UK YOUTH

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A preventative approach to public services

How the government can shift its focus and improve lives

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About this report

This report looks at the barriers to a more preventative approach to public services, how these could be overcome, and the benefits to the government and public

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Executive summary

A stitch in time saves nine. The idea that taking early action reduces the need for more expensive or intensive action later is instilled in idiom and learned in everyday life, from applying sun screen to fixing a leaking roof. Prevention, after all, is better than cure. There is a strong case for the government to adopt this idea more widely than it currently does.

We know it works because the public sector has been doing it for decades. There is good evidence that investment in benefits, primary care, public health, youth work and Sure Start centres, among other services and programmes, all delivers meaningful benefits. These accrue both to the citizens who use them, whose lives are improved, and in monetary terms for the governments that have funded them.

There are also local examples of councils achieving more by focusing on prevention. In Wigan, for example, the council has made substantial savings while significantly increasing healthy life expectancy and improving the quality of social care services.[1] Individual preventative interventions can be hard to target, take time to evidence and cannot offer guaranteed benefits – but the evidence is clear that a wide range of preventative programmes deliver meaningful returns.[2]

But while governments have often claimed a desire to pursue preventative policies, they have frequently struggled to match lofty rhetoric and ambitions with a meaningful shift in approach in policy making. Indeed, since 2010, and across a wide range of services, political attention – and with it, funding – has been pulled towards acute services. This is seen, for instance, in local authority spending on services for young people and children's services being cut by more than three quarters (77.9%) between 2009/10 and 2022/23, while spending on looked after children and safeguarding services rose by more than half (58.1%) over the same period.

Fortunately, history is not destiny. A different approach is possible. While it is made more challenging by the scale of acute demand and the tightness of public finances, those same pressures necessitate a shift towards prevention: without meaningfully limiting the growth in acute demand, it will become increasingly difficult to deliver high-performing public services, at least while keeping taxation and government debt at sustainable levels. This is recognised both by the government, which has put prevention at the centre of the public sector's productivity plans, and by Labour, which has called for "a 'prevention first' revolution".[3]

What is prevention?

The first step to taking a preventative approach is defining it. This is easier said than done. While there is a core of programmes that are clearly preventative, others contain both preventative and acute elements. Even in our interviews and roundtable there was often little consensus about what 'prevention' means or how the government should implement it. One interviewee's view was that "all government spending is designed to prevent something worse from happening".

To design a prevention strategy and implement a spending ringfence to support it – both key recommendations we put forward – the government will need to define which programmes it thinks are preventative. That will require it to draw a line through the unclear cases. We identify three key common characteristics to prevention. Most critically, there is a core criterion that should underpin all the prevention policies – including regulation, tax measures, benefits spending and service delivery:

- *Prevention reduces the likelihood or severity of acute demand.*

In addition to the core criterion, as regards preventative spending:

- *Preventative spending is not incurred in response to acute demand.*

- *Preventative spending improves the allocative efficiency of government spending.*

Barriers to prevention

There are various barriers that have made it harder for governments in recent years to adopt a more preventative approach. Critically, it has been the interaction of longstanding issues with austerity in the 2010s that has incentivised many parts of the public sector to cut spending on prevention in recent years.

- **When budgets are tight, acute pressures crowd out preventative spending.** Problems in acute services have more political salience – they are more visible to the public and politicians. Conversely, the impact of cuts to preventative services may not be felt for years. One result of the approach to austerity taken from 2010 was to encourage the public sector to protect acute parts of their budgets at the expense of preventative parts.

- **Political incentives do not align with taking a preventative approach.** The political cycle is short, while the benefits of preventative policies can take years (if not decades) to be felt. Shifting to a preventative approach can also often carry some risk, but a culture of blame makes policy makers risk averse. And the benefits of taking a preventative approach regularly accrue to other parts of government, further reducing the incentive to act.

- **Insufficient evidence for some preventative interventions means it is challenging to convince policy makers to spend more on prevention.** It is difficult to build an evidence base for many polices but prevention poses some unique challenges as it can be difficult to prove causality for early interventions and the benefits may not be realised for years.

- **Siloed funding and service delivery hinders prevention.** Policy making, funding and service design are siloed, often around Whitehall departments. But people's needs and interactions with public services are more complex. Rigid siloes make it harder to take preventative measures, as the benefits usually accrue to a different part of the public sector.

- **Overcentralisation makes it harder to shift to a preventative approach.** The government is overly centralised, too often designing and managing programmes from Whitehall, making it difficult for local areas to create preventative services tailored to local needs. Fragmented and short-term central funding streams also make it harder for local services to invest in prevention.

What should the government do to overcome these barriers?

None of these barriers is insurmountable. Funding mechanisms can be redesigned, evidence can be improved and power can be devolved. Most critically, political leaders can prioritise prevention – even in the face of pressures in the opposite direction. And this report includes examples of those who have done so.

Many more would like to do so but find the weight of incentives pushes them to act against their own instincts and the best interests of their constituents. Change will require putting a thumb on the scale in favour of prevention. We set out a five-point plan showing how an incoming government could do that.

1. Make prevention a political priority

Ministers and other politicians must lead from the front. When prevention has been most successful it has been because senior politicians – nationally and locally – have focused government's attention on it. Without political prioritisation, it is unlikely that other measures will be able to make a meaningful shift to prevention.

2. Embed prevention into the spending framework

A government committed to taking a preventative approach will want, over time, to substantially increase preventative spending. But doing so will not be cost free, and will require making trade-offs between spending, taxation and borrowing. The government should restructure decision making on public spending to encourage this shift. To do this:

1. The Treasury should publicly set out criteria for what it believes constitutes 'preventative spending'.

2. Government departments should then propose which service areas or programmes meet that definition, as part of a spending review process.

3. The Treasury and the Cabinet Office should then encourage joint spending bids from departments, as many preventative programmes will require cross-departmental working.

4. The Treasury should determine which bids meet its prevention definition and propose funding allocations in line with that.

5. The prime minister and chancellor should agree to ringfence that funding, with departments and other public bodies able to shift spending between different preventative programmes – but not outside them.

6. The Treasury and the Cabinet Office should then develop a cross-government prevention strategy, which includes the final decision about which programmes to include in the definition and should be published alongside the spending review. This would also include details on how other policies not captured within a spending definition, such as regulation changes, would contribute towards meeting the government's prevention objectives.

7. Finally, the Treasury should fund thorough evaluations of this preventative spending to build the evidence base.

3. Embed prevention into the government's performance framework

The government should translate its high-level priorities into a clear performance framework, using interim metrics of success when outcomes may take years to materialise. This framework should build on the existing outcome delivery plan (ODP) system. The government should then track progress against those metrics and be open about successes and failures.

4. Support local areas to spend preventative budgets how they see fit

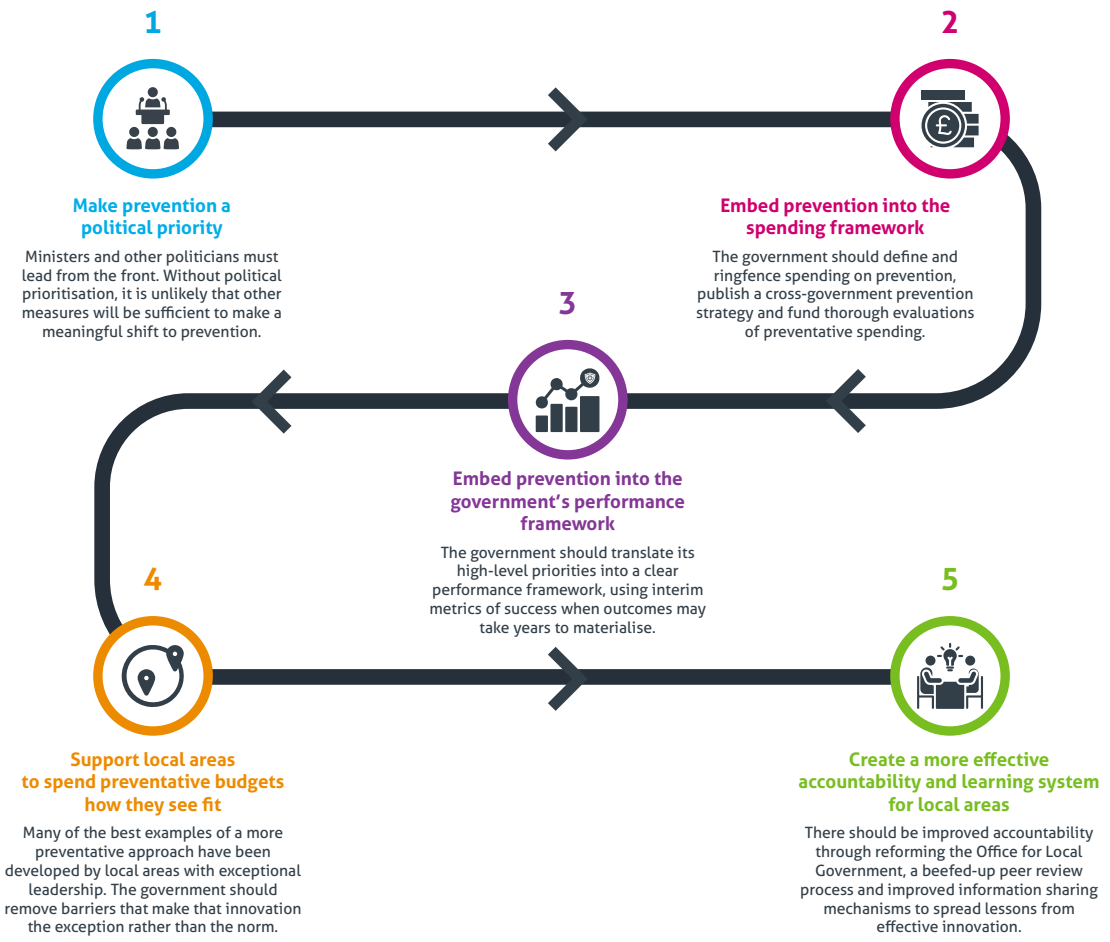
Many of the best examples of a more preventative approach have been developed by local areas with exceptional leadership. The government should remove barriers that make doing so the exception rather than the norm. This includes: reducing ringfencing around small pots of money, but putting a broad ringfence around areas of spending that local areas can use for preventative services; providing services and local authorities with longer-term funding settlements; designing financial flows that incentivise prevention; and providing political cover for local leaders to innovate.

5. Create a more effective accountability and learning system for local areas

Central government can improve local accountability by reforming the Office for Local Government into the Office for Government Improvement and Learning – to enable local and central government to hold one another to account. Key to this would be a beefed-up peer review process and improved information sharing mechanisms to spread lessons from effective innovation.

Most of the changes recommended in this report could, with committed leadership, be implemented fairly quickly. If done so shortly after the general election, the next government (whoever leads it) could start to reap the financial and political benefits of doing so before it next went to the country. But most importantly, and fundamentally, after a period in which unwanted records such as the size of NHS waiting lists have been broken time after time, the impact of these changes would be felt for decades – through the slowed growth in acute demand for services, and in the happier, healthier lives of millions.

Figure 0.1 **Five-point plan for prevention**



Source: Institute for Government analysis.

Scope of the report

This report is based on dozens of interviews, six detailed case studies (found in Annex A) and a high-level roundtable with current and former senior policy makers from the centre of government, departments, local government, the NHS and wider public sector. It first examines why prevention has not been prioritised in recent years and then sets out how any government that is serious about bucking this trend and taking a more preventative approach can do it in practice.

1. What is prevention?

Many policy makers talk confidently about prevention without explaining exactly what they mean by it. This leaves the public sector and others to interpret these pronouncements – which they may do in wildly different ways. This is a problem for any government that hopes to make a coherent shift towards a preventative approach.

This chapter looks at why it is so difficult to define prevention, and offers our view on what the defining characteristics of it might be. We do not offer a neat definition of prevention – we do not think there is one. There is not an obvious, objective way of distinguishing between acute and preventative services, policies and programmes; some are clearly more preventative, others are more distinctly acute, but many if not all will contain both acute and preventative elements and in some ways, this only becomes politically important at the point when a government has to decide how to allocate spending on prevention.

Policy makers have advocated prevention for decades, if not centuries

The concept of prevention in public services is not new. Benjamin Franklin is credited with coining the phrase "an ounce of prevention is worth a pound of cure" when discussing Philadelphia's fire service as early as 1736.[1] In the UK, the 1946 Health Act, which established the NHS, stated that it is the "duty of the Minister of Health to promote the establishment of a health service to secure improvement in the physical and mental health of the people and the prevention, diagnosis and treatment of illness".[2]

The Treasury and Cabinet Office launched the Invest to Save Budget (ISB) programme in 1998/99, which encouraged, among other things, investment in early intervention programmes.[3] As chancellor, Gordon Brown commissioned a review of the long-term trends that affected the health service in 2001. The Wanless review, published in 2002, argued that:

> **"improved public health, through health promotion and disease prevention, could therefore have a significant impact on health status and ultimately the demand for health services and the resulting cost".**[4]

As health and social care secretary, Matt Hancock was vocal in his support for prevention[5] and supported its inclusion as one of the key planks of the NHS Long Term Plan in 2019, which "set out new commitments for action that the NHS itself will take to improve prevention".[6] And in a speech setting out the priorities for her time in office, Victoria Atkins – appointed health and social care secretary in November 2023 – identified prevention as an area which "could [make] a real difference".

This rhetorical commitment to prevention looks unlikely to change whoever wins the election, with shadow health secretary, Wes Streeting, returning to Franklin's famous idiom to state that "prevention is better than cure".[7] And his party's mission to "build an NHS fit for the future", includes a commitment to "deliver a 'prevention first' revolution"[8] through policies such as encouraging cross-departmental working, launching children's health plans, making Britain "smoke-free", improving health in the workplace, expanding the number of health visitors and reducing health inequalities.[9]

There is little agreement on the definition of prevention

The benefits of acting early to save money or time later feel implicit. Politicians also like to talk about prevention, often while intoning appealing, but vague, phrases.[10,1112,13] But when it comes time to precisely label services, programmes and policies as preventative or not, there is much less agreement. Despite these debates, there is an irreducible core of government activity that is clearly designed to be preventative. Vaccination programmes, health visits for new parents and restrictions on alcohol or tobacco products are all clearly designed to prevent poor outcomes arising in the future.

However, across the dozens of interviews and the roundtable that we conducted for this report, no two people gave the same definition of prevention in the context of public services. There were three main areas of disagreement.

First, it is unclear which services are truly preventative. As many people pointed out to us, all spending by government is designed to prevent something worse from happening. Even ambulances – maybe the clearest example of an acute service – are designed to prevent someone dying, or their condition worsening, as they are transported to a hospital. Less dramatically, there was also debate about whether some (or all) spending in primary care could be classified as preventative; a similar point was made on education spending.

A service could also be argued to be preventative or acute when seen from different perspectives, including those of different parts of government. For example, pressures on local authority budgets since 2010 mean that councils have increasingly provided adult social care to only those with the most acute need.[14] But adult social care itself – when provided effectively, at least – will also prevent hospital admissions. From the perspective of local government, therefore, adult social care is an acute service, but preventative when viewed by the NHS.

Second, and relatedly, there is no agreement about what a preventative programme should achieve. For some, the primary goal is to cut demand for acute services and in turn reduce the amount that the government spends on public services. For others, it is as a means of improving outcomes like healthy life expectancy or recidivism rates. These goals are not necessarily mutually exclusive. But there can be times when they come into conflict. For example, when children attended Sure Start, they were more likely to be admitted to hospital in the short term, implying an increase in the cost of acute services (though this trend reversed in the longer term), while likely improving health outcomes throughout their lives.

Third, there are countless ways that a government could pursue a preventative approach. Some favour using relatively small-scale programmes, funded by central government, to target people right before the point of acute need. Others prefer to 'zoom out' and see the best way to prevent acute demand for public services as being to reduce the amount of poverty in the country, primarily through more generous benefits. There is also the possibility of using regulation or taxation to stop or disincentivise behaviour. Others still think that prevention requires a whole new approach to designing and delivering services.

In many ways, these debates are largely academic – until the money comes in. At the point government makes decisions about future allocations it will need to decide which programmes it deems to be preventative and which it does not. This is an important process, and will require politicians to make difficult decisions (more on which below). However, a government deciding that a programme does not fall under its definition of preventative spending does not mean it is not preventative. It merely reflects the political reality that a line has to be drawn somewhere.

Technical definitions help to bring some, if not total, clarity

The debate over the definition of prevention need not start from scratch. There are already technical definitions of different forms of prevention. This includes a typology of three stages of prevention: primary, secondary and tertiary.

