversight of operational delivery against required standards in a way that truly promotes and rewards excellence in care and innovation. In doing so, a refreshed regulator will need to ensure it is capable of navigating the complexity of patient pathways, a diversity of providers working collaboratively, and a shift in mindset as to its purpose."

10 YEAR HEALTH PLAN
THE WISHLIST

Enhancing NHS and independent health sector cooperation for seamless patient care and innovation is key, says Udara Ranasinghe, Partner

The UK independent health sector has a significant role to play in healthcare provision. Supporting greater collaboration between the independent sector and the NHS must be a key component of the plan.

A more integrated approach needs to be encouraged to allow patients to move seamlessly between NHS and independent health. This could include shared care pathways and joint initiatives, with less concern about 'loss' of income or patient numbers in either direction. Greater collaboration across the secondary care system should bring the additional advantage of improving monitoring of clinicians working across both the public and independent sector space, as part of overall patient safety and good collaborative clinical governance.

Funding models should be transparent and flexible enough to support the independent sector in delivering high-quality care that functions as a meaningful partner to the NHS, as a key component of the whole health system. Certainty around this will encourage greater independent health activity, and potentially enhance the freedom of shared innovation in services and data management described elsewhere in this 'wishlist'.

Both sectors need to make better use of technology to improve efficiency, reduce costs, and deliver more personalised care. This means supporting digital interoperability between independent healthcare and NHS and supporting investment in innovation in line with NHS priorities.

Maintaining high standards of care is critical for both NHS and independent providers. This requires clear, consistent, and fair regulatory frameworks, but also ones that take account of the different contexts of care across independent sector provision, particularly where a service is more niche or of smaller scale. On these occasions, the scale of regulatory scrutiny may feel disproportionate to the presenting risk and disincentivise expansion in independent sector provision.

NHS pay sets the floor for independent health sector pay. If independent providers do not set pay levels above NHS terms and conditions of service (TCS) for Agenda for Change, they often find it hard to attract workers. A joined-up approach to pay would help ensure the largest costs in the healthcare system are more contained for the benefit of the system. However, current competition laws are likely to prevent these discussions.

Alison Martin, Partner, calls for clarity on private finance's future role to reimagine NHS infrastructure

Faced with a vast infrastructure funding gap, the NHS has an enormous challenge to deliver the scale of investment needed to deliver a healthcare estate that is fit for the future or even, dare we say it, fit for the here and now.

One way to plug this gap is the use of private finance. However, since the government scrapped the use of the controversial private finance initiative (PFI) in 2018, NHS England, in line with government policy, has banned its use in capital projects in England. Momentum has been building within the NHS, after statements from several of its senior leaders, to revisit the role of private finance in health infrastructure projects, but still there is no clarity.

Through the 10 Year Health Plan, the government must pin its colours to the mast and address the role of private finance head-on. With this comes the need to change national policy and guidance to allow alternative private investment models, like the Mutual Investment Model (MIM), to be used, where appropriate. This has already enabled the Welsh Government to successfully deliver some projects.

Despite the bad press around the cost of PFIs, public private partnership models benefit from a transfer of risk to the private sector and can, therefore, provide cost efficiencies. If, via the 10 Year Health Plan, the government commits to a stable policy environment on the use of private finance, optimism in the investment market will surely follow, creating a steady pipeline of projects to modernise NHS buildings and infrastructure. Healthcare provision from a modern and efficient NHS estate can only help improve its productivity and the quality of services.

Anna Hart, Partner, says the missing link is a focus on social care to build system-wide resilience

Effective social care provision is a key component in keeping people out of hospital and in allowing prompt discharge - both key priorities for the NHS's future. It must be a key component within the plan.

It is well recognised that current social care provision is underfunded and undersupported and, while a rapid injection of investment is unlikely, there is more that the 10 Year Health Plan can focus on to support change. This should include creating greater parity and integration between health and social care.

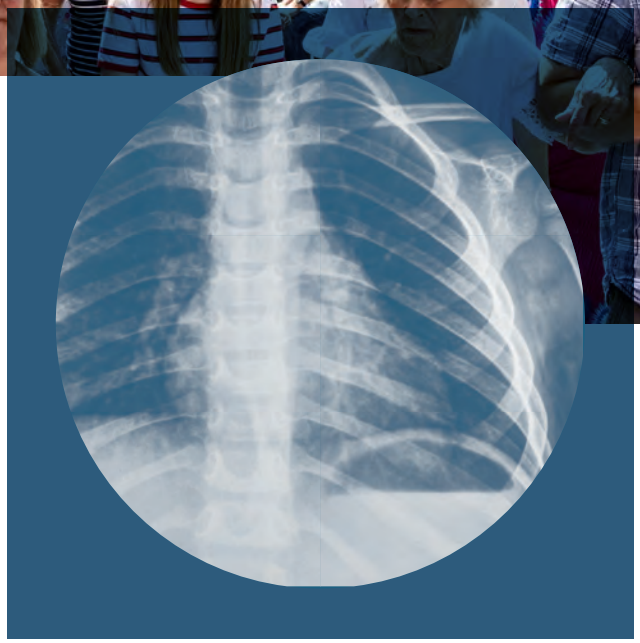
Closer collaboration between health and care providers would allow social care providers with capacity in their services to support the NHS during periods of high pressure and to plan for this well in advance, rather than only once the crisis is happening.

Creation of a single electronic social care record that can be accessed by several providers, to avoid duplication of effort, eliminates gaps in knowledge that create safety risks and improves individual experience in using services. There should be improved workforce opportunities and recognition for social care roles to encourage recruitment and retention of staff from other sectors, rather than creating competition for staff between the NHS and social care providers.

This should include clear career pathways for those working in social care and parity of remuneration and reward. Better recognition of social care as a career and profession may bring the potential for additional professional regulation in that sector, through which standards are set and monitored, however, this may be a useful marker for both recognition of it as a professional career, and a quality driver. Any such approach would need to be accompanied by more wholesale change around professional regulation in health and social care, given the inefficiencies which currently exist in existing oversight arrangements.

In focusing on improving collaboration across the sector, the 10 Year Health Plan will maximise efficiencies in the system and tap into the wealth of expertise and knowledge that social care providers can bring. This, in turn, will both support the future of the NHS and most importantly, improve the experience of individuals accessing care.

How can we move from treatment to prevention?



Health Secretary Wes Streeting said, **"Without action on prevention, the NHS will be overwhelmed"** in his speech at last September's Labour Party conference, shortly after the party assumed power.

Since the election, moving healthcare from treatment to prevention has remained a key promise from Labour and one of the three shifts which will feature in its 10 Year Health Plan.

From politicians to practitioners, there is a clear consensus that a reactive model of care is unsustainable. However, while the call for prevention has never been louder, decisive action is not being taken yet. Chronic illness is rising, health inequalities persist and, despite record spending, outcomes remain stubbornly poor.