Primary prevention covers intervening to reduce harms developing in the first place.[15] These interventions are more likely to be universal, or else very widely targeted at high-risk groups. Many public health interventions fall into this category. For example, the government offers free measles, mumps and rubella (MMR) vaccinations to infants to reduce the likelihood that they will develop these diseases in the future. In the criminal justice system, primary prevention could aim to build relationships between the police and communities, with the goal of reducing conflict, improving communication and, ultimately, reducing the likelihood of crime.[16,17]

Secondary prevention aims to detect the early stages of diseases or harms and intervene to stop them developing into a severe case.[18] These are generally more targeted than primary interventions, such as screening parts of the population for certain types of cancer to catch them in their early stages. For example, the NHS invites all women aged between 50 and 71 to come forward for breast screenings to diagnose breast cancer early.[19] Another example would be the NHS Diabetes Prevention Programme (see Case Study 2 in Annex A). In criminal justice, secondary prevention would be identifying young people who were at risk of committing crime and diverting them to other activities.[20]

Tertiary prevention involves intervening to reduce the impact of a disease or condition after it has developed,[21] such as rehabilitation services for someone who is discharged from hospital following a fall. The aim is to help that person live independently and reduce the likelihood that they will need to be readmitted.[22] The CARA programme (see Case Study 5) is another example, in which people who have committed domestic abuse attend workshops to reduce the likelihood that they will reoffend.

The terms 'early intervention' and 'early help', though sometimes used interchangeably with prevention, tend to be used to refer specifically to preventative work with children. From there, some distinguish between early intervention and early help, with the former referring to more targeted and intensive programmes, and the latter covering universal services.[23]

A further quirk is that some interviewees challenged using 'prevention' at all for the service-based interventions described in this report. They argued that these programmes are better thought of as early intervention and that true prevention only comes from alleviating poverty and the wider drivers of interactions with public services, particularly through the provision of benefits and housing.

There are common characteristics of preventative spending

If any future government wants to meaningfully track its progress on prevention, it will eventually need to settle on a definition. Key to creating a definition is drawing a line through 'edge cases', including some and excluding others.

To do that, the government should assess the extent to which an intervention or policy – including regulation, tax measures, benefits spending and service delivery – meets these common characteristics:

- **Prevention reduces the likelihood or severity of acute demand.** This means that prevention reduces future government liabilities, though it will not necessarily result in short-term cashable savings.

In addition to the core criterion, we recommend two further criteria for preventative *spending*:

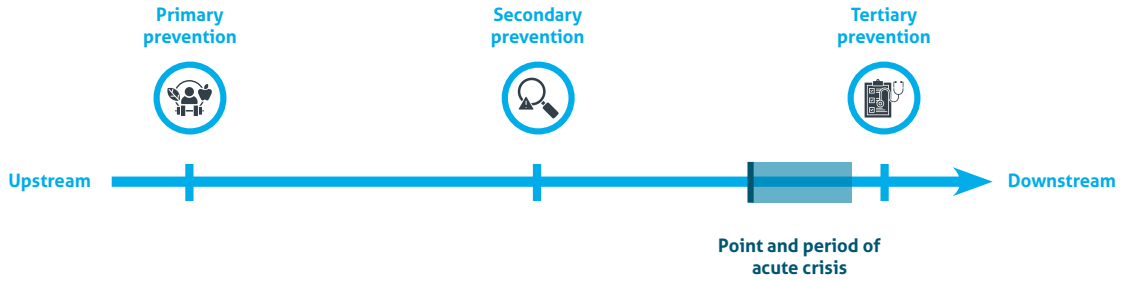
- **Preventative spending is not incurred in response to acute demand.** Prevention can involve supporting those with high levels of need, including immediately after a crisis. But support provided during a crisis – however long that may be – should not be considered preventative.

- **Preventative spending improves the allocative efficiency of government.** This means achieving the best outcomes for the money spent, for example by spending the marginal health budget on public health, rather than NHS services.

Defining 'acute' services

Throughout this report we also refer to 'acute' services. We define these as services that people rely on when their need is severe, and they are in a period of crisis. This differs from the medical definition, which usually means sudden or short-lived,[24] because acute demand for public services can last weeks or even years and can gradually worsen or improve throughout that time. It can be a need for treatment following a stroke, support for an adult to live independently at home or when a child is taken into care. It can also apply to someone convicted of a crime being sent to prison. Acute services tend to be the ones that people fall back on when there are no other options. Most services have a mixture of acute and preventative characteristics.

Figure 1.1 **Illustrative timeline of the timing of preventative interventions**



Source: Institute for Government analysis.

We also refer to 'upstream' and 'downstream' interventions. Upstream interventions are designed to address a need long before the point of acute crisis, and deal with factors such as lifestyle or the lived environment. 'Downstream' interventions are those that come closer to the point of crisis, or in the case of tertiary prevention soon after it.[25]

Defining prevention is important to effectively measure it

Famously, what a government measures, matters. But with no agreed definition there is no way of measuring what the government spends 'on prevention', making it much harder to hold policy makers to account for their decisions – bringing with it questions of democratic accountability. Currently, policy makers of all political hues can claim that they will make a shift to prevention, without ever clarifying what they mean. Indeed, the academics Cairney and St Denny even argue that the ambiguity around definitions of prevention is a core reason why it is so attractive to politicians.[26] Without a clear guide on what politicians mean when they make these promises, it will be impossible for voters to judge them against their pledges.

In an ideal world, this would not matter and policy makers would invest in prevention because of its benefits to the public. But for reasons discussed below, there are major political, practical and fiscal barriers to a shift towards a preventative approach.

Much of this ambiguity could be removed if the government set out its own definition. This would necessarily be a political choice – after all, there is no single, objective way of defining prevention or preventative spending – but defining the term at the centre of government would be beneficial as part a wider prevention strategy.

The case for a preventative approach is strong – and arguments against overstated

There is a widely held view, including in our interviews, that there is a lack of evidence on the benefits of a preventative approach in government. This is partly true: some new, more radical or transformative preventative programmes have a poor evidence base, partly because (by definition) they have not been tried before, and partly because it can be difficult to gather evidence for some preventative programmes (discussed in more detail in Chapter 3). But these arguments are overstated, for a few reasons.

First, we know prevention can work because the government does a lot of it already. Shifting to prevention is often not about rolling out a new programme, or radically redesigning existing services, but just better funding existing services or benefits where quality and accessibility have declined in recent years. For example, there is good evidence that investing in primary care and public health is either cost effective[27] or reduces demand for acute services,[28,29] while it has been estimated that scrapping the two-child limit on parental benefits, introduced in 2017, would lift nearly half a million children out of poverty,[30] with benefits being felt in acute services as a result.

Second, where a new preventative approach has been tried before, it has often been found to work. We explore six case studies in Annex A that had strong positive outcomes: Sure Start led to better health and education outcomes for children that attended; Project CARA reduced the rate of reoffending among perpetrators of domestic violence; the Supporting Families Programme led to fewer children being taken into care; the Diabetes Prevention Programme made it 20% less likely that participants would develop type 2 diabetes two years later; evaluations of youth work show that there is a "clear association" between regular youth club participation and improved education, health and wellbeing; reversing the two-child benefit cap would reduce child poverty, which would then lead to improvements in outcomes and likely a reduction in demand for acute services. These are only a few examples of positive outcomes from preventative programmes.

Third, there are good examples of prevention being implemented in local areas which are not shared nationally. In 2012, Wigan council launched the Wigan Deal, which promoted better cross-agency working to bring together local public services.[31] Gateshead council has pioneered its 'liberated method' which puts the needs of individuals rather than arbitrary siloes at the heart of service design.[32] Camden council has protected preventative spending in children's services in the face of national funding cuts and has consequently seen a steady fall in the number of looked after children in the borough.[33] These examples show that prevention is possible, but that at the moment it relies too heavily on exceptional leadership.

Given the lack of evidence for some preventative programmes, the government will have to be willing to take risks when investing – at least in the short term while the evidence base grows. The most sensible approach will be to invest in a broad portfolio of preventative programmes, accepting that some will deliver the benefits promised while others will not. And in many cases a shift to prevention needn't cost billions, with changes to regulation or tax potentially even raising revenue.

A shift towards a more preventative approach would be beneficial to most people in the UK but also to the government. It would reap the benefits of a better-educated, healthier, better-skilled and more satisfied population while such an approach would also – fundamentally, in an ageing society – slow the rate at which spending on acute services will grow in the coming decades.[34] The rest of this report will identify why this has to date not happened – specifically looking at spending trends away from prevention since 2010 – and what steps the government could take to facilitate a shift.

2. Spending trends

Since 2010, there has been an increase in the proportion of at least some parts of government spending on acute service provision, while the proportion of budgets spent on preventative services has generally fallen. This pattern is observable in health and social care, local authority housing services and children's services, among others.

This chapter will use the example of children's services to explore some of the causal factors and the implications of preventative spending cuts.*

There has been a rise in spending on acute children's services

Local authorities provide a range of services for children. These include: commissioning providers to take children into care; working with other agencies to safeguard children; operating children's centres; funding youth work provision; and running services to keep children and young people away from crime, among others.

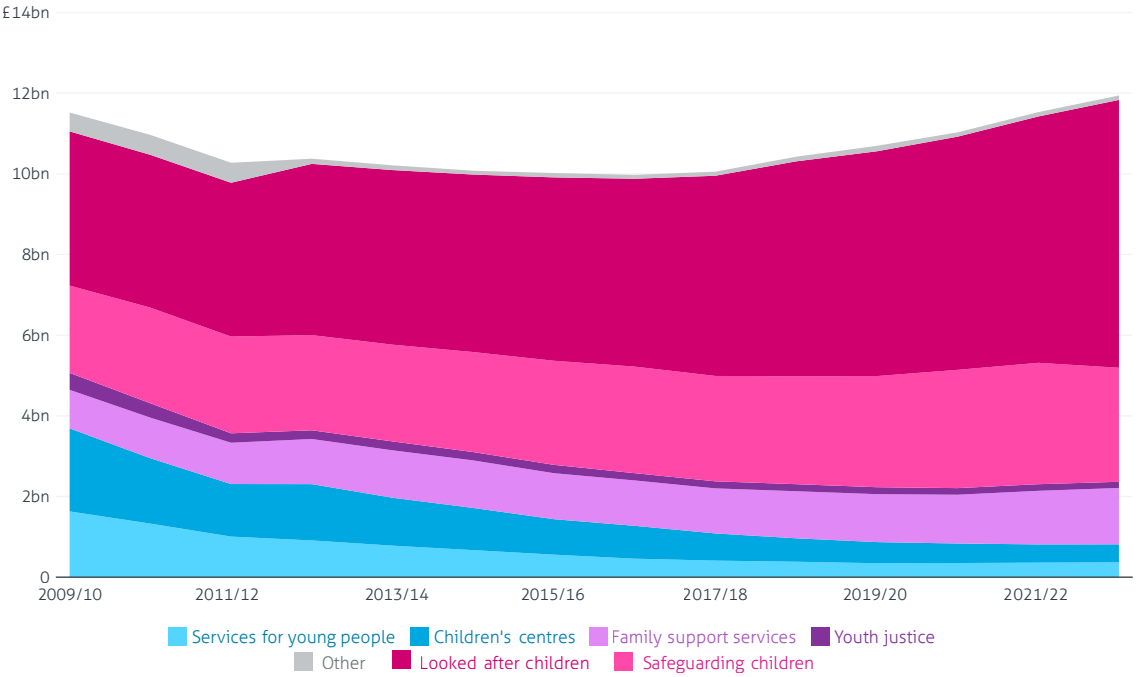
Overall, local authorities spent 3.7% more in real terms on 'children's services' in 2022/23 than in 2009/10. But the overall spending level only tells part of the story; the *way* that local authorities spend their children's services budget has changed drastically in that time.

Services specifically for young people and children's centres – shown in blue in Figure 2.1, overleaf – are both spending areas that have broadly preventative characteristics. Children's centres provide universal, early-years services to families and help signpost them to other services that might be of help to new parents.[1] Youth services are intended to provide positive activities for children, improve their emotional and social development and facilitate appropriate and timely access to other universal services.[2] By 2022/23, local authorities had cut spending on those areas by more than three quarters (77.9%) in real terms compared to 2009/10, and the proportion of local authorities' children's budgets spent on those two services had fallen to 6.8% – down from 32% in 2009/10.**

* The experience of children's services is instructive for a few reasons. First, local authorities offer a range of children's services which fall along the spectrum between early intervention and acute (see Figure 1.1). Second, there is a reliable time series of spending data that goes back to 2009/10 and which can be disaggregated into more detail, which can then be broadly (though not perfectly) categorised as more or less preventative. Details of changes in health and social care and housing spending are presented in Annex B.

** This has happened despite local authorities having a statutory duty to "secure as far as is reasonably practicable, sufficient provision for educational and recreational leisure-time activities for young people". See www.legislation.gov.uk/ukpga/1996/56/section/507B

Figure 2.1 **Local authority net spending on children's services, by type of service, 2009/10–2022/23 (2022/23 prices)**



Source: Institute for Government analysis of Department for Education, 'Local authority and school finance', 2009/10–2019/20. Notes: 'Children's centres' refers to the spending category 'Children's centres and children under 5'. 'Safeguarding' is shortened from 'Safeguarding children and young people's services'.

In contrast, local authorities have spent an ever greater proportion of their children's services budgets on looked after children and safeguarding services (pink in Figure 2.1). Both of these services are statutory, and fall at the far acute end of the spectrum for children's services. Spending on those services rose by 58.1% in real terms between 2009/10 and 2022/23 – at which point local authorities spent four fifths of their children's services budgets on those two areas (79.3%), compared to just over half in 2009/10 (52%).

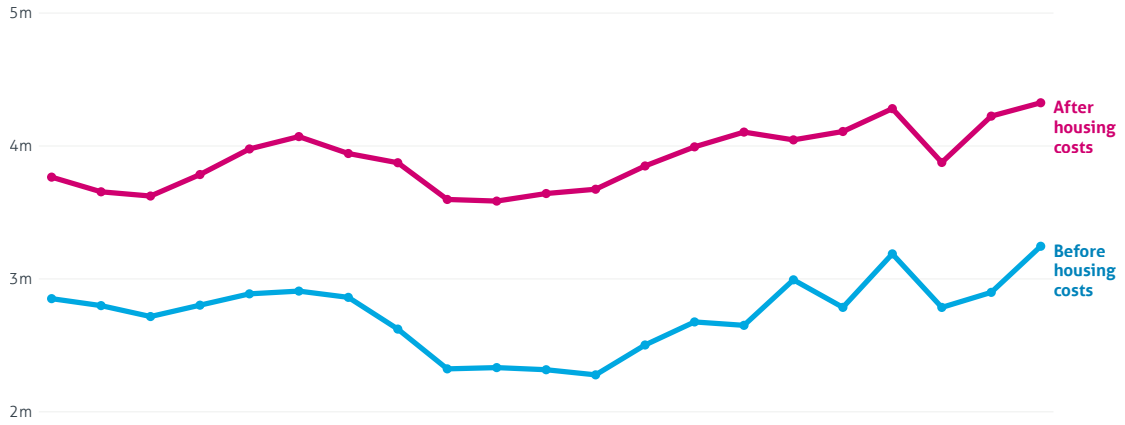
Several factors contributed to this change

The reasons for this change in local authorities' spending on children's services are complex. The number of children in care rose from 64,470 in 2009/10 to 83,840 in 2022/23 – an increase of 30%.[3] This was in part because of a drop in the number of children leaving care each year. But there were other factors at play. As the Independent Review of Children's Social Care states, "rates of child poverty, effectiveness of benefits, and availability of wider universal services are intertwined with the need for children's social care services".[4] Arguably all three of these factors have moved in the wrong direction since 2010.

Poverty is a key factor. Children living in the most deprived decile of neighbourhoods were 10 times as likely to be in care or on protection plans than those in the least deprived decile.[5] Work from the Department for Education (DfE) also found that children living in deprived areas and with lower family incomes are more likely to interact with children's services – though the report does not assign causality to this relationship.[6] And one study found that "a 1 percentage point increase in child poverty was associated with an additional five children entering care per 100,000 children".[7]

Regrettably, from a low of 3.6m in 2011/12, the number of children living in relative poverty (after housing costs) in the UK steadily grew to a record high of 4.4m in 2022/23 – a rise of 20.6% compared to 2011/12.[8] This has undoubtedly placed additional demand on acute services.

Figure 2.2 **Children living in relative poverty, before and after housing costs, 2002/03–2022/23**



Source: Institute for Government analysis of Department for Work and Pensions, 'Households Below Average Income: an analysis of the UK income distribution', 1994/95–2022/23.