For years, prevention has been the policy ambition that struggles to become operational reality. Hospitals dominate headlines and budgets, while upstream interventions, although cost-effective and often transformative, struggle to gain traction.

However, change is beginning to take root. Whether through national research programmes, local provider partnerships or community-led initiatives, the left shift - moving people from hospital to community care - is already under way. But how do we build momentum, measure and showcase the impact of initiatives and expand what is working nationally to realise the left shift at scale?

Guy's and St Thomas' NHS Foundation Trust supporting young people

At Guy's and St Thomas' NHS Foundation Trust (GSTT), prevention is not a hopeful slogan but a system-wide commitment backed by strategic intent and operational change. The trust's 2030 strategy positions prevention as one of its five key priorities, recognising that the current hospital-centric model is no longer viable in the face of rising chronic disease and demand.

"We must invest in prevention - not just because it's the right thing to do, but because the current model is unsustainable," says Lawrence Tallon, the new Chief Executive Officer (CEO) of the Medicines and Healthcare products Regulatory Agency (MHRA) and former deputy CEO of GSTT.

"We have evidence from international systems, we have a step change in our technological capability and, most importantly, we have clinical staff who are engaged and ready to act."

That commitment is being realised through Value-Based Integrated Care (VBIC). This is a formal joint venture with local GP practices in Lambeth and Southwark.

"We've come together across traditional organisational boundaries to create a system that is incentivised to keep people healthy and out of hospital," Tallon explains. **"Rather than focusing on episodes of care, we're focusing on outcomes across the whole patient journey."**

VBIC includes the establishment of a new Population Health Hub, which integrates primary and secondary care datasets and enables proactive care planning using advanced analytics. **"It allows us to predict risk, personalise interventions and target resources where they can have the biggest impact,"** Tallon says. The MyChart app, used by more than 600,000 people across GSTT and King's College Hospital, is another tool empowering patients to self-manage and engage with their care. Perhaps the most striking example is the Child Health Integrated Learning and Delivery System (CHILDS) framework, developed to support children and young people with chronic conditions such as asthma. Weekly triage meetings bring together GPs, community nurses and patch paediatricians to collaboratively review referrals and tailor care.

Technology is being deployed as a core enabler of this shift. **"For the first time, we can now track whether an upstream intervention - like an AI model that predicts falls - actually reduces A&E attendances downstream. That's transformational and gives us the foundation to shift from activity-based funding to outcomes-based investment."**

Critically, VBIC is designed with equity in mind. **"A value-based system must address under-use, overuse and variation. In our CHILDS model, we're reaching proportionately more children from the most deprived quintile and that's how we know we're beginning to close the gap."**

What next for GSTT?

The GSTT model could provide a template for others, but only if the system is brave enough to follow through. Tallon says, **"We must invest in prevention. The nation is behind the 'three shifts' and there is broad agreement the current model is unsustainable. We have evidence on how to deliver higher-value care from other health systems, there has been a step change in machine learning and technology capabilities for population health management, and our staff are engaged and mobilised to act.**

"Set your ambition at board level. You can't deliver long-term change on short-term funding. Invest in prevention, grow a coalition of clinical leaders and shift your financial modelling from organisational silos to whole-pathway outcomes. If we get this right, VBIC could become a blueprint - not just for London, but for the NHS as a whole."

Prevention is often discussed as community led, but Tallon argues hospitals must also lead the way. **"We believe that we have a significant role to play as an acute provider in the development and delivery of preventative strategies. Without acute providers at the table, the gravitational pull of resources to hospitals will persist. Previous restructurings, and budget allocations not aligned to outcomes, have left us in a position where treating acute illness is rewarded disproportionately more than disease prevention and maintenance of good health. Our overarching hypothesis is that if we work collaboratively with primary care partners, across and beyond historical organisational boundaries, we could make better use of the combined annual budget per person to keep our residents healthy and out of hospital."**

Case Study: The CHILDS framework in action

What is it?
The CHILDS framework is a practical example of early intervention, integration and prevention in action. It is an integrated care model for children and young people, developed by the Children and Young People's Health Partnership and now embedded within Guy's and St Thomas' NHS Foundation Trust's VBIC approach.

How does it work?
Each primary care network hosts weekly child health team meetings, bringing together GPs, community nurses and patch paediatricians to review referrals. Most cases are managed through:
- Advice and guidance for GPs
- Nurse-led support
- Monthly in-reach clinics.

Only a small proportion require full specialist referral and more complex cases are escalated to monthly multidisciplinary team reviews involving school nurses and health visitors.

What is the impact?
For children with asthma, outcomes in the six months after intervention included:
- 49% reduction in emergency attendances
- 45% drop in hospital admissions
- 30% savings per patient at 30 to 40% population coverage.

The outcomes across all cases:
- 49% were resolved via GP advice
- 26% were seen in a community clinic
- Just 14% needed specialist referral.

Why it matters:
It strengthens primary care, empowers professionals and reduces acute demand while delivering better outcomes for families.

Building the evidence base for prevention

Dr Raghib Ali is the CEO and Chief Medical Officer of Our Future Health, a UK charity - the largest health research programme of its kind in the world, designed to predict and prevent disease at population level.

He believes building a prevention-first NHS begins with evidence and says, **"Our focus is to identify those at highest risk of future disease and to act early enough to prevent it, but to do that, we need robust data, diverse participation and long-term commitment. That's what Our Future Health provides."**

With support and funding from the government, the programme has already recruited more than 2.3 million participants, with a target of five million. Each volunteer provides detailed information about their health, lifestyle, genetics and environment, helping researchers build a real-time view of disease risk across the UK population. **"Too often, prevention has been based on generic advice, but people have different risks and different needs,"** says Dr Ali. **"Stratified prevention means targeting interventions to the right people at the right time, based on real evidence."**

By combining genomics with longitudinal health data, the initiative is enabling the development of early detection tools and personalised screening strategies - from cardiovascular disease to cancer and diabetes. Crucially, the cohort has been designed to be diverse and representative, helping address long-standing gaps in population health data.

Dr Ali is candid about the barriers. **"The NHS is built to respond to illness, not to anticipate it and, politically, it's always easier to fund treatment today than prevention tomorrow. But a short-term treatment-based approach is unsustainable. We measure the cost-effectiveness of drugs and operations - we need to do the same for upstream interventions.**

"We now have the data, the tools and the public mandate. What we need is for government and the NHS to build the bridge between evidence and delivery and to fund prevention with the same seriousness as cure."

Charity sector playing a crucial role

Health is shaped by far more than clinical care and for Charlotte Osborn-Forde, CEO of the National Academy for Social Prescribing (NASP), that recognition is long overdue. **"Social prescribing recognises that health isn't just about medical treatment,"** she says. **"Things like social connections, physical activity, access to nature and creative pursuits all play a vital role in keeping people well."**

NASP is a national charity that champions social prescribing across the UK, helping people improve their health and wellbeing through non-clinical support. **"We act as a link between healthcare services and community organisations,"** Osborn-Forde explains. **"While GPs and other healthcare professionals can refer people to social prescribing, it's often delivered by voluntary groups, charities and local services."**

The organisation works across sectors, providing funding for community initiatives, supporting policies that embed prevention and working closely with the NHS to scale up social prescribing across both primary and secondary care. It also plays a vital role in developing evidence and guidance to ensure that the benefits of social prescribing are recognised across the health system.

However, the delivery of this kind of preventative support depends on the voluntary, community and social enterprise sector and Osborn-Forde is clear about the scale of its contribution. **"It is essential because it delivers many of the activities that help people stay well, such as social groups, exercise classes, and mental health support,"** she says. **"These organisations need stable funding, stronger partnerships with healthcare providers and recognition of the vital role they play in public health.**

"There are a wide range of evaluation frameworks that can be used to measure the value of social prescribing. Tools like patient surveys, case studies and economic modelling can all help show the impact. For local, small-scale organisations, it's important to take a proportionate approach, in order not to overwhelm people who take part in their activities. However, there is more that can be done to use data collected through social prescribing more effectively, and to track the longer-term impact, and we are working with researchers to do this."

Osborn-Forde cites promising national programmes like green social prescribing, which ran from 2021 to 2023 and connected people experiencing poor mental health with nature-based activities. **"The independent evaluation showed significant improvements in wellbeing and mental health, in a way that was cost-effective. These kinds of outcomes point to what is possible, but only if the infrastructure to support community-led care is properly resourced,"** she says.

"Social prescribing is already playing an important role in prevention and we hope that there will be ongoing incentives for primary care networks to prioritise social prescribing and employ link workers. Our research shows that this can have a positive impact - not just for patients, but for health services themselves in terms of reduced GP appointments and hospital admissions."

Link workers act as connectors, helping people navigate local resources and reduce their reliance on clinical services - and there is also potential to go further, including within hospitals. **"There are hugely promising social prescribing projects in secondary care, with hospitals employing link workers to support patients with social factors that may be affecting their health,"** she adds.

"We need more support for link workers, including through training and development opportunities, and strong partnerships between the NHS and community organisations. If we continue building on this momentum, we can create a healthcare system that truly prioritises keeping people well."

Turning potential into practice

Taken together, these three perspectives offer a clear message: prevention is not abstract, it is happening now:

- At GSTT, prevention is being embedded into care pathways through integrated models and shared budgets
- At Our Future Health, it is being scaled through national data infrastructure and risk-based research
- Across NASP and the voluntary sector, it is being delivered every day through trusted relationships, local networks and front line experience.

However, the perspectives also share a warning - progress will stall without the right conditions for prevention to thrive.

Measurement is essential and whether through cost-effectiveness analysis, clinical outcomes, or patient-reported experience, we need robust, proportionate ways of tracking impact. Without this, prevention remains hard to prove and easy to deprioritise.

Funding must follow function. From research to community groups, prevention is too often funded in fragments or pilots. What is needed now is long-term investment - not just in new technologies or link workers, but in the infrastructure that supports early intervention across the system.

Most importantly, collaboration is non-negotiable. Prevention cannot be owned by any one part of the system; it demands new partnerships between primary and secondary care, NHS bodies and the voluntary sector, and researchers and front line teams. Each plays a role and none can succeed alone.

As the NHS moves into the next phase of its transformation, prevention must move from the margins to the mainstream. The models are there, the evidence is growing, the challenge now is scale and the opportunity is national.

Alistair Robertson, Partner at DAC Beachcroft, says, **"Changes to the legal framework and policy initiatives in the forthcoming 10 Year Health Plan are now genuinely enabling the 'left shift' towards prevention. In the NHS we are advising providers and commissioners on how to take advantage of these flexibilities by collaborating to deliver properly integrated care that values and rewards actions taken to prevent the need for treatment later on. This involves innovative arrangements, delegating and sharing functions across organisations, and requires careful contracting and incentive frameworks."**

Consumerisation of healthcare

In 2023, more than 400,000 British residents travelled abroad to access lower-cost medical procedures, including elective surgeries, dental work, and cosmetic treatments.

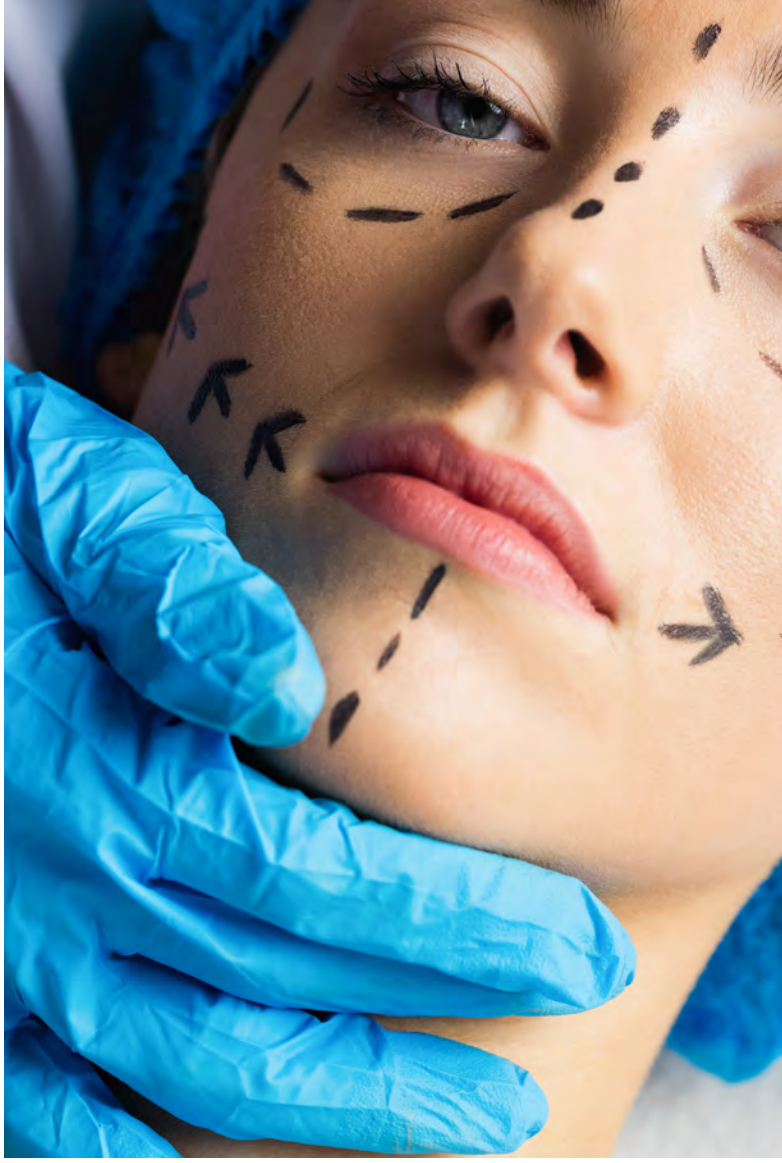
This rising trend brings increasing costs to the NHS, which is often left to manage complications when procedures go wrong.