The government is also spending less per person on working age benefits than it was in 2010. The amount of per capita benefit expenditure fell by 21.9% in real terms between 2010/11 and 2019/20.[9] The government has also made child benefit less generous over time. In 2013, for instance, the government changed child benefit from universal to means tested.

Finally, cuts to preventative services also contribute towards increased levels of acute demand. Early intervention children's services are effective at recognising problems early and either intervening themselves or directing the children and families towards the most appropriate service. For example, children who attended Sure Start centres were more likely to attend hospital then their peers at age one[10] – potentially as problems that might have gone unnoticed were detected by staff[11] – but as those children aged they were less likely to be admitted to hospital than their peers, potentially due to factors such as a reduction in the prevalence of preventable diseases, improved parenting due to information provided through Sure Start centres, and a reduction in admissions for weight-related issues due to better spaces for active play.[12] These effects are also strongest in the most deprived parts of the country, indicating that early intervention could be a way to reduce health inequalities[13] (see Case Study 2)

Similarly, there is good evidence that youth work (Case study 4) improves mental and physical health, and helps people to avoid negative outcomes like interactions with social care and the criminal justice system. A working paper looking at the effect of shutting down youth centres found that the closure of a youth centre was linked to a 10% increase in the number of crimes – particularly drug-related offences – committed by 10- to 18-year olds living nearby.[14]

Another study found a statistically significant, if small, improvement in health outcomes for children that engaged in youth work both in the short term and as they continued into adulthood.[15]

Despite these benefits, local authority spending on services for young people and Sure Start has been cut dramatically since 2009/10. This led to a damaging feedback loop of spending cuts (partially) contributing to rising acute demand. As the Independent Review of Children's Social Care said in its *Case for Change* report*:*

> **"At a time of wider budgetary pressures, local authorities trying to balance their books are increasingly stuck in a cycle of spending more on short-term reactive interventions, including the most drastic measure of moving children away from their family to live in a residential home, at the cost of the preventative work that could lead to better long-term outcomes for children and families."**[16]

Those patterns are repeated across various services

Other services have seen similar changes in the way that money is spent. Within local authorities, this is particularly true in housing services. Spending on homelessness services – incurred either immediately before or at the point when someone becomes homeless – now accounts for a far greater proportion of spending than it did in 2009/10, while again more preventative service spending has fallen in both absolute terms and as a proportion. Similarly, spending in health and care services is now even more tilted towards acute services than it was a decade ago (please see Annex B for more details on housing and health and care services).

As with rising demand for acute children's services, the causes of higher acute spending in these areas are complex, but have likely also been driven by a combination of high numbers of people living in poverty, reduced generosity of benefits and cuts to preventative services.

3. Barriers to a more preventative approach

Despite broad agreement on the unsustainability of increased acute spending, there has been little success at fundamentally shifting government towards a more preventative approach. This chapter looks at why this is the case.

Acute pressures crowd out preventative spending when budgets are tight

Politicians may have ambitions to make a shift towards prevention before coming to office, but these do not often survive the reality of being in office. In a Ministers Reflect interview with the Institute for Government, James Brokenshire said that even though he felt relatively well prepared for his job as minister for crime prevention, he still warned that "You have to be prepared for some of the more operational stuff that just gets thrown at you".[1] It is, after all, very hard for a minister to focus on improving the wider determinants of population health when there are ambulances queuing outside hospitals or staff undertaking industrial action.

The inevitable trade-offs faced by ministers are much harder when budgets are being cut, or growing at a rate that fails to keep pace with demand and other pressures – as the governments since 2010 have done for many services.[2]

In a tight fiscal environment, policy makers will often choose to prioritise spending on acute services over spending on preventative ones. This is partly because of political incentives – acute pressures are often far more visible to the public – but also because providers often have a statutory (that is, legal) duty to deliver those services. This also makes it harder for agencies to economise on those services.* When confronted with a choice between breaking their budgets, failing to meet their statutory duties or cutting non-statutory preventative services, most providers will choose the last option.

There is also often little immediate political cost to cutting preventative spending. In the case of holding down welfare spending, governments since 2010 have found it politically advantageous to be seen to be tough on benefit claimants. And the impact may not be obvious. For example, a cut in youth justice spending by local authorities in 2010 did not *immediately* translate into an uptick in demand for police services or a noticeable increase in crime. This mirrors the incentives when it comes to capital spending; the cuts to capital spending that the government chose to implement in the 2010s are only now being felt by many services.[3]

* Though not impossible. Local authorities have a statutory duty to provide adult social care, though many have effectively rationed care over the last 14 years as they have battled with restricted budgets and rising demand.

The way that governments cut spending from 2010 incentivised disproportionate cuts for preventative services

Cutting overall spending should not necessarily entail cutting spending on prevention. It is possible to imagine a counterfactual set of spending reviews in the 2010s where spending was cut more efficiently by prioritising spending areas – such as prevention – that would have reduced the need for more spending in the future. In a 2018 report that aimed to improve the government's planning and spending framework, the National Audit Office (NAO) judged that there is an "absence of an overarching strategic framework for achieving government's objectives and balancing short-term priorities with long-term value for money"[4] in the way that the government handles spending reviews. It is hard to disagree.

The government has arguably changed its approach since that report was published. But it almost certainly prioritised short-term spending control in the 2010 and 2015 comprehensive spending reviews at the expense of longer-term efficiency.[5] This often manifested as 'salami-slicing' departments' budgets, rather than meaningfully reducing the responsibilities of the state by, for example, changing statutory duties.

The pattern of decreasing proportion of services' budgets being spent on preventative services that we described in Chapter 2 may not, therefore, be an inevitable consequence of fiscal consolidation but the result of the specific approach taken by governments in the 2010s.

Breaking the cycle is difficult

If acute demand rises faster than budgets, there is no 'headroom' to spend more on prevention, creating a vicious cycle. To do so within existing budgets would require the government to cut spending on acute services, raise taxes or raise borrowing. This is not impossible, and the concept of 'double-running' – paying for a temporary increase in prevention spending using higher taxes or borrowing – is explored in more detail in Chapter 4.

Political incentives are poorly aligned with a preventative approach

Prevention outcomes are mismatched with politicians' timeframes

The benefits of preventative spending can accrue over a long time but the political cycle is incredibly short. MPs face an election at least every five years and the average tenure of a secretary of state is shorter still – averaging just 18 months between 2015 and 2020.[6] This rapid turnover is not conducive to long-term policy making.[7]

This timing mismatch also biases politicians towards late-stage preventative activity. These are usually either secondary or tertiary interventions, for which results are often quicker to be felt. For example, the Supporting Families programme (Case Study 3) led to improved outcomes over the course of a few years – a timeframe in which a minister could feasibly claim some credit. But this was at least in part because it was targeted at people who were known to local authorities and were likely already interacting frequently with services. An earlier programme of intervention would arguably have been more effective in the long run,[8] but harder to effectively target, and so also more expensive.

Most preventative policy levers are outside any one politician's control

Prevention often requires collaboration between multiple departments, layers of government and arms' length bodies. On top of this, tackling many of the factors that contribute the most to acute demand – such as housing, poverty and poor quality employment – are 'wicked' policy problems and notoriously hard to resolve.[9]

Even when a politician does have critical levers at hand, the benefits – both financial and political – will often accrue to other parts of government, reducing the incentive to act. For example, a health and social care secretary is more likely to be fired for failing to address A&E waiting times than for failing to invest in adult social care, where many of the benefits (or blame) will accrue to the Department for Levelling Up, Housing and Communities, (DLUHC) or local authorities. Similarly with its net zero ambitions, it is notable that the UK has made good progress reducing emissions from energy, which is the responsibility of the Department for Energy Security and Net Zero – the department with lead responsibility for meeting the 2050 net zero target – but that limited reductions have been made in areas that are the responsibility of other departments which are less politically accountable.[10]

Politicians can find the challenges of preventative policy making dispiriting. The academics Cairney and St Denny argue that even in cases where politicians have a strong desire to shift towards prevention, the overwhelming difficulty they face in overcoming these wicked policy problems quickly erodes enthusiasm.[11]

Blame culture makes policy makers risk averse

Shifting to a preventative approach often requires someone to take a risk. There is a chance that a new approach or programme could fail. Policy makers – both politicians, but also bureaucrats such as officers in a local authority – could then be blamed for that failure, harming their career prospects.

But those policy makers receive much less flak for making an acute intervention – even if that acute intervention leads to worse outcomes. One interviewee gave an illustration of the negative incentives this can create. They claimed that it is often less risky for a director of children's services (DCS) within a local authority to take a child into care than it is for them to find creative ways to allow that child to continue living at home,[12] because the blame for any harm that comes to the child if they remained with their family would fall to them,[13] whereas none would come to that particular DCS for any poor outcomes that child may experience later in life as a result of being taken into care. Paul Corrigan, a former adviser to the prime minister and health secretary, has made the same point about making even relatively small changes to current ways of working in the NHS.[14]

There are examples of innovation in public services leading to a more preventative approach. But in each case, a new approach has required strong leadership, an innovative culture, and often an individual willing to take on more risk than is typical. As an example, one interviewee from a local authority told us that they were able to implement preventative services because they had a finance officer who was willing to hold higher levels of financial risk in their budget for a substantial number of years – something which other finance officers would likely not choose to do.[15]

It should not be the case that making a shift towards prevention is the rare exception rather than the rule and only occurs when there are outstanding individuals in leadership positions who are willing to take on more risk than they would usually be comfortable with.

The evidence base for individual interventions can be thin, but the importance of that is overstated

Building an evidence base for prevention poses some unique challenges

Interviewees claimed that the evidence for preventative interventions is often weak, for several reasons. Some of these problems are unique to gathering evidence for prevention. But others are common to all evidence-gathering exercises in government. Table 3.1 below explains some of the general reasons that it is difficult to gather evidence from policy making.

Table 3.1 **General reasons for difficulties gathering evidence**

Reason for poor evidence	Explanation
There is no evidence available for new policies	New programmes or approaches do not, by definition, have an evidence base. This creates what some interviewees called a "chicken and egg" situation; the government won't fund an intervention because there is no evidence, and there is no evidence because the government won't fund the intervention.
It is harder to quantify non-cash benefits	Some policies generate a wide range of positive outcomes. They might improve people's fitness, generate a stronger sense of community, or improve security of housing tenure. It is difficult to quantify the monetary benefits of these outcomes.
Success might be highly contextual	The success of policies may be highly context specific. For example, it might be because of exceptional leadership in a local area, because of particularly good relationships between different agencies, or because of strong consensus between elected members in a local authority and the council's officers. Many of these factors are difficult to observe and quantify and could therefore provide 'evidence' for an intervention that wouldn't work elsewhere.

While the above reasons are not unique problems for prevention, they still contribute to the relatively thin evidence base for some programmes. In contrast, the issues identified below are more specific to preventative policy making and therefore act as an additional barrier to building a good evidence base.

Table 3.2 **Reasons for a poor evidence base that are more specific to prevention**

Reason for poor evidence	Explanation
Benefits may not be realised for years	Some preventative interventions are very long term, with the benefits appearing years after the programme began. Sure Start was launched in 1999, but the Institute for Fiscal Studies is still publishing new findings about its impact more than two decades later.[16] Timelines like this make it very difficult for government to determine 'what works' and implement findings. Many services cannot afford to wait decades for the government to decide how best to spend money on prevention.
It is difficult to prove causality for early interventions	It is easier to build evidence for targeted interventions that are close to the point of acute crisis. There are fewer intermediate steps between the intervention and the improved outcomes, and fewer other factors that could affect an individual's life and muddy the causality
Prevention can often be 'transformational' in nature	Many interviewees suggested that prevention would require a fundamentally different approach. In the language of the Treasury's *Green Book*, these are 'transformational' programmes, which lead to a permanent change in the way that a service is designed or delivered.[17] It might be difficult to measure the amount spent on a new approach, and it would likely involve multiple interventions happening simultaneously. Determining causality for transformational change is therefore harder than for neatly prescribed interventions. This can be overcome by considering evaluation in the programme design.

This is not necessarily the case for all preventative interventions. Some lend themselves better to evaluation and evidence gathering. Clinical and pharmacological interventions are more amenable to running randomised control trials (RCTs) and are therefore better evidenced. But if the government focuses on these interventions at the expense of others, it will only partially realise the potential benefits of shifting to a preventative approach.

Policy makers' scepticism makes it difficult to shift spending to prevention

Interviewees repeatedly told us that policy makers often cite insufficient evidence to justify not shifting funding to prevention. This locks policy making teams in another viscous cycle. First, this pattern plays out in departments. Individual departments have control over a certain amount of spending. Each department has a delegated authority limit (DAL), which is a cap on the amount that they can spend without Treasury consent.[18] The Treasury determines the level of a department's DAL and there is substantial variation between departments. For example, the Department for Digital, Culture, Media and Sport (DCMS) had a DAL* of £60m in 2023/24, while the limit for the Home Office was £300m.[19]

* This is only for resource departmental expenditure limits (RDELs); there is a separate limit for capital departmental expenditure limits (CDELs).

With some of the larger DALs, it would be possible* for a department to invest in a preventative programme that would have meaningful benefits. But a lack of certainty about the outcomes of those spending plans discourages departments from committing spending.

Second, the Treasury can be sceptical when preventative spending proposals reach it, normally as part of the spending review process. This may be justified. Treasury officials are accustomed to departments presenting overly optimistic spending proposals and so request stronger evidence that a proposed new intervention will work, which departments often feel is too hard to provide. This leads to the perception among departments that there is a higher evidential bar for new programmes than for existing ones. As one interviewee put it:

> **"who's doing the business case for the status quo?"**[20]

Third, and relatedly, departments claim that the Treasury is overly focused on the economic case of spending proposals, often at the expense of consideration of the wider benefits in the strategic case. The economic case "identifies the proposal that delivers best public value to society, including wider social and environmental effects", mostly in the form of a cost-benefit analysis (CBA).[21] This is problematic for programmes – often preventative – where the outcomes are difficult to monetise or that are part of a transformational programme. (The Treasury disputes this claim and points to the 2022 update of the *Green Book*, which included new guidance on how to appraise transformational programmes,[22] as proof. This change is welcome and should help in the medium term, but this shift in focus has yet to translate into different behaviour by departments.)

Regardless of how the Treasury weights the economic and strategic cases when assessing bids, it is difficult to build either a strong economic or strategic case when the evidence base is weak. Evidence alone is not sufficient to catalyse a shift to a preventative approach.

Even when there is good evidence for a programme, there is no guarantee that policy makers will adopt it. First, it may not align with the government's political priorities (in *Green Book* language: it has a weak strategic case). For example, there is good evidence that continuity of care in general practice would lead to much better health outcomes. But the government is not willing to make the investment in general practice that would be necessary to improve retention and in turn support greater continuity of care. This is a reasonable political choice. Policy makers should only ever expect evidence to bring some clarity to, but not settle, decisions that are ultimately political. Investing in prevention can be expensive and may, for example, require difficult decisions about levels of taxation and borrowing. No amount of evidence in favour of preventative interventions will remove the politics from that decision.

* Though proposals that are "novel, contentious or repercussive" will require Treasury consent, regardless of a department's DAL. See https://assets.publishing.service.gov.uk/media/65c4a3773f634b001242c6b7/Managing_Public_Money_-_May_2023_2.pdf, p80.

Second, some interviewees implied that better evidence would automatically lead to more prevention. But this fundamentally misunderstands the nature of evidence. Evidence is never a settled, final position, especially in the social sciences. The field of psychology has recently been through a "replication crisis", in which researchers have struggled to demonstrate that the results from small-scale experiments translate into larger populations.[23] The evidence base for preventative interventions is also likely to be contestable and subject to change. Expecting evidence to provide definitive answers will likely leave policy makers disappointed.

Third, policy makers often have limited ability to understand the full range of policy options and fully appraise which projects would be the correct ones to follow. This is quite natural and what academics call "bounded rationality". Instead of being fully rational, policy makers rely on biases and heuristics to make decisions. This is particularly true when there is a large amount of information; policy makers cannot possibly sort through all evidence and come to a definitive answer. Instead, they may rely on pre-existing ideas and ways of viewing the world to inform their decision.[24,25] This can mean even the presence of convincing evidence on its own is not a sufficient condition for the government to implement a policy.

Fourth, policy making is far from a coherent, linear process. It is instead messy, with multiple actors pulling policy makers' attention in multiple directions.[26] Evidence, while important, is only one input into a policy maker's decision making process.

This could be interpreted as a cause for pessimism. It needn't be: given the problems of building an evidence base for prevention as outlined in Table 3.2, a more linear policy making process that required strong evidence could preclude a shift to prevention for decades – while researchers painstakingly evaluate policy after policy to clarify to perfectly rational policy makers which decision they should take. Instead, that evidence is not the critical factor in the majority of spending decisions should offer hope for those who advocate a preventative approach, as it becomes more contingent on political will and strong leadership that while rare are far more likely to materialise in the short term than an extensive evidence base for some of the newer or more radical preventative interventions.