But what are the factors fuelling this rapid rise? What are the challenges for the NHS – in particular managing issues that arise overseas? And how can this trend be better managed to improve patient outcomes and ease the NHS backlog?

Increasing patient demand and uptake

The consumerisation of healthcare has significantly influenced the growth of health tourism, particularly among British citizens seeking cost-effective medical procedures abroad. Health tourism, also known as medical tourism, involves travelling to another country to receive medical care, such as elective surgeries, cosmetic treatments, and specialised procedures.

This trend has emerged as patients become more proactive in their healthcare choices, increasingly prioritising affordability, access to specialised treatments, and shorter waiting times. As a result, an increasing number of British residents are going to places like Turkey, India, Hungary and other countries where medical treatments can be considerably less expensive and more easily accessible than in the UK. The treatments may span the full range of medical services, but most commonly include dental care, cosmetic surgery, elective surgery and fertility treatment. The Office for National Statistics indicates a notable resurgence in outbound medical tourism, with approximately 430,000 UK residents travelling abroad for medical treatment in 2023, up from 348,000 in 2022.



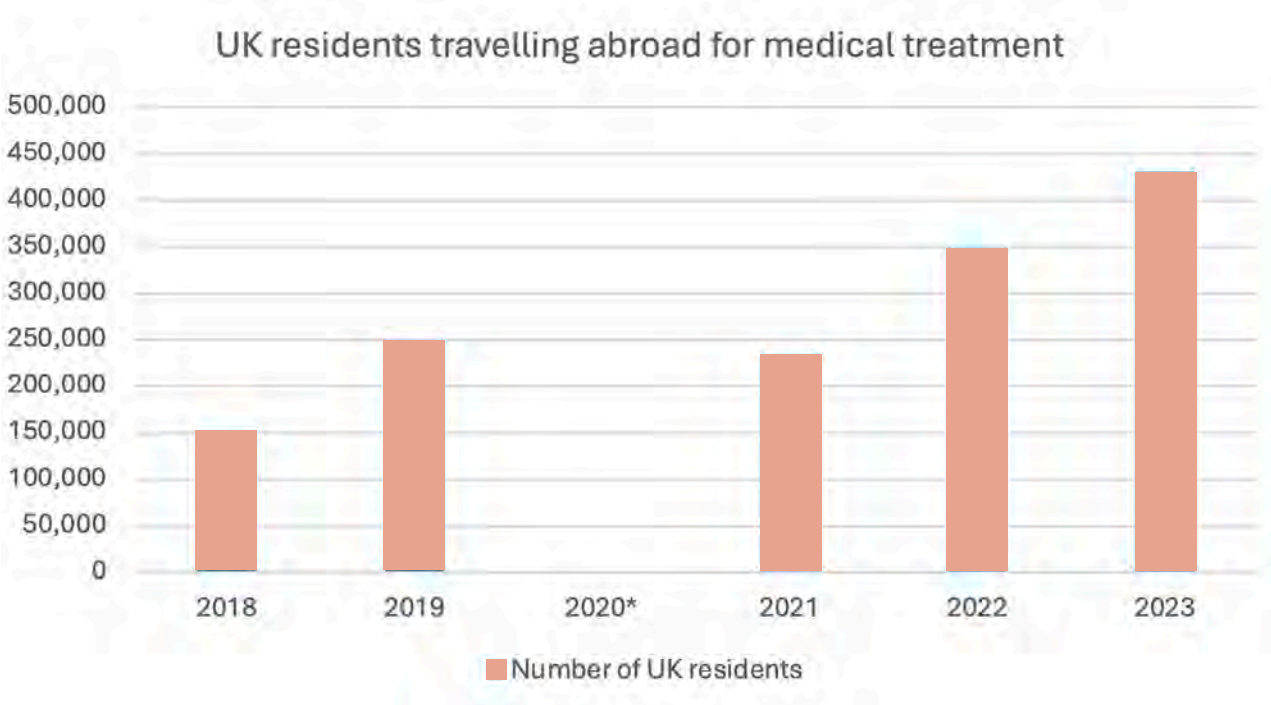


Figure 1: Number of UK residents who travelled abroad for medical treatment between 2018 and 2023

* Data for 2020 not shown due to Covid-19 pandemic, which significantly affected travel

Cost saving

The rise in health tourism is closely tied to financial pressures faced by patients seeking private care, particularly when timely treatment is unavailable on the NHS. The cost of medical and dental treatment prices can vary dramatically across countries, often due to differences in labour costs, government subsidies, and the overall cost of living. For instance, a dental implant in the UK private care system typically costs between £2,000 and £3,000, whereas in Turkey, the same procedure averages around £900.

In the UK, private knee replacement surgery can cost around £14,000, but in India, it can be performed for between £3,000 and £6,000.

This trend extends to cosmetic surgeries as well. For example, a rhinoplasty procedure costs about £2,300 in Turkey, compared to between £4,000 and £7,000 in the UK.

Omar Ahmed, Consultant Plastic and Reconstructive Surgeon, who chairs the British Association of Plastic, Reconstructive and Aesthetic Surgeons (BAPRAS) Communications Committee, says, "The reasons for UK-based people to seek treatment abroad are likely multifactorial. When it comes to aesthetic (cosmetic) surgery, often the biggest driver is the cost of the procedure. Most aesthetic surgery interventions are quite a bit more expensive in the UK than in countries such as Turkey, Poland or Lithuania. The cost of living tends to be lower in such countries and, therefore, the overheads for the surgeons are lower. This means it probably costs significantly less to establish and run clinics and hospitals in these countries.

"Another big driver is social media. There are a huge number of clinics in Turkey and eastern Europe that heavily advertise on social media, sometimes showing exaggerated results and photoshopped images, whereas surgeons in the UK don't tend to advertise to the same degree and follow very strict General Medical Council (GMC) regulations in relation to advertising."

NHS-funded treatment abroad

NHS-funded specialised commissioning abroad allows a specific number of UK patients to receive medical treatments abroad at the NHS's expense. This is reserved for highly specialised cases. These treatments may include proton beam therapy for certain types of cancer, organ transplants, rare disease therapies, and some surgical procedures.