And, as many interviewees told us, government should be bold and take risks on policies that may not have the best evidence but for which there is strong justification to believe they would improve people's outcomes; as one pointed out, it can't be much worse than the status quo.

Siloed funding and service delivery hinders prevention

Siloed policy making in Whitehall is unhelpful for a preventative approach

Departments in Whitehall are bad at cooperation. This is particularly damaging for any shift to a preventative approach. Departments often make policy with little consideration of what is happening in other departments and what the overall impact of services in a local area will be. Interviewees from local areas described a situation in which they would receive direction about policy from one department that often clashed with policy from another.[27] In some instances, departments even compete with one another over policy: one interviewee told us that DfE and DCMS disagreed over which department would be allowed to publish its school sports plan first.[28] Competing demands and direction from Whitehall reduce the likelihood that services will be able to work together and therefore hinder prevention. One interviewee called departments' focus on their own interests "departmentalitis".[29]

One barrier to improved departmental cooperation that was mentioned time and time again in interviews was that prevention often required one department to spend money, while the benefit and potential savings might accrue to another. For example, responsibility for investing in youth services is held by DCMS nationally and councils locally. But at least part of the benefits of that investment will accrue to the Department of Health and Social Care (DHSC), Department for Work and Pensions, Department for Education, the Home Office and the Ministry of Justice. Together these benefits might be relatively large, but smaller to each individual department. None of those departments are then prepared to make it a political priority to make the case for DCMS's spending during spending reviews, instead focusing on their biggest priorities. And DCMS – particularly if it is faced with cuts to spending already – has less incentive to put aside its political priorities in order to maintain that service.

Like departments, services also operate in siloes and are not responsive to users' needs

The siloes that exist in Whitehall extend into the services themselves. There is often little communication between different services, including between ones that exist under the same nominal banner, such as primary and secondary care within the NHS.[30] These problems are even worse between other services. One interviewee told us that there is a "fundamental lack of trust and/or alignment between local government partners and the NHS".[31] This is both frustrating for the people who use multiple services – which is more or less the entire population over the course of their lives – and an inefficient use of scarce resources.

The problem of siloed services is frustrating but manageable when an individual has a single need, for example, a referral to the elective waiting list for cataract removal. But many of the most intensive users of services – who would benefit most from preventative services delivered further upstream – have multiple, complex needs.[32] This might include someone who is on the waiting list for social housing, is in receipt of multiple benefits, has children at school, experiences mental health episodes which lead them to seek care in an A&E department, and occasionally interacts with the police. Currently, those individuals might find themselves passed between multiple agencies, each of which undertakes an 'assessment' of their need for that service alone, before referring them on to another service.

People experience this as a baffling array of people and agencies, completely disconnected from one another and which do little to help improve the underlying problems in their lives. This is also a waste of money for government, as each body conducts similar assessments, sometimes multiple times, with little progress being made to help the individuals.

A preventative approach would instead focus on the specific needs of the individual, and would work out why they frequently presented to multiple services, and what could be done to address their underlying problems.[33] This approach is currently made very difficult by the rigid walls between services.

Financial flows are siloed around services

Just as departments are siloed, and services are siloed at a local level, funding from government is siloed. Spending envelopes are decided by the Treasury following bilateral negotiations with departments. This is more or less a zero-sum game; more funding for one department implies less funding for one or a number of other departments. Within that process, the Treasury commissions individual departments to show how they expect to achieve savings against their baseline.[34] Joint spending bids are possible – and even encouraged by the Treasury – but few are actually made.[35]

As a result, the government conceptualises spending in neat boxes, intended to deal with discrete problems. There is health spending for the NHS (which in turn is allocated to hospitals, general practice and mental health services, among others) and there is spending on housing, which is largely directed through local authorities. This system does not reflect how interdependent the outcomes of this spending are. Poor housing leads to worse health outcomes,[36] which drives people to seek care in the NHS. But the current system incentives services to closely guard their budgets even if a shared approach would lead to better outcomes. As a result, it is, for example, very unusual for the NHS to share any budget with local authorities to prevent people developing health problems in the first place.

In many ways, the reasoning for this is understandable. Even in a more favourable fiscal environment than now, departments and services will always feel like they need more money. Most parts of government have their own acute pressures, that may seem endless, as well as many non-acute things which they would like to fund but can't. In that environment, it is difficult to make the case for funding preventative activity in another area. This is reinforced by the accounting officer system, through which departmental permanent secretaries and agency chief executives are personally accountable to parliament for the spending of their organisation.[37]

Overcentralisation makes it harder to shift to a preventative approach

Policy making and service design is often done in central government

The management of public services is often centralised in Whitehall. The NHS's approach to pandemic recovery is a clear example. NHS England (NHSE) and the Department for Health and Social Care (DHSC) have designed policies – such as patient initiated follow up,[38] virtual wards,[39]and community diagnostic centres[40] – which they then roll out to the entire country, often with little flexibility about how they should be implemented at a local level. The same is often true for preventative programmes. The Supporting Families Programme, Sure Start, and the Changing Futures programme (a DLUHC initiative targeted at improving "outcomes for adults experiencing multiple disadvantage"[41]) are all examples of programmes designed by departments and rolled out to local areas from the centre, albeit with some flexibility for how local areas implement these policies. And at the same time as local government-funded youth work was cut substantially during the 2010s, central government provided more than a £1bn for the National Citizen Service.[42]

Some policy is better designed at a national level. But policy makers in local areas are often better-placed to design preventative policies than their centralised national counterparts: they have a better understanding of the context and nuanced demands of the population that will benefit from them. There was frequent frustration among frontline interviewees about the relationship with central government, and a sense that it did not understand how services are delivered or what pressures local areas face.

This not only reduces the effectiveness of policy that departments and the centre designs but also means that money is spent far less effectively than it would be otherwise. That is partly due to a better understanding at the local level of what drives costs. On a site visit to a hospital, a doctor could name the people who most frequently attended A&E, which other services they drew on, and what the best course of action for that person would be. But they were prevented from acting due to the siloed nature of spending and rules promulgated from central government.

Performance management by central government incentives a focus on acute services

Central government's performance management of services makes it difficult to shift towards prevention.[43] Targets work well at directing attention towards what a government is targeting.[44] But performance management frameworks often require easy-to-measure, readily trackable, and unambiguous performance metrics. These can be things like waiting times in hospitals or attainment scores in school. In contrast, the outcomes of a preventative shift will often take longer, sometimes decades, to determine, and will be hard to attribute to a single policy decision. The result is that central government tends to target acute metrics, which in turn focuses the attention of government on those acute measures, likely at the expense of preventative activity.

This micromanagement makes it difficult for the public sector to shift towards a preventative approach. Some of the most innovative examples of prevention come from decisions taken on the frontline. Those decisions are harder for leaders to make if they are primarily being held to account for performance against acute metrics.

Funding is fragmented and often tightly controlled by central government

Funding is often very fragmented and ringfenced for specific purposes. The Local Government Association (LGA) estimates that between 2015/16 and 2018/19 local authorities received approximately 250 grants per year on average from central government, with almost a quarter of those worth less than £1m each.[45] This fragmentation has increased over time. The National Audit Office (NAO) found that in 2013/14 central government only provided local government with 61 grants.[46] This followed a conscious choice by the coalition government to attach fewer conditions to local authority funding;[47] a pattern which seems to have reversed since the middle of the 2010s.[48]

Some of this is likely due to political incentives: ministers like to announce new initiatives with pots of money attached to them. Thus, the government announced the Adult Social Care Discharge fund,[49] the Market Sustainability and Improvement fund,[50] and the services grant[51] for local authorities in recent years. Those pots of money, however, often come with restrictive reporting burdens and tight requirements for how areas should spend the money.

This is not just the case in local government. Central government often approaches funding the NHS in the same way. As an example, the government has provided large amounts of additional funding for the additional role reimbursement scheme (ARRS), a programme aimed at increasing the number of 'direct patient care' staff* in primary care. But despite consistent problems retaining GPs, the government has resisted calls from leaders in general practice[52] to be allowed to spend ARRS money on other staff groups.

Spending to address the underlying causes of problems is much harder to do when there are many, small pots of money, each earmarked for an incredibly specific area. The political incentive to announce pots of money for specific purposes also biases spending on acute services. This hinders a shift to prevention.

Funding is still too short term

A preventative approach requires long-term planning and spending to realise its full benefits. Even when outcomes improve in a relatively short timeframe, such as three to five years, the agency responsible needs to be able to continue to deliver support consistently into the future to reach multiple cohorts and reduce the likelihood that improved outcomes will backslide. But the current approach to government funding does not support long-term planning.

At a national level, there has been a welcome move towards longer-term financial planning. The New Labour government introduced multi-year spending reviews in 1998, which replaced a series of ad hoc annual "public expenditure surveys".[53] While the government has increasingly used single-year spending rounds in recent years, the pattern has been for longer-term plans. But departments have not always translated their own multi-year plans into multi-year budgets for frontline providers. This is

* These are staff other than GPs, nurses and practice management staff – for example, clinical pharmacists, social prescribing link workers and physiotherapists.

most obvious in local government, where the government has largely relied on single-year finance settlements, often finalised a matter of weeks before the start of the financial year.[54]

Even when the government provided the local government sector with a four-year settlement between 2016/17 and 2019/20, the NAO still found that the government's frequent updating of initiatives and funding pots meant that "the funding environment [was] characterised by one-off and short-term funding initiatives".[55]

Departments do this because they generally favour the flexibility over providing longer-term plans to frontline public bodies, but it makes it much harder for those bodies to shift towards a preventative approach.

4. Recommendations

The barriers to government taking a more preventative approach are many but not insurmountable. Change will require shifting the incentives faced by policy makers to favour prevention. The recommendations set out below explain how the next government could do that.

Ultimately, decisions about how best to allocate spending and to what ends are political and involve trade-offs; spending more money on prevention will entail higher taxation, more borrowing, or less spending elsewhere. As such, the support of the prime minister and chancellor will be key. That political will can then be used to drive decision making across government through changes to Whitehall funding and performance frameworks, and delivery and accountability mechanisms.

While central government has a critical role to play, excessive top-down control will stymie frontline efforts. We argue that the most meaningful changes to public services will happen locally, centred around the people who use them, in the places that they live, and set out what central government can do to empower and support this.

Make prevention a political priority

The government should identify taking a preventative approach as a political priority

The government should set its main priorities soon after the election. These should be agreed by the most senior ministers – with the buy-in of the prime minister and chancellor being critical – and should be used to set budgets. Those priorities, underpinned by prevention, should then be embedded into the government's performance framework.*

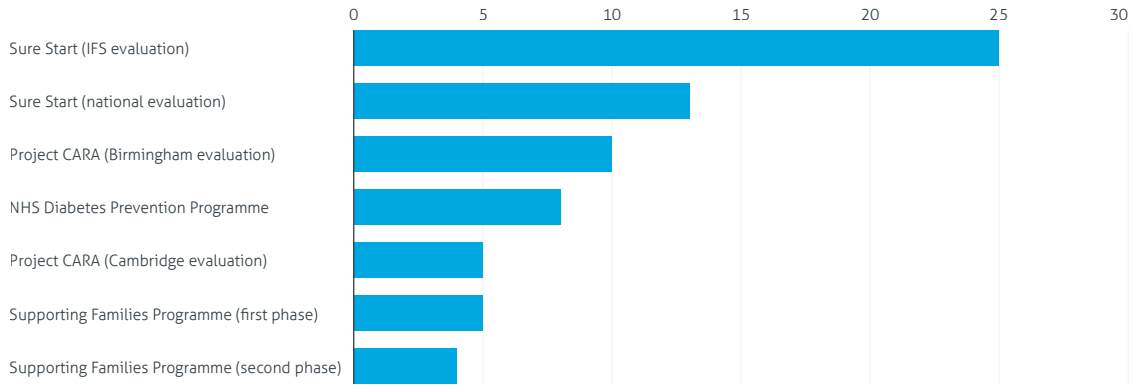
Ministers must lead from the front

Political incentives are generally poorly aligned with prevention, but there are benefits in long-termism, particularly following the turmoil of recent years. Both the prime minister and the leader of the opposition used their 2023 conference speeches to try to claim the mantel of long-termism. Rishi Sunak chose "long-term decisions for a brighter future" as his key message[1] and Keir Starmer spoke of Labour's plan for a "decade of national renewal".[2] There is also consistent public support for long-term policy making. Some 70% of people support the UK's target of reaching net zero by 2050[3] and, despite a number of immediate crises to choose from, a fifth to a third of people consistently identify the environment as one of the most important issues facing the country.[4]

* Previous Institute for Government work has suggested that the government should agree and announce its priorities as part of a modernised King's Speech at the beginning of a parliament. Rather than being a list of planned legislation, it would instead be a statement of the government's ambitions and objectives, and would include the principal outcomes that it is seeking to improve. These priorities would be agreed by a new executive cabinet committee, comprised of a handful of key ministers, and would be used to determine departmental spending allocations. See: www.instituteforgovernment.org.uk/commission-centre-government

Ultimately, if ministers want a change of approach then they need to make the case for it. As previous Institute for Government work has argued: "A chancellor (and prime minister) who tells their officials that their priority is making policy for the long term will shift the focus of the Treasury and the rest of Whitehall."[5] Often, especially to start with, that will mean choosing to invest in preventative programmes or making regulatory changes despite a shallow evidence base. As shown in Figure 4.1, it normally takes at least five years, and often much longer, for a detailed evaluation of a programme to be published. To make a meaningful shift towards a preventative approach (and so to claim the political credit), ministers, particularly the prime minister and chancellor, need to be consistently firm in the face of short-term pressures.

Figure 4.1 **Years between launch of case study programmes and publication of last evaluation**



Source: Institute for Government analysis of preventative case study evaluations.

Past examples show the importance of high-quality leadership

In the new Labour years, Tony Blair made Sure Start a flagship policy and set a clear target for 3,500 children's centres by 2010.[6] His chancellor, Gordon Brown, worked in lockstep with the prime minister to ensure that the Treasury led the way in designing and implementing Sure Start, with senior officials tasked with reviewing children's services, setting goals for the programme and designing ways to meet them.[7] When he became prime minister, Brown renewed the government's commitment to Sure Start despite early evaluations showing mixed short-term effects.

As with Sure Start, the Supporting Families Programme (SFP) enjoyed high-level support from the government throughout the 2010s. David Cameron often publicly referred to "troubled families"[8] and committed £448m for the first phase of the programme in 2011.[9] The government then increased funding for the second phase of the programme despite critical evaluations of the first phase. It is arguable that in the absence of high-level political support, the SFP would have been cut before it was able to demonstrate a more sustained positive impact, as it eventually did.

Strong leadership is also critical at the local level. One local authority interviewee spoke of the importance of having political and official leadership who are "comfortable holding risk".[10] Wigan council launched the 'Wigan Deal' in 2011 in the face of cuts to funding from central government. The deal aimed to join up local services around the needs of individuals and draw on the strengths of the community

to improve service delivery.[11] The Wigan Deal was not underpinned by established evidence, but rather driven by a local authority which experimented with new, more flexible approaches to delivering public services focused on improving outcomes for the local community.[12] This would have been impossible without strong leadership within the council.[13]

Leading from the front means taking difficult decisions and risks. Risks that might not pay off in the short term. But, in many cases, the risk of continuing with the status quo is even greater.

Embed prevention into the spending framework

The government must confront the trade-offs associated with increasing preventative spending

A transition to a more preventative approach in government would not be cost free, and will require making trade-offs. One option would be to shift the balance of spending, without spending more. Given the tightness of spending plans from April 2025 onwards, this would imply real-term cuts to some acute budgets or to capital spending. Neither would be attractive given high demand for acute services and the impact of historic underinvestment in capital on public service productivity[14] and economic growth.

Another option would be to raise taxes or increase borrowing, leaving other spending categories unaffected, but with implications for the country's wider fiscal position. The government could choose to do so temporarily, hoping that upfront investment in prevention would reduce demand and lead to slower growth in acute spending. 'Double-running' would allow a government to ramp up prevention spending much more quickly, and so realise the benefits more quickly. However, given the time period over which some prevention benefits are realised, it may be necessary to do this for the best part of a parliament or longer.

Others have argued for the creation of a new fiscal rule that treats prevention spending differently.[15] This would echo Gordon Brown's 'golden rule' and its treatment of capital spending. This required that, over the economic cycle, the government would only borrow to invest in capital and that revenue spending would be funded from income. Such a rule would allow for increased borrowing to fund preventative programmes, while retaining a more restrictive fiscal rule for other revenue spending.