Following Brexit, access to treatment in Europe has changed, and there are two main funding routes available:

- the S2 (Planned Treatment) Route, with a direct funding arrangement between the NHS and the chosen country's healthcare provider
- the EU Directive Route, only applicable for treatments approved before 31 December 2020, which lets patients pay up front and claim eligible costs from the NHS upon return.

For the S2 funding route, patients require prior approval from the NHS, clinician support, and written confirmation from the overseas provider detailing diagnosis, treatment, and costs. This route ensures patients receive timely and appropriate care abroad when facing long waiting times or unavailable treatments in the UK. Nonetheless, patients must find a healthcare provider themselves and organise their own travel. Key challenges include language barriers, medical communication between UK and overseas doctors, and the follow-up care. Crucially, the NHS is not liable for malpractice or treatment failures abroad, so patients must have the right insurance coverage, understand the funding routes, and be aware of the potential risks.

Currently, there is a significant gap between the number of patients seeking medical treatment in the EU and those attempting to do so via the NHS. In 2021, out of the estimated 234,000 patients who travelled for medical treatment, 152,000 went to EU countries, while only 301 patients applied for NHS authorisation for treatment in the EU. Before Brexit, that number was significantly larger, with more than 3,000 applications for NHS authorisation, as the more popular route (the EU Directive Route) was still possible. Nonetheless, that remains a small number in comparison to the overall number of patients seeking treatments abroad at their own expense.

Quality of care

The reputation and accreditation of healthcare facilities play a vital role in someone's choice. The presence of internationally accredited hospitals reassures patients regarding the standards of medical care they can expect. Turkey has rapidly established itself as a global hub for medical tourism, particularly for British tourists seeking affordable healthcare options. The country possesses a growing number of Joint Commission International (JCI)-accredited hospitals and medical centres that offer a wide range of services at lower costs compared to the UK. The JCI accreditation is a globally recognised certification for hospitals and medical centres that signifies adherence to high-quality healthcare and patient safety standards. Many people travel to Turkey for cosmetic surgery and dental procedures, lured by the combination of high-quality care and attractive pricing.

This is also the case for patients seeking care in other countries in Europe, such as Lithuania, Spain, or Hungary. For dental care, countries like Hungary and India are renowned for their large pools of well-experienced dental professionals, many of whom have international qualifications and are skilled in the latest techniques and practices.

Combining treatment with travel

This growing market is also characterised by the integration of healthcare services with leisure travel. Medical tourists can combine medical procedures and having a holiday. India and Turkey are two of the countries which offer health tourism packages including accommodation, transport, and sightseeing tours, so patients can experience the country during their stay. Various agencies provide comprehensive high-end medical treatment packages to these countries, including services like consultations, hospitalisation, accommodation, transportation, and post-treatment follow-up, for much lower than UK prices.

Photo by Mariia Belinska on Unsplash

Challenges of health tourism

The consumerisation of healthcare has led to a significant increase in health tourism among Britons. However, this trend comes with several challenges, risks and additional costs. Medical tourists may find it challenging to identify well-trained doctors and hospitals that provide high-quality care. Also, they may need post-treatment care and rehabilitation services, especially if complications arise.

Various medical associations have highlighted the challenges and risks of medical tourism. The UK's Foreign, Commonwealth & Development Office takes into account the number of UK nationals having surgical procedures in Turkey, and liaises with the government there on how best to support them.

Wes Streeting has raised concerns following the deaths of some British patients who had cheap Brazilian butt lift cosmetic surgery in Turkey. He advised people to, "think very carefully" before travelling abroad to undergo this procedure.

Gemma Brannigan, Partner at DAC Beachcroft, says, "Some lessons are being identified by English coroners, where they investigate deaths which have occurred after surgery outside of the UK. A 'Report to Prevent Future Deaths' has been published following a death in Turkey."

"Many patients are sold surgical treatments abroad as glorified holidays when they are far from it," Dr Ahmed warns. "Some are having several hours of surgery and then hopping on a three to four hour flight within a day or two. There may be lots of very skilled surgeons in the countries that cater to surgical tourism, and the UK is one of them, but it is simply not safe to travel so soon after major surgery."

BAPRAS reported a 94% increase in patients requiring post-surgical treatment after returning to the UK between 2020 and 2023. This includes life-threatening complications such as sepsis, following procedures performed abroad.

"A number of patients return to the UK after interventions abroad and then develop complications that often have to be managed in NHS hospitals. This is on the increase," says Dr Ahmed. "Consent and governance arrangements in relation to patient safety and discharge planning are crucial to get right," adds Brannigan.

The British Obesity and Metabolic Surgery Society has also emphasised that access to bariatric surgery on the NHS is limited and often frustrating. They are particularly concerned about the number of patients experiencing complications from procedures performed outside the UK. These concerns stem from the unknown quality and safety of such procedures and the risks associated with long-distance travel immediately after surgery, including the development of potentially life-threatening blood clots in the legs or lungs. Furthermore, there is often inadequate or no access to routine post-operative follow-up care, which increases the likelihood of negative outcomes such as weight regain and nutritional deficiencies.

The Human Fertilisation and Embryology Authority says fertility treatment regulations vary significantly outside the UK and advises people to check a country's legal situation before having treatment. Also it warns that reputable clinics' advertised high success rates may not be as they seem, because their data may be only for younger women with mild fertility problems. The NHS advises people seeking medical treatment abroad to identify warning signs of possible issues.

These include:
- hard sells
- lack of information
- pressure on making a quick decision
- lack of discussion of possible complication and aftercare.

Increasing worries from UK government and medical officials about the risks of medical tourism are leaving NHS doctors wondering how to deal with its adverse health effects.

They are ethically obligated to manage these complications to promote patient health. This includes treating complications, addressing psychological distress from unsatisfactory outcomes and ensuring appropriate aftercare, even for procedures unavailable on the NHS. Many of those experiencing complications often have life-threatening conditions that require emergency surgery and intensive care.

A study conducted in 2023 focusing on bariatric surgery tourism found that managing complications at the nearest hospital to Gatwick Airport - East Surrey Hospital - cost the NHS more than £100,000 in a single year. Another study by the British Medical Journal found that 20% of patients who undergo cosmetic surgery abroad experience complications necessitating follow-up care in the UK. The British Association of Aesthetic Plastic Surgeons estimated that each patient needing corrective surgery costs the NHS £15,000. Additionally, many patients require private treatment, negating any savings they may make from seeking medical care abroad.