However, this approach would be extremely risky. As one interviewee told us: "if there is a fiscal rule and the government is not meeting it, the Treasury will game it". This is obviously true for all fiscal rules. But other types of spending – capital or R&D spending, say – have better-established definitions that make them more resistant to gaming. Widespread gaming of a new fiscal rule that treated prevention spending differently could result in a substantial increase in debt, and the risk of this would damage the government's credibility with markets.

While we think that a separate prevention spending classification (PDEL) could, if possible to create, help protect prevention spending (as discussed below), the integrity of the classification would be fatally undermined by creating a fiscal rule based on it.

Departments should bid for shared funding that supports a preventative approach

Cross-departmental working is vital for a preventative approach. The chancellor and prime minister should encourage departments to work up joint spending bids that would fit an agreed preventative spending definition and would contribute to the government's priorities. This would help to circumvent the problems associated with siloed budgeting and policy making identified in Chapter 3.*

The Institute for Government has previously argued that there should be three types of spending bids.[16] One for departments managing activity that does not contribute to a cross-cutting agenda. A second for activity that contributes to a cross-cutting agenda, but where the activity is predominantly managed by one department. And a third where there is cross-cutting activity that is managed by several departments. Under the third spending category, the government would identify a lead secretary of state and accounting officer for each of the priorities that these bids contributed, who would lead joint teams of politicians and officials across departments with a responsibility in the delivery of the cross-cutting activity. Much of this is possible under existing government guidance,[17] but without clear political leadership that encourages and prioritises cross-cutting bids, it will only happen rarely.

The government should be transparent about how it makes its spending decisions. Alongside approved bids, the government should publish a document explaining all spending decisions made in a spending review. This should include spending on the status quo.

This could be a standalone document, published alongside the spending review, or the information could be incorporated into updated versions of outcome delivery plans. This would include the evidence that supports the outcomes government expects the spending to achieve, a cost-benefit analysis (CBA), and an outline of other benefits and costs that it expects to arise but which cannot be neatly captured in a CBA. A lack of evidence should not impede the government from allocating spending it believes will support a preventative approach. But where this is the case, it should clearly explain the theory of change, how it would expect outcomes to change over time, and any intermediary indicators that would demonstrate it is progressing as expected. Interviewees told us that publishing this information would make it easier for policy makers to resist short-term political pressures to direct spending towards more acute pressures.

A less radical approach than this would be to extend the use of the Shared Outcomes Fund (SOF). The SOF is the government's current system for funding cross-departmental spending and encouraging departments "to work collaboratively across challenging policy areas".[18] Under this approach, departments bid for funding for specific projects, which the Treasury then approves or denies. The Treasury also emphasises the importance of evaluating the projects it funds through the SOF.[19]

* Future Institute work on spending reviews will address the question of cross-departmental bids in more detail.

The ambition behind the SOF is admirable and it is good that the government recognises that the problem of cross-departmental working needs innovative solutions. But the scale of the investment is negligible. The government has allocated the third round of the SOF, which runs over 2023/24 and 2024/25, with just £100m for 16 projects. That means the average annual funding for a project is £3.1m. As it stands, the SOF is nowhere near the scale it would need to be to support a meaningful shift to a preventative approach. As one interviewee put it, the existence of the SOF is an "admission of failure" to embed cross-departmental working into the spending review process.[20] It would be better to address the fundamental problem, rather than extend the use of this sticking plaster.

The government should set a clear strategy for and definition of prevention and ringfence preventative spending

Government efforts to encourage spending bids that prioritise prevention would be aided by the development of a long-term prevention strategy which it would publish alongside the next comprehensive spending review. This would include a clear definition of preventative spending and the creation of a ringfence around those programmes and services that meet this definition.

To develop that strategy, the government will need to prioritise which preventative programmes it wants to protect and, potentially, increase funding for these. It should do this by considering the criteria we set out above, and also by weighing up its own political priorities. It is clear, though, that whatever it chooses to protect should be a balanced portfolio including a range of primary, secondary and tertiary interventions. It should likely also include some annually managed expenditure (AME) spending in the form of increased benefits.

Whatever the composition of this portfolio, it will require difficult decisions. Programmes and policies that have an excellent claim to being preventative will need to be excluded. Once again, this doesn't mean that they are not preventative, just that they do not meet the requirements to be protected by the government's ringfence.

Ringfencing this spending would send a clear political signal that investing in prevention was a government priority. It would provide greater clarity for ministers and civil servants on the expectations of the prime minister and chancellor, and help to align work across the public sector. Second, it would provide a baseline for prevention spending, enabling the government and public to track progress over time. This would then allow ministers to take credit for progress on prevention. Third, it would strengthen accountability. If a ringfence was put around prevention spending, then Treasury sign-off would be required if public bodies wished to use prevention budgets for other purposes.

Creating a definition of prevention spending is not a silver bullet. But it would subtly shift the incentives for policy makers, making it easier to protect existing budgets and to boost spending over time.

The government should develop the definition of preventative spending as part of the upcoming multi-year spending review, with input from departments and frontline services. During the spending review, the government should identify which spending contributing to the government's priority outcomes is preventative. At a minimum, this spending should:

- reduce the likelihood or severity of acute demand
- not be incurred in response to acute demand
- improve the allocative efficiency of government spending.

The government may also add criteria relevant to its chosen priorities. The definition could be high level – for example, in health services it might include all public health and primary care spending. Alternatively, the government could adopt a more granular programmatic definition. Ultimately, this would be a political tool, rather than an objective definition, and its effectiveness will in large part be determined by how closely aligned it is with the government's priorities.

As part of spending bids, departments would then propose, in partnership with frontline services, which programmes or services to include in the preventative spending definition, setting out how these will meet the government's priorities. These bids would be scrutinised by Treasury spending teams, who would make recommendations to ministers, with the final decision made by the prime minister, chancellor and senior ministers.

When determining what to include, the government should aim for a balanced portfolio of interventions. Preventative programmes will include primary, secondary and tertiary interventions and deliver benefits over different time periods, ranging from months to decades, and those chosen should represent a good mix. Indeed, the Treasury may wish to create sub-categories of preventative spending, requesting bids for and tracking each, based on how long term the investment is and the stage at which the intervention is made.* Otherwise there is a risk that departments will predominantly choose tertiary interventions which generate benefits quickly.

In assessing prevention spending, the government should not restrict itself just to DEL spending as there is good evidence that spending on benefits – which is classified as AME rather than DEL – also helps to prevent worse outcomes (see Case Study 6).[21] In an ideal world, whoever forms the next government would properly consider the role of benefits spending in delivering their prevention objectives as part of the first multi-year spending review after the election. However, while there are exceptions such as the 2010 spending review, most spending reviews only really assess DEL spending. As an alternative, the government could undertake a full assessment of benefits spending in the year after it has conducted its first multi-year spending review. Table 4.1 sets out the types of spending that the government may wish to include in the definition.

* Though we would not recommend creating separate ringfences.

Table 4.1 **Framework for preventative spending**

Category	Indicative options
Government activity	DEL spending
	AME spending
Stage of intervention	Primary
	Secondary
	Tertiary
Period of impact	< 1 year
	1–2 years
	3–5 years
	6–10 years
	> 10 years
Service area	Health and care
	Criminal justice
	Education
	Children and young people
	Housing
	Social security
Nature of investment	Expansion of existing services
	New programme
	Transformation programme

The final decision about which programmes to include in the definition should be included in a cross-government prevention strategy, published alongside the spending review. This would also include details on how other policies not captured within a spending definition, such as regulation changes, would contribute towards meeting the government's prevention objectives. It would also lay out how the government expects local government to contribute to its preventative agenda, including how it intends to measure local government performance.

The RDEL spending identified as preventative should be ringfenced. This would operate like the current R&D ringfence, with departmental allocations set out in the spending review. Departments would be able to shift spending between prevention programmes, but would require Treasury approval to use prevention budgets for wider resource spending. While excessive use of small ringfences can be an impediment to taking a preventative approach, a broad ringfence with sufficient flexibility would help to protect spending earmarked for prevention.

Public health is a good example of where preventative spending has been protected by a ringfence. Though the value of the public health grant provided by central government has been cut, without its ringfence it is highly likely that local authorities would have raided it to cover other funding pressures in recent years.

A ringfence around preventative RDEL would increase the political cost of cutting preventative spending. Departments would pass down the prevention ringfence in their allocations to public bodies such as local authorities and integrated care boards (ICBs). Like departments, these bodies would be free to use their prevention budgets on any programme within the agreed definition. Over the course of the next spending period the government should develop the evidence base for the programmes included within its prevention ringfence.

Creating a new spending classification could provide further protection to prevention spending

Other organisations, including Demos, The Health Foundation and IPPR, have recommended creating a new prevention spending classification. Unlike a service- or programme-based ringfence, this would be principle based, and would require the development of new accounting standards. There is precedent for using budget classifications to protect certain types of spending. Since 1998, government capital and resource budgets have been split in order to protect the former.

Departments require Treasury approval to use these budgets for other purposes. That approval has on occasion been forthcoming. During the 2010s, capital budgets were repeatedly raided to cover shortfalls in day-to-day spending. Interviewees also agreed that the protection for capital is subject to some gaming – though also that it increases the political cost of switching budgets and that spending on capital would be lower without it.

However, preventative spending is harder to categorise than capital, which has an agreed international definition. And while there is, for example, an OECD, Eurostat and WHO definition for preventative healthcare spending, this is far narrower than any definition provided by interviewees, not least as it only covers health. So the government would need to develop its own, working with organisations such as the ONS, the NAO, CIPFA and the OECD, to support the new accounting framework. However, as advocates for categorising preventative spending have noted, there is no easy objective definition as spending will contribute to multiple goals and its 'preventativeness' will depend on both evidence and intention.

Given the difficulties involved, establishing a robust new classification is not a realistic objective for a single spending review process or, probably, a single parliament. And in the short to medium term, a ringfence would provide sufficient protection.
Over the long-term, however, a new classification would provide slightly more protection, being somewhat harder for a future government to scrap than a ringfence, and increasing the political cost of deprioritising prevention.

The government should fund ongoing evaluations of preventative programmes

The evidence base for individual preventative interventions is often thin. Robust evaluations – for example those cited in the case studies in Annex A – would help improve government decision making about which preventative changes to make. We have argued that the government need not wait for a large evidence base to be built, but there is clearly a benefit from a better evidence base in the longer run. To this end, it should provide funding for consistent, long-term evaluations of all programmes included within the prevention definition and for pilots of new programmes.

In theory, this is already government policy. According to the *Magenta Book*, the government's guidance on evaluation, "All policies, programmes and projects should be subject to proportionate evaluation". However, this does not always happen in practice – for example, only nine out of the 108 most strategically important projects the government was undertaking in 2019 (those in the Government Major Projects Portfolio) had a robust evaluation plan in place; 77 had no evaluation arrangements at all.[22]

As now, evaluations would be commissioned by departments and other public bodies, with some conducted internally and others contracted out to academic organisations, What Works centres and other organisations. The Evaluation Task Force (ETF – the government unit responsible for encouraging the greater use of evidence in spending decisions) would continue to play a critical role in this.

We recommend giving local areas far more flexibility over how they deliver services. Given the large number of local service delivery agencies, this could generate a large number of programmes that require evaluation. So the remit and budget of the ETF should be expanded to include support for large-scale evaluations being undertaken by a wider range of public bodies, including local authorities and ICBs.

The ETF and Treasury spending teams would use the output of evaluations to inform spending decisions and iterate the prevention spending definition. Not all bids for preventative spending will prove to be worthwhile and the government needs to be able to judge the value of different proposals against each other and other spending priorities.

The outcomes of evaluations would also feed into the newly created Office for Government Improvement and Learning, which would then determine common themes from the evaluations and how they can be applied to other parts of the country.

One goal of better evaluations and evidence gathering would be to provide the Office for Budget Responsibility (OBR) with enough information to allow it to assess the impact of increased preventative spending on long-term fiscal aggregates. The government should create a requirement for the OBR to include a scenario of preventative spending in its annual fiscal risks and sustainability report.

This would give the government a clear view of the possible impact of its decisions – and allow it to take credit in the present – for spending that benefits the long-term fiscal picture.

Using existing data will help

One way to improve the quality of evidence would be to make better use of existing data. The government holds a huge amount of rich data about people's lives, including their education, employment, health and interaction with the criminal justice system. But this is all held by different departments; finding ways to more easily link this administrative data would greatly aid the evaluation of spending on preventative programmes. As previous Institute has identified, there are important lessons government should learn from data sharing during coronavirus.[23]

As a first step, the government should standardise the way that bilateral data-sharing agreements between departments are negotiated, which in most cases would not require legislative or regulatory changes. In the longer term, we recommend that an incoming government assesses the ease of sharing data within government and brings forward necessary changes to legislation and regulation to streamline the process. This could involve changing the ownership model. At present, departments have little incentive to share their data if other departments are not offering to share theirs. By changing the data owner – for example to the Treasury or an arm's-length body – or by pooling ownership of data over a certain age, the government could encourage better use of this powerful resource.

Embed prevention into the government's performance framework and increase accountability

Translate high-level priorities into a clear performance framework

Setting clear political priorities and intent is important to drive a preventative approach across government. The government then needs to translate those priorities into a performance framework that allows the centre of government to track progress and hold departments and the wider public sector to account.

This should build on the existing outcome delivery plan (ODP) system. Previous Institute for Government work has set out how ODPs could be improved – including that plans should include clear interim input, output and outcome metrics that demonstrate that a department is progressing towards the topline, long-term outcome metric.[24] This would apply well to prevention, as would the recommendation that departments detail the input and cooperation needed from other organisations, given the cross-cutting nature of preventative work. Previous Institute for Government work has also set out how performance management could work in a reformed centre of government.[25]

New Zealand offers an example of how a well-designed performance framework can encourage preventative activity. The country launched its *Better Public Services* programme in 2012 with the express intent of improving cross-agency collaboration. Within that programme, the government set 10 high-level targets that included such things as increasing children's participation in early childhood education from 94.6% in 2011 to 98% and reducing the number of serious crimes by 10,000 between 2017 and 2021. A report on the programme's progress in 2017 found that the government made progress on all 10 targets, though did not achieve the desired outcomes in all.[26]

The same report identified a number of success factors for the programme. First, it was important to have a small number of easily understood targets against which the government regularly and openly reported its progress. Second, it was more effective to hold leaders from multiple agencies accountable, rather than a single person.

Third, the most successful cases limited decision making to two or three agencies, with other agencies with less of an interest involved more peripherally. The New Zealand example shows that, while UK targets have tended to focus attention on acute services, it is possible to design targets that encourage a shift to prevention.

Track performance closely and be open about progress

Once the government sets the performance framework, it then needs to track progress against the agreed metrics. This should be led by the centre of government.

Progress would be tracked by the relevant parts of the centre using the recently developed Government Reporting Integration Platform (GRIP), which streamlines the collection of performance data across government. At a headline level, accountability would come as part of regular 'stocktakes' conducted by the prime minister with secretaries of state and senior officials to assess progress on the government's top priorities – as used effectively by Tony Blair to pursue his government's priorities.

The cabinet secretary should also make use of prevention performance data in their regular appraisal meetings with permanent secretaries. The government should publish regular updates about how it is progressing towards its priorities. The New Zealand government published annual reports about its progress towards its *Better Public Services* goals. And the Institute for Government has previously recommended that the centre of government should "publish interactive versions of the quarterly performance dashboards for all departments and outcomes, so that there is an up-to-date, central view of the government's performance available to the public at all times".[27]

The government might want to target increased spending on prevention, but that comes with risks

If the government creates a new prevention spending definition, it may wish to create a target for increasing the proportion of government spending accounted for by this. For example, the Hewitt Review recommended that "the share of total NHS budgets at ICS level going towards prevention should be increased by at least 1% over the next 5 years".[28]

This could be an effective way of focusing attention on prevention and, given the process of defining preventative spending outlined above, could be a clear indication of the government's progress towards long-term outcomes.

There are, however, some risks that come with a target of this nature. First, it could encourage gaming. If the government is close to missing its target on a spending increase, it might be incentivised to classify some programmes as preventative that it would not otherwise. That would be a mistake as it would dilute the value of the measure. Second, it is a narrow, input-focused metric. While higher spending on prevention is necessary, it would be better for government to focus on impact rather than inputs, not least as there could be relatively low-cost interventions – such as regulatory changes – which could deliver better outcomes than more spending.