Opportunities and risks

The expansion of health tourism necessitates a careful examination of its challenges to ensure that patients, healthcare providers, and regulatory bodies can navigate the complex landscape effectively. Health tourism can have positive effects by providing individuals with affordable treatments or access to procedures that may not be available or easily accessible in their home country. It can foster the development of a specialised private healthcare sector that caters to both local and international patients, attracting wealthier individuals to private facilities. This shift can alleviate the burden on public healthcare systems, making them more accessible to underprivileged populations. Additionally, health tourism can boost the economy of destination countries by generating revenue and creating jobs in the healthcare sector.

However, a primary concern lies in the inconsistency of quality and safety standards across different countries, which can lead to varying patient outcomes. There is a need for comprehensive regulatory frameworks that not only ensure the qualifications of healthcare providers, but also establish standardised procedures and protocols for medical treatments performed in foreign countries. The variation in standards can lead to discrepancies in patient outcomes, raising ethical questions about the safety of seeking care overseas.

Patient education plays a crucial role in mitigating these risks. The NHS recommends that people consult their GP and consider the risks that arise from surgeries and the qualifications of healthcare providers before proceeding with treatment abroad. Healthcare providers and medical tourism facilitators share the responsibility of ensuring that patients are adequately informed.

Ethical considerations must be addressed to ensure patient safety and quality of care. Many patients face ethical dilemmas as they encounter the commodification of healthcare and potential exploitation, particularly among vulnerable populations seeking affordable treatment options. Regulatory challenges include ensuring patient privacy, data protection, adherence to international accreditation standards, and the financial burden of follow-up care. While some private insurers offer coverage for complications that arise from overseas procedures, it is not yet a standard offering across all policies.

Staysure, a provider of private insurance for British residents, has warned that many who travel to countries like Turkey for medical treatments are not aware that standard travel insurance policies do not cover complications. Since Turkey lacks a reciprocal healthcare agreement with the UK, patients are fully responsible for unexpected medical costs. Without specialist cover, those who suffer complications or require corrective treatment may face substantial expenses, including air ambulance evacuation from Turkey, which can exceed £33,000. This highlights the need for greater awareness and regulatory safeguards to protect patients from financial and medical risks associated with health tourism.

This is a critical issue, as patients seeking affordable procedures abroad may face hidden costs or gaps in insurance coverage for follow-up treatments. Healthcare providers must navigate these complexities to maintain high standards of care and protect patients from potential harm. Establishing robust regulatory frameworks and ethical guidelines is crucial to mitigate risks and ensure that health tourism benefits all involved.

Could AI be a game-changer for early diagnosis?

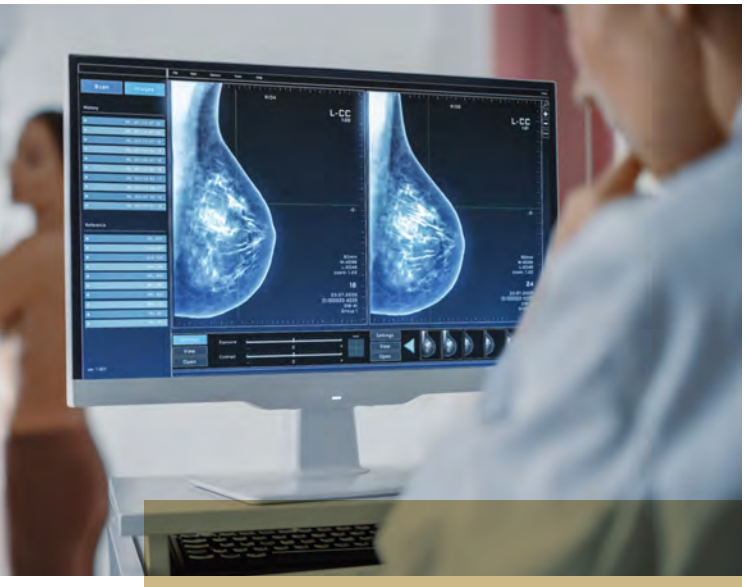
Diagnosing cancer at an earlier stage is a key priority for the NHS. AI has the potential to save lives if the NHS can adopt it at pace. Here, AI experts make the case for change.

The NHS's ambition is to diagnose 75% of cases at stage one or two by 2028, with Cancer Research UK estimating that early diagnosis could prevent thousands of deaths each year. The NHS's 2028 ambition was set in its 2019 Long Term Plan, but six years on we still have a long way to go. Data released in January 2025 showed that 58% of the most common cancers were diagnosed in stage one or two. Performance is improving, but not quickly enough for the NHS or those affected by cancer.

Fresh thinking and quicker adoption of new approaches is needed. While policymakers search for answers, a technological revolution is quietly taking shape. AI has been touted as a game-changer, offering solutions that could transform early diagnosis and streamline healthcare services.

AI is no silver bullet, but its rapid progress has sparked optimism. With trials under way across many NHS trusts, experts are cautiously optimistic that AI can help alleviate key bottlenecks in diagnostic services. The technology is already proving its worth in detecting cancers earlier, supporting overburdened radiologists, and even predicting life-threatening conditions such as stroke and dementia.

Here, some of the latest developments in research and implementation of AI in the NHS are covered, and considerations to how procurement and regulation rules can support a growing British industry.



AI analysis already showing promise

Medical research has always been the foundation of healthcare innovation, and AI is rapidly becoming one of its most powerful tools. By analysing vast datasets, identifying patterns, and accelerating discoveries, AI has the potential to revolutionise early diagnosis.

A prime example of this is the newly launched Cancer Data Driven Detection programme, a £10 million initiative that promises to transform how we detect, diagnose – and even prevent – cancer in the future.

Led by Professor Antonis Antoniou, Professor of Cancer Risk Prediction at the University of Cambridge, the multi-institutional project brings together partners across the UK and is jointly supported by Cancer Research UK, the National Institute for Health and Care Research, the Engineering and Physical Sciences Research Council, Health Data Research UK, and Administrative Data Research UK.

"The main goal of the project is to improve the understanding of who is most at risk of developing cancer and transform how cancer is prevented, detected and diagnosed early," says Professor Antoniou. "AI has the potential to significantly improve early diagnosis by analysing large. Diverse datasets and identifying patterns that can predict cancer risk.

"This ambitious new initiative aims to harness the wealth of data available in the UK and apply advanced analytics, including AI, to predict the risk of cancer in individuals, both with or without symptoms. Bringing all these different types of complex data together, exploring electronic health records, and using trajectories of disease within them to capture information that can be used to predict risk is very important."

Professor Antoniou also highlights that AI-based image analysis has already shown promise, saying, "Breast cancer is one example, where data from mammograms can be used to both diagnose the disease and to predict an individual's future cancer risk, with clinical trials recently funded to evaluate these approaches."

The initiative will also support the next generation of cancer researchers, with funding allocated for 30 PhD students and early career researchers in cancer data sciences.

Manchester leading the way with AI usage

While the UK has long been at the forefront of new discoveries, integrating innovation into the NHS can be difficult.

In Manchester, AI is no longer a futuristic concept and is being used to help doctors to detect diseases, including lung cancer, more quickly.

Seven trusts across the region have begun using a powerful new AI system that analyses chest X-rays and flags potential abnormalities in under a minute. The technology, developed by health-tech firm Annalise.ai, can detect up to 124 findings on a single radiograph. When the tool identifies potential signs of lung cancer, the scan is rapidly prioritised for clinical review - cutting average reporting times from nearly two weeks to less than 24 hours.

It is part of a co-ordinated push by the Greater Manchester Imaging Network and the Greater Manchester Cancer Alliance, funded through the NHS's Artificial Intelligence Diagnostic Fund. The goal of this rollout is to speed up diagnoses, improve patient outcomes, and reduce health inequalities across a region where lung cancer rates are 24% higher than the national average.

"We have deployed an AI system across the entire Greater Manchester imaging network to enhance early diagnosis, particularly focusing on cancer detection," says Dr Rhidian Bramley, the network's Clinical Lead for Diagnostics, Digital and Innovation.

"Our journey began with a joint procurement for a single digital imaging solution, which included a platform to deploy AI products efficiently. This procurement was a catalyst for our AI initiatives, allowing us to test the concept of deploying AI at scale and learn valuable lessons about its implementation and impact."

A region-wide deployment means that all trusts are working from a single digital platform, ensuring consistency in how AI is used and evaluated, and helping improve equity in the region.

"By bringing together all the trusts, we have created a unified approach to digital imaging and AI deployment, ensuring that the benefits of this technology are accessible to a large and diverse patient population," says Dr Bramley.

The impact is already visible. Alongside reduced reporting times, use of AI has improved diagnostic accuracy, particularly among clinicians who are not radiologists. For patients, this means faster access to follow-up tests and, potentially, earlier treatment. "We have seen a marked improvement in the accuracy of diagnoses," Dr Bramley notes. "By providing an additional image with AI findings and prioritising abnormal cases, the system enhances the accuracy and efficiency of clinicians, ultimately benefiting patient care."

Cancer Alliances help their system to avoid inequalities and ensure equitable access to innovative solutions. Dr Bramley says, "By rolling out the AI system across the whole of Manchester, we've addressed potential disparities in access to advanced diagnostic tools."

The system is still being evaluated, but early signs suggest a model that other regions could adopt. If the NHS can replicate Manchester's collaborative approach - and overcome historical barriers to change - AI could play a much bigger role in reshaping diagnosis across the country.

"It's not just about deploying technology," Dr Bramley adds. "It's about building the infrastructure, aligning the people, and generating the evidence to show that innovation genuinely improves patient care."

As more NHS regions look to harness AI, Manchester's experience offers valuable lessons in both strategy and implementation. Dr Bramley believes success depends not just on technology, but on planning, collaboration and evidence-building.

"It's crucial to define key research questions, gather comprehensive data, and build a robust business case to justify the use of resources," he says. "This approach ensures that the project is not only about deployment, but also about generating evidence to support its effectiveness and safety for patients."

The Greater Manchester model demonstrates that large-scale AI integration is achieveable, but this can only be delivered with strong digital foundations, joined-up governance, and buy-in from clinical teams.

"We managed to make this happen by centralising expertise, avoiding duplication of processes, and ensuring everyone was aligned and supportive of the project," Dr Bramley explains. "By deploying the AI system as a single instance with our digital imaging solution, we've streamlined the process and built up experience that benefits the entire network."

If replicated nationally, that experience could help the NHS finally overcome its long-standing innovation gap and deliver better care for patients across the country.

British firms must learn procurement rules

Despite its potential and the successes in Manchester, integrating AI into the NHS is not as simple as plugging in a new software system. Procurement processes are often complex, slow, and risk-averse, which can act as a barrier to innovation. If AI is to make a real impact, the NHS must rethink how it evaluates, purchases, and deploys new technology.

What does the current procurement landscape look like, how can it be improved and how might a more agile approach support the UK's own AI industry?

Katherine Calder, Partner at DAC Beachcroft and a specialist in public procurement, subsidy control and public law, explores the challenges and opportunities in bringing cutting-edge AI tools into the NHS.

Public procurement law in the UK has just undergone its biggest change in a generation with the introduction of the Procurement Act 2023 on 24 February. If I was to summarise the law pre and post the act to a layperson, they may ask whether the law has really changed - but perspective is all. The real shift for me is not so much in the detail, but rather in the policy changes that have accompanied the act and these changes should be of interest to the UK's fledgling AI industry too.

Firstly, it is important to understand why procurement law is typically seen as a barrier to UK start-ups. The point of public procurement law, when it was first introduced by the World Trade Organization (WTO), and then in earnest by the EU, was to ensure there are no cross-border barriers to trade. A tech company in the US or the EU should be able to compete on an equal and fair basis with UK companies for UK public contracts. This means a UK public body cannot reject a bid because of where the supplier is based.

However, these policies only work where trade is open and growth is abundant. Large international competitors can subsidise highly attractive bids for UK contracts and hire experienced bid writers and advisers, whilst some UK based start-ups may struggle to get the support they need to understand the basic selection criteria.

We 'are where we are' with WTO rules, but the policy and objectives underlying the new Procurement Act are intended to redress the balance and limit these rights for international competitors, where it is possible to do so while remaining compliant with international law. The new approach focuses on the four stages of public procurement - planning, defining, procuring and managing. Throughout it all, NHS bodies must have regard to the overarching objectives in the Care Quality Commission's (CQC) Regulation 12 and the National Procurement Policy Statement (NPPS), which is a short read, although much is between the lines.

The first key mission is to use public procurement to:
- kick-start economic growth through opportunities for small businesses and social enterprises across the country
- offer high-quality jobs with fair wages and good working conditions
- introduce innovation and the development of new technologies in line with the industrial strategy.

Other missions are equally as UK-focused such as 'making Britain a clean energy superpower' and 'taking back our streets'. In other words, there is a clear message here to procurers and suppliers: 'Think not what your country can do for you but what you can do for your country.'

What does 'have regard to' actually mean and what can NHS bodies do given the equality rules? It means splitting opportunities down into smaller contracts to assist small and medium-sized enterprises and setting the initial 'conditions of participation' at a level which small start-ups can meet. It means drafting procurement documentation in easy-to-understand language and carrying out significant pre-mark engagement to upskill the relevant market so it can prepare for the procurement. Forward-thinking NHS bodies already have teams engaging with local and national suppliers, upskilling them in the rules of public procurement and matching up innovators with opportunities. This must be encouraged within our AI industry.

The Social Value Model is also key to this. Every public procurement above the relevant threshold must allocate at least 10% of the scoring criteria to a bidder's offer of social value, which must be linked to one or more of the above UK-based missions.