Consider creating an independent body to track prevention

A preventative agenda requires policy stability and long-term planning. But there is a serious risk that, following an election, a new government would be tempted to cut flagship programmes and policies from the previous government, particularly if there is little short-term cost to doing so. This makes prevention a likely candidate for cuts. Sure Start is an example of when this has happened before. The incoming coalition government in 2010 cut the funding for Sure Start substantially, reducing the number of centres and the range of services delivered (see Case Study 1). A government therefore needs to try and find ways to bind its successors to a preventative approach.

One means for doing this could be an independent body that monitors the government's performance on prevention over time. There are several functions the government could include in this body's remit. First, it could track spending on prevention over time, reporting on the extent to which changes in preventative spending were the result of gaming. Second, the government could commission this body to look at ways of expanding or deepening the definition over time. The recommendations that would come out of that process would be more politically neutral than if it came from the government. Finally, it could track the contribution of preventative policies to the government's stated priorities, publishing an annual report on the government's progress, highlighting where it is on track and what other work needs to be done.

The fear of public criticism from a body like this could deter future governments from making cuts to prevention. This is not foolproof; 'naming and shaming' often does not work when it comes to encouraging desired behaviour, and difficult arm's-length bodies can be abolished (though this is harder, but not impossible, if they are established in primary legislation). But it would still increase the political cost of cuts, even if only slightly.

We would not recommend giving these powers to the OBR, as there is a risk that its effectiveness in delivering its current remit could be threatened. There is also a risk that creating too many independent bodies will reduce the impact of any single body's warnings or recommendations. However, if the government is establishing a new, relevant body – such as the Office for Value for Money proposed by Labour or the Office for Spending Evaluation suggested by David Gauke – then it should extend its remit to include oversight of government prevention spending.

Enable and support local areas to design and deliver services

Many of the best examples that we encountered of services adopting a preventative approach came from innovation at the local level as opposed to top-down policy designed in Westminster. Some of the most high-profile examples of this can be found in places such as Wigan, Gateshead, Camden, and Barking & Dagenham. But these examples are the exception rather than the rule, and happened despite the current system, rather than because of it. Any government that is serious about adopting a preventative approach should work to create the conditions for more areas to follow their lead. This will require rationalising funding mechanisms, and providing additional support to local areas. Further devolution may also be beneficial.

Rationalising services' finances is key to supporting prevention at a local level

Create financial incentives for prevention across NHS services

The government uses a multitude of mechanisms to fund the NHS, with few of them well designed to support a preventative approach. Most notably, 'payment by results' (PbR) in hospitals encourages increased acute activity.

If designed well, the financial structure of the NHS can help to deliver a government's priorities by incentivising desired activity. The New Labour years provide a good example. Blair made reducing NHS waiting lists a priority for his government. To do that, his government introduced PbR and designed accountability mechanisms (including clear targets) which pushed activity in the same direction. These actions contributed to waiting lists falling to a record low.

Reducing waiting lists is more straightforward than shifting to a preventative approach but there are lessons that a government should learn. First, identify priorities. It will be a political choice to determine which programmes within the NHS are identified as preventative. Second, align incentives. Once those programmes have been identified, the NHS should ensure that accountability mechanisms – including but not limited to targets – and funding mechanisms are aligned to deliver those priorities, just as they were under the New Labour years. Third, take a whole system view. A preventative approach requires many agencies to work together. ICBs provide an opportunity for

the NHS to take a more holistic view of how patients flow – or, for the purposes of identifying problems, do not flow – through the entire system and provide a forum for many of the agencies that would be required to cooperate in the preventative agenda.

Incentivising prevention does not mean that the NHS would no longer focus on acute care. Done well, incentivising prevention and acute care could be mutually beneficial goals. For example, reducing acute admissions by incentivising primary and community care to improve prevention would free up beds that hospitals could then use to increase elective care. Under a payment by results system, that would lead to increased income for the hospital. In other words, if the government can effectively incentivise prevention, it would free up hospitals to more quickly respond to the remaining acute demand, while improving outcomes for patients who do not end up in hospital for preventable reasons.

The exact details of how a new funding mechanism would work would depend on the government's priorities and which NHS programmes are included in the prevention spending definition. Others have suggested a similar mechanism to one used in Denmark, under which municipalities (who in Denmark are responsible for out-of-hospital care, including preventative activity) fund part of the cost of patients being admitted to hospital. This approach is designed to encourage municipalities to improve population health and prevent avoidable admissions.

Give local authorities more financial freedom

Central government provides funding to local authorities through a dizzying array of different funds and grant pots. The Local Government Association (LGA) estimates that local government in England receives more than 200 grants per year, with 120 to 130 of those worth less than £10m each. Each of those grants is earmarked for spending on a specific purpose, making it difficult for local areas to direct funding to where they think it would be best spent.

Grants often come with disproportionate reporting burdens, given the amount of funding involved. For example, the Adult Social Care Discharge fund for the winter of 2022/23 required local authorities to provide a detailed plan of how they would spend their allocations, report progress against those plans once a fortnight and finally provide an evaluation of how they spent the money. The administrative burden is even greater if central government requires local authorities to bid for competitive funding pots.

This is not to say that ringfences serve no purpose in a preventative approach. For example, one interviewee reported that the ringfence around the public health grant ensured that spending earmarked for that area was not raided by local authorities seeking to cover spending shortfalls for other services.

Conversely, removing ringfences around local government spending in the early 2010s, while at the same time severely cutting central government grants, and leaving the barriers to prevention in place, led most councils to shift spending away from preventative services.

But we recommend that central government vastly reduces the number of ringfences that it places on local government funding and broadens out the few remaining ringfences to protect government prevention priorities. This would protect funding that government deems strategically important, while allowing local areas flexibility in how they spend that money. As above, there should be one broad ringfence around preventative spending, which would allow local areas to identify their own priorities for spending within that broad definition.

Provide longer-term funding settlements

A preventative approach requires sustained and long-term funding. The government should set longer-term budgets. It should also align budget horizons of services within an area; a theoretical decision by DHSC to give ICBs five-year budgets would be much less effective if DLUHC only provides local authorities with single-year settlements. More specifically, the budgets for a place should be set over the entire length of a spending review period, with allocations announced not long after spending envelopes have been agreed. This would allow cross-departmental bids to be translated into place-based budgets and allocated to the agencies that will then deliver those services.

Departments are averse to setting multi-year settlements because they value having flexibility over their spending plans and like to respond to ministers' changing priorities. This is understandable, but frustrates any longer-term strategic approach, including on prevention. It is entirely within their gift to set longer-term budgets and they should do so. The centre of government should heavily encourage departments to follow this practice. This can come from informal pressure, but also by the translation of preventative priorities into departmental performance frameworks.

Longer-term budgets for services should be supported by longer-term spending plans from the centre of government. Other Institute for Government work has recommended that the government set spending plans for five years, with a review of those plans after three years.[29] That means that there will always be a minimum of two years of spending plans in place, unlike the current system where, at best, the government 'pencils in' spending plans for the whole of government spending beyond the end of the spending review period – currently under a year away – with no allocations to either departments or frontline services.

Pooling services' budgets could incentivise cooperation

As discussed in Chapter 3, barriers between services' budgets disincentivise a more preventative approach. This is partly because much preventative work also does not neatly fit into one service, and partly because prevention often requires one service to incur spending, while the saving or benefit accrues to another service. Pooling budgets could help overcome both issues.

This recommendation comes with precedents. The last Labour government launched Total Place – a pilot programme for pooled local budgets and greater flexibility over spending decisions – in 2009 (see Box 4.1). Several attendees at our roundtable cited

Total Place as a model that the next government should emulate when trying to shift towards a preventative approach – one even said "we've spent 14 years trying to reinvent Total Place". Many local services would undoubtedly look quite different had governments of the last 14 years stuck with this approach.

In that time, there has been limited pooling of budgets in more specific areas of local service delivery. The government launched the Better Care Fund (BCF) in 2015 as a shared budget between the NHS and local authorities, to improve the integration of health and social care. An evaluation of the BCF from 2018 found that it had led to improvements in some areas of health and care performance, including reducing delayed discharges from hospitals. The evaluation also found that the BCF contributed to improved relationships and collaboration within areas.

Policy makers should, however, recognise that pooled budgets alone are not a panacea. For example, the BCF is often used to plug short-term, emergency gaps that arise during NHS crises, and tends to be directed towards the priorities of acute hospitals.

Pooled budgets also do not automatically break down barriers between organisations

These problems are not insurmountable. The BCF is still a relatively small pot of money compared to total health and care spending and a much larger pooled budget could be much more disruptive of existing institutional and *de facto* power structures in which acute trusts are dominant. Funding is also only as effective as the goals that leaders have for that spending. Services have slipped into using BCF funding to target improvements in metrics such as delayed discharge from hospitals, but that is often in response to intense political pressure to improve delayed discharge. Similar pressure to support prevention could make large differences.

Box 1: Total Place

Description and initial outcomes

The Labour government introduced Total Place in 2009 as an initiative to improve public service efficiency and outcomes at a local level.[30] Its core objective was to "put the citizen at the heart of service design"[31] by encouraging collaboration between service providers and engaging communities in the development of services to better meet their needs.[32] It is a prominent example of a place-based approach, where the delivery of public services is tailored to the needs and characteristics of a locality.

The Treasury and Department for Communities and Local Government (DCLG) jointly led Total Place with input from other government departments.[33] They selected 13 pilot areas to explore ways to improve the efficiency of existing budget allocations, with emphasis on integrating services that were delivered by local authorities, primary care trusts, police and other providers.[34]

Several areas consequently identified prevention as offering potential for long-term improvements in local public service outcomes and efficiency, and began to plan a preventative shift.[35] Birmingham proposed integrating parenting information and support services to reduce later demand for more costly and specialised interventions by children's social care.[36] Bournemouth, Dorset and Poole, noting a rising population share aged over 65, planned to integrate community services, including early dementia diagnoses and falls prevention, to lower emergency hospital admissions among older residents.[37]

In 2010, a joint Treasury and DCLG report found that Total Place pilot areas already demonstrated increased integration and alignment of services between different agencies and were on track to deliver better outcomes for local people, while spending less money than before implementation of the programme.[38]

Thwarted plans for the future

Ultimately, Total Place was a short-lived initiative and did not expand beyond the 13 pilots as the coalition government discontinued the scheme after the 2010 general election.[39] While several pilot areas including Birmingham then took part in a place-based community budgets pilot within the Supporting Families Programme,[40] this offered less flexibility as it was only focused on families with complex needs.[41]

Despite its curtailment after less than two years, Total Place is now seen as a model for how place-based approaches can improve public service efficiency without significantly increasing local spending. Pilot areas had identified barriers to effective place-based working and shifting to preventative services. These included centralised ringfencing,[42] as well as different frameworks, reporting requirements and targets across services.[43]

Several advocated removing ringfences to allow them more leeway over spending decisions, such as allowing drugs funding to also be used for alcohol treatment, and for the ability to streamline smaller funding grants in the future.[44]

In response to the feedback, the Labour government declared it would remove ringfences on grants totalling £1.3bn from the 2011/12 financial year and progressively reduce the number of national indicators used to assess local performance.[45] While the coalition government replaced the national indicators with a reduced single data list in 2011,[46] the Local Government Association reported that central grants for local authorities continued to be ringfenced, fragmented and allocated on a short-term basis a decade after Total Place ceased.[47]

Central government should proactively support local areas to shift to a preventative approach

Allow local areas more freedom to design services

Some policies, such as the government's recently announced programme to gradually ban the sale of tobacco products,[48] make sense to implement in a uniform way across the country. But in most cases, there is large variation in demographics, geography, deprivation and other factors at a local level. This makes it much harder to create policy nationally that is equally effective in all areas. In addition, coordination of policy is much easier at a local level than it is nationally where it is difficult to see how initiatives might come into conflict with one another, as previous Institute for Government work has shown.[49] We recommend that to support a preventative agenda, local areas should have more discretion over how services are both designed and delivered.

As a first step, central government needs to stop being so prescriptive about service design and delivery. For example, one interviewee said that while the funding for family hubs was welcome, the need to comply with central government's requirements for how the money was spent almost negated the benefit.[50] In another example, a trust told us that NHS England required that they put an x-ray machine into their newly funded community diagnostic centre (CDC), even though there was no excess demand for x-rays in the trust. These examples are small, but also emblematic of the tight grip that much of the centre of government chooses to exert over services around the country.

Local services should drive innovation, even without the help of central government

Even if central government does not relax its hold or provide new powers, there are things that local government can do to try and stimulate an innovative approach to prevention. The Wigan Deal worked to break down barriers between different services by creating 'service delivery footprint huddles' which brought together representatives from multiple agencies to coordinate their response to individuals or families.[51] ICBs offer a pre-existing forum designed to incentivise collaboration between services, though this may be too health focused for the purpose of integrating a wider range of local services.

Wigan also benefited from having the CEO of the local authority work as the chair of the local NHS clinical commissioning group (CCG). CCGs, like the ICBs that have succeeded them, have tended to be dominated by the NHS. Having a local authority chair can help to guard against this and encourage cooperation between different agencies.

Agenda Alliance have recommended a "systems-navigator" role in local government to help those with multiple and complex needs coordinate support across multiple agencies.[52] Similarly, Making Every Adult Matter have pioneered an approach with a number of local areas which sees a coordinator design services in partnership with those with lived experience.[53] This would be a single point of contact that would break down the barriers between services within a local authority to find the best way to provide early support to an individual. There is also evidence that a lack of engagement with marginalised groups means that it is more difficult for those individuals to access services.[54] These approaches would serve to alleviate some of those issues.

Further devolution of some services may be appropriate

A government that is serious about prevention should consider if there are services which could be sensibly devolved to a place-based level. One service that was mentioned to us in interviews and the roundtable as a potential candidate for devolution to local authorities was Jobcentre Pluses; the Institute too has previously called for Jobcentres to work more closely with local authorities.[55] Many felt it strange to work with individuals with multiple complex needs but then be cut out of important conversations around their work and employment prospects. Similarly, Transform Justice, a charity, has argued for greater devolution of some parts of the criminal justice system, with the explicit reasoning that it would incentivise areas to shift spending towards crime prevention.[56]

This is not to specifically recommend that a government devolves responsibility for Jobcentres or justice, but more to illustrate that there is space for creative thinking about which level of government is most appropriate to deliver services and where further devolution could help support a preventative approach. Previous Institute for Government work has set out how the next government should approach English devolution.[57]

The government should also recognise that devolution can come with costs. For example, it might lead to fewer economies of scale, increase variation in service quality between places, or exacerbate inequalities.[58] Many of these costs would be offset by benefits, but the government should bear them in mind if devolving more powers. There are also steps government can take to mitigate some of those risks, explored in more depth below.

Prevention pilots would allow for experimentation with different models of prevention

The government should not expect that putting in place the recommendations described above will automatically lead to a substantial increase in preventative spending. Interviewees repeatedly stressed to us that while acute pressures remain so high, and funding remains so tight, local areas will continue to spend the vast majority of their budgets on acute services, regardless of the structures or the will to innovate.

Ultimately, local areas need the financial room to breathe to make a meaningful shift towards a preventative approach. Without that, it will be much harder for local areas to escape the all-too-familiar pattern of spiralling acute demand.

A substantial increase in central government funding for local authorities to spend on prevention is unlikely to transpire in the current fiscal environment. Instead, the government could trial 'preventative pilots' across a number of high-performing local authorities, with variation in type, location and demographics of authority. Councils would be provided with some extra funding, plus some combination of the flexibilities recommended above, including longer-term funding settlements, more financial freedom, opportunities to pool budgets, more freedom to design services and/or devolution of additional services. This would provide those pilot authorities with sufficient funding and political cover to experiment with more preventative models. The pilots should be rigorously evaluated, with successful innovations rolled out more widely.

Create proportionate accountability mechanisms for devolved power

The current system of regulation, intervention and performance management for local areas is not set up well to deal with a shift to prevention. There are ways government can improve the tracking of performance in local areas and central government that would help it evaluate different ways they are pursuing a preventative approach and share learning across the sector.

The government should reform Oflog into a genuinely collaborative body that encourages learning

When the secretary of state for levelling up, housing and communities, Michael Gove, first announced the Office for Local Government (Oflog), he pitched it as an "opportunity to highlight excellence in local government, to celebrate it and share best practice",[59] alongside more typical roles such as evaluating performance and ensuring value for money. Its launch has been met with suspicion from the local government sector that Oflog would simply provide ministers with a "stick to beat local government" and would ultimately become the "Audit Commission 2.0".[60]

There are certainly issues with the way that the government has established the body and subsequently communicated with the sector. But those early teething problems do not negate the benefits that might emerge from a genuinely collaborative body designed to hold both local and central government to account for delivering a

preventative approach. The Future Governance Forum has recommended that Oflog is turned into an Office for Government Improvement and Learning[61] (OGIL) and, for consistency, we will follow their lead on naming as there are many elements of their framework which we think are applicable to our recommendation.