UK suppliers clearly have the advantage here in terms of promising benefits to the local workforce, educational institutions, area and climate change targets etc. Let's allow them to use this advantage by drafting smart criteria.

NHS bodies should also take more time to understand what solutions are available in the market, why they are innovative and where the intellectual property (IP) is held in that tech. The act maintains the current exemption where only one supplier can deliver the requirements for technical reasons and or 'exclusive rights', including IP rights. NHS bodies could be bolder with this exemption and less risk-averse with their specifications where they are confident one supplier is offering something genuinely innovative.

However, for UK tech companies, what can you do to prepare yourself? Understanding the constraints and rules that apply to public procurement is important. Ensure you understand the process you're engaging in and the difficulties your NHS colleagues are facing and 'play the game'. The computer doesn't want to say 'no', but suppliers must help it by getting their bidding 'hygiene' in order. Before you bid for the first time, read procurement policy notes and identify where the pass/fail criteria are likely to apply. Review standard form 'conditions of participation' and get advice on how to read and win at scoring methodologies. Public procurement can feel like a foreign language, but one that has to be mastered.

AI innovation must consider people's privacy

AI in healthcare could be a double-edged sword. While it holds immense promise, it also raises critical questions about safety, ethics and accountability.

Regulation must play a vital role in ensuring that AI-driven diagnostics are accurate, unbiased, and safe for patients. In the UK, AI in healthcare is overseen by a patchwork of regulatory bodies. However, are these frameworks fit for purpose, how do they compare with the likes of the US and the EU, and what lessons can the NHS learn from other models to ensure AI delivers without compromising patient safety?

Darryn Hale is a Partner at DAC Beachcroft and a specialist in information law including data protection, confidentiality and freedom of information. He says,

The regulation of AI is at an interesting crossroads globally. This is demonstrated by the US and UK refusing to sign the Statement on Inclusive and Sustainable Artificial Intelligence at the AI Action Summit in February 2025. That, to some extent, exemplified the diametrically opposed approaches of the US and the EU to regulation of AI, while the UK sits somewhere in the middle. The US is currently following a very deregulated approach, while the EU continues to implement its flagship legislation AI Act, which is the first attempt to comprehensively regulate the system. It ascribes levels of risk to AI depending on its functionality and purpose and then imposes increasingly onerous obligations, depending on which risk category applies. Medical devices are deemed high-risk and so give rise to legal compliance requirements relating to quality management, post-marketing monitoring, transparency, governance and human oversight.

The UK's position to date has been to avoid specific regulation of AI. It has instead adopted a non-statutory, policy-driven approach by establishing high-level principles on the use of AI, which individual regulators should then apply to their respective areas of regulation. This means that sector-specific regulators, such as the CQC and the MHRA, will have to apply those principles when respectively regulating the delivery of care to patients and to the operation of medical devices. The Information Commissioner's Office will do so when assessing compliance with the UK GDPR.

Notwithstanding the absence of AI-specific regulation, there are a number of broader legal and regulatory compliance obligations that those developing and deploying AI in the UK will need to navigate. The UK GDPR will apply whenever personal data is used by AI, to include training it, and also contains specific restrictions around automated decision-making. The Equality Act 2010 prohibits direct and indirect discrimination against individuals based on protected characteristics, such as race, age, and disability, and so is highly relevant to AI, which carries risks of bias.

Public bodies will have to consider the Human Rights Act 1998, which could manifest itself in a number of ways, but may be particularly relevant to ingesting large volumes of data to train or deploy AI in a way which is overly privacy intrusive. In addition, public bodies will need to comply with the Public Sector Equality Duty, which includes considering the need to ensure equality opportunity between those with a protected characteristic and those without. This could be relevant in implementing AI to deliver services which could inadvertently cause digital exclusion.

It is too soon to tell which of the respective approaches to regulating AI is the right one. An entirely deregulated environment may promote innovation but cause greater risks to end users of AI, and so, in the health sector, compromise patient care. A highly regulated environment on the other hand arguably creates the inverse of that scenario. Plotting the middle course, as the UK appears to be doing, seeks to navigate between those two extremes but effectively devolves responsibility to individual regulators and so, for the health sector, much will turn on how the likes of the CQC and MHRA approach AI in practice. For the NHS specifically there is much to be said for a centralised assurance process concerning AI, which assesses against the legal frameworks outlined above and then enables ICBs and/or trusts to adopt it at greater speed. This would mirror the UK government's approach of balancing safety with innovation.

DAC Beachcroft - key contributors

Hamza Drabu
Head of Health
+44 (0)20 7894 6411
hdrabu@dacbeachcroft.com

Gemma Brannigan
Partner
+44 (0)20 7894 6027
gbrannigan@dacbeachcroft.com

Charlotte Burnett
Partner
+44 (0)113 251 4785
ckburnett@dacbeachcroft.com

Katherine Calder
Partner
+44 (0)191 404 4060
kcalder@dacbeachcroft.com

Emma-Jane Dalley
Partner
+44 (0)117 366 2960
ejdalley@dacbeachcroft.com

Darryn Hale
Partner
+44 (0)20 7894 6125
dahale@dacbeachcroft.com

Anna Hart
Partner
+44 (0)191 404 4177
ahart@dacbeachcroft.com

Alison Martin
Partner
+44 (0)117 918 2318
amartin@dacbeachcroft.com

Udara Ranasinghe
Partner
+44 (0)20 7894 6727
uranasinghe@dacbeachcroft.com

Alistair Robertson
Partner
+44 (0)20 7894 6020
arobertson@dacbeachcroft.com

Corinne Slingo
Partner
+44 (0)117 918 2152
cslingo@dacbeachcroft.com

Gill Weatherill
Partner
+44 (0)191 404 4045
gweatherill@dacbeachcroft.com

With thanks to all our guest contributors
Dr Raghib Ali, CEO and Chief Medical Officer of Our Future Health
Omar Ahmed, Consultant Plastic and Reconstructive Surgeon, Newcastle Hospital NHS Foundation Trust
Professor Antonis Antoniou, Professor of Cancer Risk Prediction at the University of Cambridge
Dr Rhidian Bramley, Clinical Lead for Diagnostics, Digital and Innovation at the Greater Manchester Imaging Network
Dr Nav Chana, Senior Partner at Cricket Green Medical Practice and Non-Executive Director at Lewisham and Greenwich NHS Trust
Professor Andreas Terje Eikemo, Director of Centre for Global Health Inequalities Research
Joe Gallagher, Vice President of Indigenous Health and Cultural Safety at the Provincial Health Services Authority
Charlotte Osborn-Forde, CEO of the National Association for Social Prescribing (NASP)
Lawrence Tallon, CEO of the Medicines and Health products Regulatory Agency (MHRA)

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