OGIL should evaluate outcome metrics that support a shift to a preventative approach

Oflog's current approach to evaluating service performance relies heavily (though not exclusively) on input and output metrics. For example, the Data Explorer's first metric for adult social care performance is requests for support that result in a service.[62] A preventative approach will require more than counting how many care packages a local authority provides, or totting up the number of completed diagnostic tests. For any kind of meaningful evaluation of a local area's performance, the government should look at outcome metrics like healthy life expectancy, health inequalities, literacy rates and many others, using appropriate interim metrics where outcomes will take years to assess.

As a final step in the translation of its priorities into a performance framework, central government should outline how it expects local areas to contribute towards achieving its national priorities. This light-touch performance framework should be relatively broad, and should allow local areas to set their own priorities in addition to central government's priorities. This is particularly true for local authorities, who have a democratic mandate of their own that is independent of government.

In developing this performance framework, the government should learn from the experience of Local Area Agreements (LAAs). Under that initiative – which the government rolled out nationally in 2007/08 – each upper-tier local authority agreed an LAA with central government, targeting specific outcomes and the indicators which could be used to track progress.[63] Central government then allowed local authorities to pool funding (albeit a small amount initially) to achieve those priorities. In theory, this model fits well with a preventative approach, combining an outcomes-focused performance management framework (agreed between local authorities and central government) with a pooled funding model. However, LAAs were widely seen to be overly bureaucratic[64] and any modern version would need to be substantially less cumbersome.

An independent body such as OGIL would be well placed to evaluate progress against these relaunched LAAs. Central government could play that role, but there is a risk that local government would be resistant to the idea that central government is 'marking their homework' (or that central government should be giving them any homework to do in the first place). OGIL would not face the same accusations, as long as it had effectively demonstrated its independence.

The peer review process should be strengthened

How the government conducts inspections of local government also matters. It is important that inspections are collaborative, and include the sector in their design, implementation and feedback process. A collegial approach to inspections will result in better outcomes, as the local government sector is more likely to accept and take on board the recommendations of a review it feels is conducted in good faith by inspectors who are genuinely invested in their success.

Luckily, there is already a process which could be easily adapted to a preventative agenda. The LGA operates the Peer Review Challenge (PRC), a programme under which senior members of a number of local authorities inspect a single local authority over the course of a few days.[65] A PRC focuses on "what is most important for councils locally"; criteria which are agreed in advance between the LGA and the council. The team that conduct the PRC then produce a report, which the LGA encourages local authorities to publish, alongside an "action plan", which takes into account the recommendations outlined in the challenge.[66]

We broadly support this approach to evaluating the performance of local authorities, with a few caveats.

Currently, PRCs happen irregularly. In August 2023, the LGA estimated that "more than 200" councils had had a PRC in the previous five years[67] – implying that more than a third of authorities had not. The fact that some councils go more than half a decade without any clear view of how they could improve undermines the effectiveness of the system and probably does little to reassure central government that the process is thorough. We recommend that peer challenges happen on a more frequent and predictable timetable. Conducting at least one PRC every five years should be possible.

PRCs should evaluate how the actions of local authorities are influencing outcomes in their areas. An inspection should evaluate local areas' progress against the light-touch performance framework described above. It should also consider how policies and conditions outside the control of the local area affect outcomes, including the impact of decisions taken by central government.

Councils should not be able to choose who conducts their peer reviews. There is the perception from some that we spoke to that the peer challenge process is too "chummy", with an incentive to select peers who will be more forgiving. The government should give the LGA the power to choose the peers that conduct the inspection.

Historically, local authorities have not had to make the results of an inspection public. The LGA is now moving towards a mandatory regime.[68] This is welcome. Local authorities should not have discretion over whether they publish potentially damning inspection reports.

There should be a process for escalating concerns about the performance of a local authority or area. The Future Governance Forum recommends a three stage process.[69] The first stage is roughly what has so far been described; a regularly scheduled and

beefed-up PRC. The second stage would be "co-intervention" between the local area, those who carried out the peer review, and the relevant Whitehall department. The improvement would focus on areas of concern identified in the first stage. The final stage would be triggered if the second stage did not lead to improvement. In this, a local authority would be identified as at risk of "financial and/or service delivery failure".[70] This would trigger intensive, but time-limited, support from both central and local government colleagues, with the goal of continuing vital services for residents and putting the local authority on a financially sustainable footing.

The guiding principle for a PRC process should be one of collaboration between central and local government. Local government should not feel as though this is a process that is imposed on them, but rather one that is conducted in a spirit of cooperation and genuine desire for improvement.

The process is currently run by the LGA, which is the national membership body for local authorities.[71] There is no need to take it out of its hands, though Future Governance Forum suggested that for the process to work effectively the LGA would need to become a mandatory organisation for all local authorities, as opposed to the voluntary membership organisation it currently is.[72] The same report suggests that OGIL could also oversee the performance framework and manage the phased intervention approach described above, while the LGA continues to run the PRC process.

Regardless of where the PRC ultimately sits, the steps above would strengthen the process and encourage buy-in across the local government sector.

OGIL should allow local government to hold central government to account

Central government can act as a hinderance to a preventative approach at a local level. Despite this, local government has little recourse to hold central government to account. OGIL could help redress the current imbalance between central and local government.

OGIL should write an annual report that evaluates central government policy making. It could answer questions such as:

- Is central government effectively supporting local areas to shift towards a preventative approach?
- Are central government's priorities realistic and achievable?
- Are local areas sufficiently well funded to meet the government's stated objectives?
- How well is government working across departments and how well aligned is government policy?

This would serve two purposes. First, and most obviously, it would highlight issues in the way that government operates, with the aim of improving performance and supporting local areas to deliver a preventative agenda. Second, it would act as a

signal to local government that OGIL was a truly independent body that acted as a vehicle for their grievances, rather than a "beast of Whitehall" that would be used as a central government tool to allocate blame for poor performance.

This would likely require OGIL to be established as an independent body, in the way that Oflog currently is not. The Institute for Government has previously argued that Oflog would be more effective as an independent body, while acknowledging that *de facto* independence is still possible without *de jure* independence.[73] This argument still stands for OGIL.

The government should fund evaluation of local areas' various approaches

We recommend that the government should fund long-term and thorough evaluations of preventative interventions. More freedom for local areas to design and deliver services will create a nationwide 'policy lab', with hundreds of local areas running thousands of policy experiments. OGIL should consolidate cross-cutting and common findings from all evaluations and spread key lessons to local areas. In doing so, it should recognise that there are few solutions that apply to every part of the country and 'what works' in one context may not work in another.

There is scope for greater focus on preventative services by regulators and inspectorates

Interviewees and roundtable attendees reported that the current approach to regulation and inspections was rarely conducive to implementing a preventative approach. In particular, local areas are subject to a highly fragmented regulatory and accountability landscape,[74] in part because regulators and inspectorates tend to be established around traditional service siloes.

Ofsted inspects schools and children's services. The Care Quality Commission (CQC) inspects hospitals, adult social care providers and, more recently, local authorities. The Regulator of Social Housing assesses the quality of social housing. All of these remits are important, and help to protect those who rely on services. But they limit the extent to which regulators can understand the performance of service areas within the context of a more cross-cutting, preventative approach. At the same time, the constant cycle of inspections from disparate regulators is a drain on a local area's time and resources and rarely focuses on how individuals experience services.

Regulators and inspectorates should take a more joined-up approach to inspections at a place-based level. This may include more collaboration between different organisations in conducting the inspections and implementing the findings. As with OGIL, there is also the potential for a more outcomes-based framework of evaluation that considers how a local area is progressing towards its priorities as laid out in light-touch performance frameworks, while still protecting those who rely on the more 'business as usual' services.

Annex A: Prevention case studies

Case study 1 – Sure Start

Description

The Labour government launched Sure Start in 1999 with the objective of improving long-term outcomes for children under five. Sure Start began as a targeted programme to support children living in the most deprived areas, before the government overhauled it into a wider children's centre offering, with services to support all children aged 0–5 and their families.[1]

At the height of the programme in 2010, local authorities operated 3,620 Sure Start children's centres,[2] offering a range of services.[3] Since then the number of children's centres has declined, primarily due to reduced funding from subsequent governments. Despite that, Sure Start arguably remains one of the largest and most ambitious early years initiatives that any government has implemented.[4]

Implementation

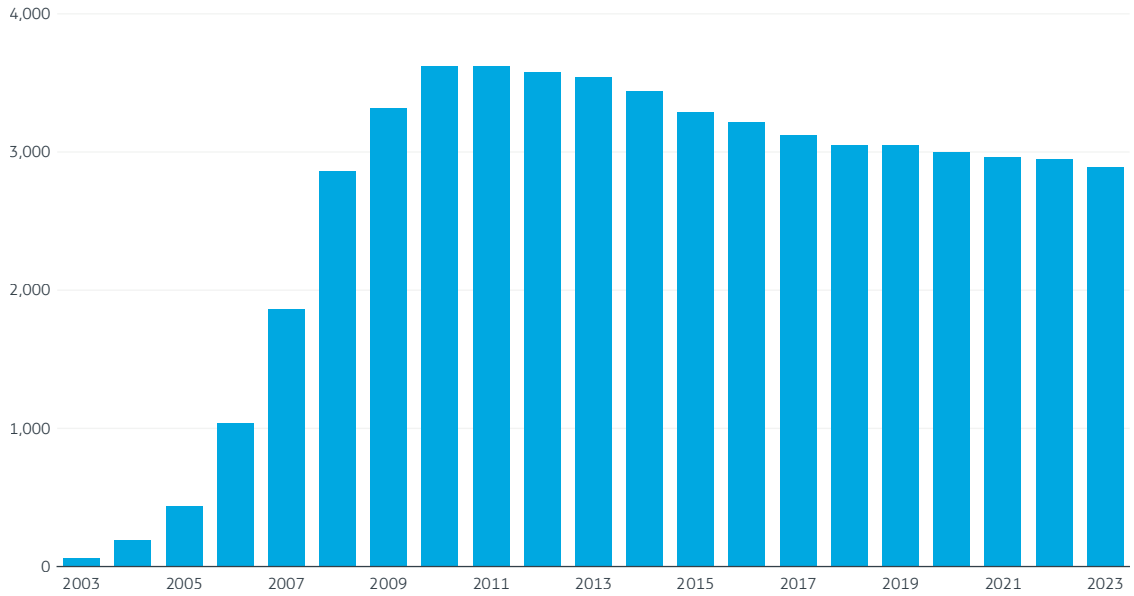
Labour's senior leadership made Sure Start a key political priority even before entering government, committing to the programme in the party's 1997 election manifesto.[5] It was one of the main announcements in the 1998 comprehensive spending review and the focus of a cross-departmental review of children's services.[6] There was strong ministerial support for Sure Start, led by the treasury under Gordon Brown, and for a new preventative approach to children's services, inspired by a growing international evidence base on the benefits of early years intervention for later childhood outcomes.[7]

Initially, the government set a target to establish 250 Sure Start Local Programmes (SSLPs, the precursors to Sure Start children's centres) in the most deprived local authorities in England by 2002, for which it committed £452m in funding.[8] The government expected local authorities, health boards and voluntary organisations to collaborate in tailoring services to local needs but required them to provide the following:

- outreach services targeted at children and families usually unable or unlikely to access local services, including home visits
- family and parental support
- play, learning and childcare
- primary and community health care including advice about children's health
- special needs support.[9]

The 2000 spending review included another £948m in central funding to double the number of SSLPs to 500.[10] Sure Start significantly expanded after 2003 when the government merged existing children's services into SSLPs to turn Sure Start into a national network of children's centres.[11] The then Department for Education and Skills provided ringfenced grants to local authorities and set a target of 3,500 children's centres by 2010, one in every community.[12] In 2009, legislation enshrined a statutory obligation for local authorities to provide children's services through Sure Start.[13]

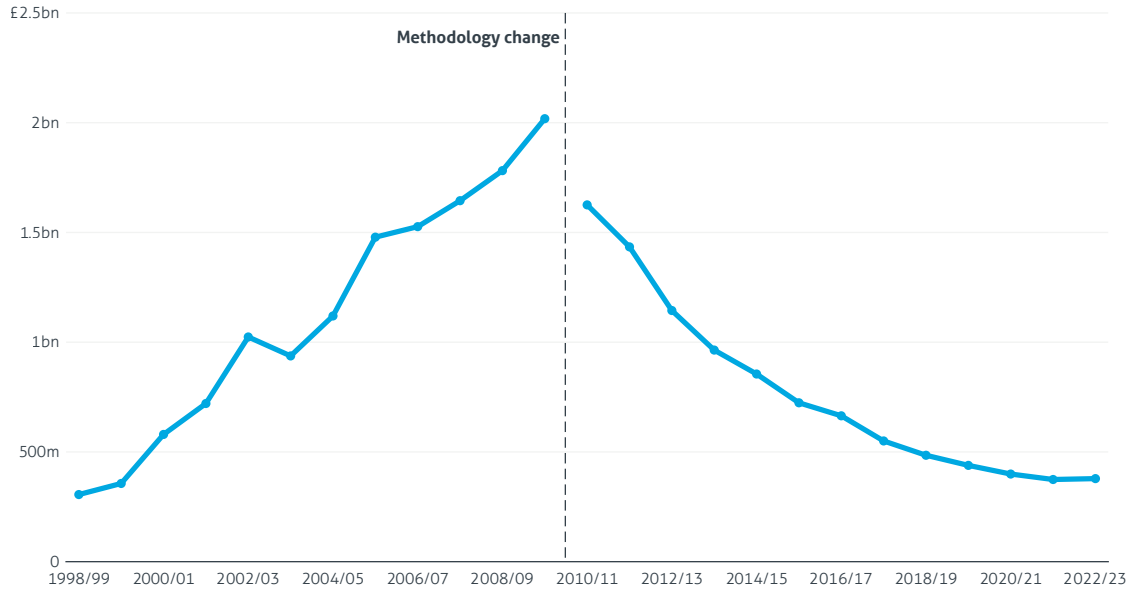
Figure A.1 **Sure Start children's centres, 2003–23**



Source: Institute for Government analysis of DfE, 'Number of Children's Centres, 2003 to 2019' and DfE Get Information about Schools (GIAS) 'Children's centre fields'. Notes: GIAS data is from September 2020 to June 2023. This excludes Sure Start Local Programmes (which the government launched in 1999) and amalgamates full Sure Start centres and linked sites, which offer fewer services, from 2010 onwards.

Sure Start remains in operation, but from 2011 the Conservative–Liberal Democrat coalition removed the ringfence around funding for children's centres[14] while also reducing central funding for councils. Local authorities responded by reducing the range of services offered or by closing centres: in 2023 there were 2,890 Sure Start children's centres open, a reduction of 20% since 2010, though it is difficult to assess how the range and quality of services that the remaining centres provide have changed. Spending declined in real terms (2022/23 prices) from £2bn in 2009/10 to £378m in 2023/23 – a fall of 81.2%.

Figure A.2 **Spending on Sure Start centres, 1998/99–2022/23 (2022/23 prices)**



Source: Institute for Government analysis of K Stewart, 'Labour's Record on the Under Fives: Policy, Spending and Outcomes 1997 - 2010' ('Table 2: Spending on early education, Sure Start and the childcare tax credit in the four UK nations (2009-10 prices') and DfE, 'Local authority and school expenditure' 2010/11 to 2022/23.

Impact

The Labour government commissioned a National Evaluation of Sure Start (NESS), a longitudinal study which reported annually from 2002 to 2012.[15] NESS collected information on children and families who lived in areas with an SSLP and compared them with a group of similar families living in areas without Sure Start services before 2003 (that is, when it began transitioning into children's centres).

NESS released an initial evaluation in 2005, stating that Sure Start had "extremely few overall main effects" for children aged between 9 and 36 months.[16] It even found adverse outcomes* for children from more disadvantaged households – including those with teenage mothers and single parents – living in areas with an SSLP.[17] The findings led to media reports that Sure Start was failing to support deprived families or to reduce the disparity with more affluent households, who could access Sure Start services due to the lack of income-based means testing.[18] Despite this, the programme retained strong political backing: in 2006 Tony Blair declared Sure Start as "one of the government's greatest achievements".[19]

NESS continued to track children who were nine months old at the time of the first report and found stronger benefits in later studies. In its second report (which evaluated outcomes for children aged 36 months), Sure Start was linked to improved parenting, a higher level of social development in children, higher immunisation rates and fewer accidents.[20]

* For example, three-year-old children scored lower in verbal ability.

The study did, however, caution that the latter two results may have been affected by the comparison group of children being on average two years older.[21] More positive effects from Sure Start were apparent when children reached five, where NESS found they had lower Body Mass Index (BMI) and better physical health than the comparison group.[22]

The Institute of Fiscal Studies (IFS) released its initial evaluation of Sure Start in 2019, which focused specifically on the programme's impact on children's health. A new Sure Start centre was linked to a fall of 18% in hospitalisation rates for 11-year-olds compared with a baseline cohort (children born in 1993, who were the last to reach age five without exposure to Sure Start).[23]

A follow-on study in 2021 found that access to Sure Start conversely increased the rate of hospitalisations for children under five years old for infectious diseases but lowered admissions for other causes (e.g. accidents).[24] It also confirmed that Sure Start reduced hospitalisations for children after age five, an effect which continued into adolescence – this offset the initial rise for the youngest children in the IFS study.[25]

In 2024 the IFS published research on Sure Start's impact on educational outcomes, which found positive effects on school attainment for children who accessed Sure Start services before they turned five.[26] Sure Start exposure is associated with a statistically significant and sustained increase in test scores from the age of seven.[27] Pupils who had lived within 2.5km of a Sure Start children's centre achieved GCSE results on average 0.8 grades higher across subjects than peers who lived further away and so had less or no exposure.[28]

Sure Start led to particularly strong improvement in attainment for children from disadvantaged households as measured by eligibility for free school meals, where increases in test scores were six times greater than for ineligible pupils.[29] This evaluation has uncovered how the first phase of Sure Start had a positive, longer-term impact on children's physical health and education which was not captured by earlier studies.[30]

Potential lessons

- Universal early intervention services such as Sure Start reach more people and can lead to long-term, positive outcomes for large parts of the population. But they are also much more expensive than targeted services and necessarily end up directing resources towards people who would not have required acute services in the future.

- The universal nature of Sure Start and its rapid national expansion made it difficult to evaluate because it reduced the pool of potential comparison groups. NESS consequently found it difficult to draw causal links between Sure Start and improvements in children's outcomes (such as with immunisation rates).[31]

- The stronger benefits that the later evaluations uncovered show that there can be a long time lag between an intervention and its outcome. NESS stated that it would take 15 years from the start of an intervention for benefits from Sure Start to become fully apparent.[32]

- A solid international evidence base for early intervention, especially from earlier programmes including Head Start in the US,[33] helped to convince Labour to implement Sure Start. But it is unlikely that in the absence of strong political will, a solid evidence base would have been sufficient to create such an expansive programme.

- Strong political support also ensured that Sure Start continued to receive funding and expand even after initial evaluations revealed that it had not delivered a reduction in socio-economic disparities as originally envisioned, which enabled later evaluations to collect evidence supporting long-term positive impacts for health outcomes from the programme.

- Sure Start was a flagship policy for Labour which benefited from consistent and high-level political support from both Tony Blair and Gordon Brown. This broke down many of the barriers to preventative programmes in government, but also made it a target for cuts when a new government took power.

Case study 2 – NHS Diabetes Prevention Programme

Description

The NHS Diabetes Prevention Programme (NDPP) is a national programme targeting adults at risk of developing type 2 diabetes.[34] The NDPP consists of lifestyle-based interventions designed to reduce weight and increase physical activity among participants and is a joint initiative between NHS England (NHSE), the Office for Health Improvement and Disparities (OHID)* and Diabetes UK.[35] Inspired by international diabetes prevention programmes, the NDPP is currently the largest programme globally to achieve universal coverage across a country, with sites in every region in England.[36]

NHSE announced the NDPP in its 2014 *Five Year Forward View*, drawing on existing evidence on the efficacy of lifestyle interventions.[37] This was part of a wider focus on secondary prevention in public health, in particular the lifestyle factors driving ill health. NHSE aimed for the NDPP to reduce future demand and costs for treating diabetes, which had an annual estimated cost of £10bn.[38] Around 80% of this is spent treating complications including heart disease, kidney or nerve problems.[39]

Implementation

NHSE, OHID and Diabetes UK initially reviewed the evidence base on type 2 diabetes prevention and established a framework for the programme. The NDPP launched in March 2015 in seven 'demonstrator' areas, selected to trial different approaches, before being rolled out across England from 2016,[40] with national coverage being achieved in 2018.[41]

Adults at risk of developing diabetes are referred onto the NDPP in one of three ways: directly by their GP following a blood test; a diabetes risk assessment through the NHS Health Check, run by local authorities; or an online self-referral run by Diabetes UK.[42] Over a minimum of nine months, participants receive personalised support including advice on dietary and lifestyle changes, and physical activity.[43] Participants can choose between in-person group sessions or an online programme.[44] By 2023 the NDPP had provided support to over 1.2m people.[45]

Impact

NHSE began its assessment of the NDPP's impact on health outcomes and financial benefits almost as soon as it rolled out nationally. In early 2016 it carried out an impact analysis to estimate the programme's monetary and health impacts over a five-year period. It forecast 390,000 referrals onto the programme at an estimated delivery cost of £105m between 2015 and 2021.[46] It expected the NDPP to save between 700 and 1,100 quality-adjusted life years (QALYs, or an additional year in perfect health[47]) over this period.[48]

Alongside this assessment, the National Institute for Health and Care Research (NIHR) commissioned the Diabetes Prevention Long term Multimethod Assessment (DIPLOMA) study, a mixed methods evaluation into the NDPP which began in 2017 and ended in

* Public Health England was responsible for designing and overseeing the programme until it disbanded in 2020 and responsibilities transferred to OHID. We will refer to OHID throughout for consistency.

2023.[49] In February 2023, DIPLOMA released analysis comparing outcomes for people referred onto the NDPP by GPs with a group of people with similar characteristics from GP practices elsewhere in the UK who were not referred onto the NDPP (since the programme is limited to England).[50] It found that NDPP participants were 20% less likely to develop type 2 diabetes three years after the intervention than counterparts who had not been referred onto it,[51] and therefore estimated that the NDPP had prevented 30,000 diabetes cases between 2016 and 2023.[52]

In October 2023, DIPLOMA released an observational study covering almost 385,000 referrals between mid-2016 and March 2019, finding that the NDPP was associated with 1,773 QALYs, higher than the estimated figure included in the impact analysis, at a cost of £119 per participant.[53] The study estimates the cost-per-QALY at £24,949,[54] which falls within the National Institute for Health and Care Excellence's (NICE) £20,000–£30,000 threshold for a cost-effective intervention.[55]

While DIPLOMA was unable to carry out a fully randomised evaluation, its findings are in line with international randomised trials demonstrating that lifestyle interventions reduce the risk of developing type 2 diabetes.[56]

The NHS regards the programme as a success,[57] but it has not been able to stem the tide of increasing incidence of diabetes. Since its launch, the number of cases has risen from 3.8m cases in 2016 to an estimated 5.1m in 2023.[58] Moreover, low completion rates have affected the NDPP: DIPLOMA carried out an observational study of the first 100,000 referrals and found that only 22% completed the nine-month programme, while 44% did not participate at all.[59]

Potential lessons

- The NDPP is voluntary: patients must consent to GPs referring them onto the programme and are able to drop out at any stage, limiting the programme's ability to prevent diabetes at scale.

- Participation rates were lower in more deprived areas and for Black and Asian adults,[60] even though diabetes prevalence is higher in these ethnic groups compared with the White British population.[61] Reducing these socio-economic disparities in take-up and preventing more diabetes diagnoses in the long term may therefore require greater collaboration between centralised public health bodies and service providers at the local level who are better able to engage with local communities.

- NHSE designed the NDPP based on a solid international evidence base confirming the effect of similar lifestyle-based interventions on diabetes prevention. Its impact analysis was therefore confident that the programme would deliver.[62]

- At the NDPP's estimated delivery cost and the 30,000 prevented cases of diabetes, the programme cost around £3,500 per case. The NHS in 2012 spent £11.7bn[63] on type 2 diabetes, with 1.9m people with type 2 diabetes in England and Wales.[64] This equates to around £6,170 per person in 2012, demonstrating that the NDPP is cost-effective in comparison to acute intervention.

- A preventative programme can be successful even if the problem it is addressing is not fully resolved.

Case study 3 – the Supporting Families Programme

Description

The Supporting Families Programme* provides targeted support to families with multiple challenges, including poor school attendance, incidents of crime and antisocial behaviour, health issues, domestic abuse and unemployment.[65]

Launched in 2011, Supporting Families is designed around a 'whole family approach'. This is in contrast to more traditional delivery models, in which siloed agencies provide services to individual family members at the point of acute need "without either understanding or tackling underlying root problems or the inter-connectedness of other family members' problems".[66] Under this programme, the Department for Levelling Up, Housing and Communities** (DLUHC) outlines a national framework that sets criteria for identifying vulnerable families and measuring outcomes, while also providing local authorities with flexibility in how they deliver the programme's intended goals. As a result, local authorities have a high degree of autonomy over service design, with the intention that they adapt local services to the needs of residents.[67]

Implementation

The government has funded three phases of the Supporting Families Programme. It ran the first phase between 2011/12 and 2014/15 with the objective of 'turning around' 120,000 families. 'Turning around' involved four outcomes:

- children having fewer than three fixed exclusions from school and an attendance rate of at least 85% across three consecutive school terms
- a 60% fall in antisocial behaviour
- a 33% reduction in youth offending in six months
- at least one adult moving to 'progress to work' status (not in full-time employment but volunteering).[68]

To achieve these, DLUHC encouraged – but did not mandate – local authorities to assign a key worker to each 'troubled' family who was responsible for creating a support plan and coordinating local services to address their problems.[69]

The government estimated that it would cost £10,000 to 'turn around' a family and designed several funding streams to reach this total. Central government provided local authorities with £4,000 per family, with some of that offered as an upfront grant and up to £2,400 released to a council when a family met the criteria described above.[70] The government then expected local authorities to provide the remaining £6,000.

* The Supporting Families Programme was known as the Troubled Families Programme until 2021. Throughout this report we will refer to it as the Supporting Families Programme for consistency.

** The department was called the Department for Communities and Local Government (DCLG) at the time that Supporting Families launched, but this report will refer to DLUHC throughout for consistency.

The government implemented changes to the programme before launching the second phase in 2015. It required all local authorities to develop an 'outcome plan', to set local criteria for assessing successful outcomes, and mandated that they assign a key worker to each family.[71] Central government reduced the amount of funding it provided as an upfront payment to £1,000, compared with up to £3,200 previously. It kept a payment linked to the success of the intervention, but local authorities had to prove "sustained and significant progress" in addressing a family's issues for at least six months to claim it.[72]

Shortly before the end of the second phase, the government announced there would be a third phase between 2022 and 2025, following a transitional year.[73] It introduced a new framework with 10 headline outcomes – education, early years development, mental and physical health, substance use, family relationships, safeguarding children, crime prevention, domestic abuse, secure housing and financial stability. The framework lists specific family needs under each outcome, with families qualifying for the programme if they have at least three of these needs. The third phase retains a similar payment by results structure as phase 2, except for 15 local authorities which have shifted to an 'earned autonomy' model, meaning they receive all funding up front.[74]

The Treasury committed £448m to the first phase, £920m for the second phase, and has allocated £695m in central government grants for the third phase.[75] If the government meets that commitment, it will bring total central government funding for Supporting Families to more than £2bn by the end of 2025 – equating to an average of approximately £150m for each year that the programme has existed.

Impact

Interviewees in government see the Supporting Families Programme as a major success.[76] This is based on the evidence gathered during the evaluations of the first and second phases, though the evidence for the positive impact of the second phase is stronger.

The evaluation of the first phase was commissioned in 2013 and released in 2016, just over a year after the conclusion of that phase. It observed outcomes for households on the programme – through analysis of national datasets and a separate qualitative survey – and subsequently compared this to a group of families with similar characteristics, but who did not receive an intervention under Supporting Families.

The government reported that local authorities 'turned around' almost all of the families in the first phase (116,654 of 117,910 – 98.9%)[77] and delivered £1.2bn in savings.[78] However, the evaluation was "unable to find consistent evidence" that Supporting Families improved outcomes for vulnerable families against the comparison group.[79] In its investigation into the programme, the BBC pointed out that the government overstated the benefits of the programme owing to the vague criteria used to define a successful outcome.[80] The Public Accounts Committee (PAC) supported this view in its own report, which argued that most families experienced short-term improvements instead of sustained changes in outcomes, and also stated that the estimated savings omitted the costs to deliver the programme.[81]

Finally, PAC also claimed that the payment by results mechanism incentivised local authorities to "move families through the programme quickly in order to draw down payments without providing the support necessary to tackle deep rooted problems" and recommended that DLUHC review the system.[82]

The second phase of Supporting Families resulted in arguably more enduring positive outcomes. DLUHC intended for the second evaluation (which began in 2015 and wound up in 2019) to track outcomes throughout the programme's duration and released annual progress reports and interim evaluations. It found that two years after the start of the intervention, the proportion of families in the programme with looked after children was a third lower than comparable families who were not on the programme.[83] There were 25% and 38% reductions in custodial sentences for adults and juveniles respectively.[84] There was also a fiscal benefit; the evaluation estimated that for every £1 the government invested, it saved £1.51, with total savings of £147m across the second phase.[85]

While the second phase's evaluation had a similar design to the first phase, it was far greater in scope. The first phase only had information for the first 12 months after families enrolled and the survey was conducted just nine months after the first intervention. In contrast, the second evaluation was able to track outcomes for each family for 24 months after the initial intervention, and model effects for the full five years of the phase. The evaluation also included personal data on eligible families provided by local authorities, which was then matched to existing national datasets every six months to track outcomes.[86]

Both the first and second phase evaluations used a quasi-experimental design, which compares outcomes between the group receiving the intervention and a matched comparison group to ensure differences in outcomes are directly related to the intervention.[87]

Following the success of Supporting Families, the government is designing other programmes and their evaluations – for example the Changing Futures programme[88] – on similar principles.

Potential lessons

- The Supporting Families Programme had high-level political support from its inception, including from then prime minister David Cameron.[89] Even though the first phase's evaluation revealed limited impacts, there was continued backing for the extension into a second phase, which showed evidence of positive impacts.

- Supporting Families is a relatively late-stage intervention. It is easier to make the case for and evaluate this type of spending than it would be for earlier interventions because it is much easier to make a direct causal link between these interventions and the desired positive outcome.

- The evaluation of the second phase of Supporting Families is widely regarded as a flagship example of policy evaluation,[90,91] but only cost £3m,[92] less than 0.5% of central government spending on the programme, and even less of total spending.

- There were still limitations in the evaluation design. The analysis of outcomes was focused on the fiscal benefits and did not measure Supporting Families' impact on wider outcomes such as health and wellbeing.[93] Moreover, the final report acknowledged that its cost estimates included only funding from central government, while ignoring the costs that local authorities incurred to deliver the programme.[94]

Case study 4 – youth work

Background

Youth work comprises a range of services, support and activities aimed primarily at people aged between 11 and 18.[95,*] The defining characteristic of youth work is that participation is active, voluntary, informal and based on building a relationship between a trusted adult and a young person to support their emotional and social development.[96] Youth work provision can be either universal, in which case it is an example of primary prevention, or targeted at groups with specific needs, where it is classified as secondary prevention.[97]

Youth work providers aim to support a variety of positive outcomes for young people including developing essential skills (such as team work, emotional regulation or public speaking) and behavioural management, and improving physical and mental health.[98] It is also designed to help participants avoid negative future outcomes such as crime, antisocial behaviour or being outside education, employment or training (NEET).[99] If successful, youth services can reduce future demand for social services, the criminal justice system and welfare.[100] While youth work can involve sport or creative arts such as music to engage young people, it excludes services aimed at developing a specific elite talent in these areas.[101]

Youth work can be delivered as a stand-alone service, or youth workers can be embedded in other public services like formal education,[102] housing[103] or health care.[104]

Local authority provision of organised youth services has been a consistent central government policy since the 1940s,[105] and it became a statutory duty in 2007.[106] The New Labour administration promoted greater integration of youth services across agencies and ringfenced local authority grants for youth work.[107] After 2010, the coalition government encouraged more involvement by volunteers and businesses in youth work.[108]

Implementation

A range of voluntary and community sector organisations provide youth work services alongside local authorities.[109] Providers frequently deliver services in youth centres or other designated indoor facilities, but services can also involve outreach or be 'detached' (street-based or in other non-designated spaces), provided outdoors or through digital means.[110]

It is difficult to know exactly how much is spent on youth work per year. By one estimate, total annual expenditure equates to approximately £2bn. Of this, around a quarter is accounted for by specific and identifiable government funding for youth work – most of which is spent by local authorities. Wider government funding accounts for a further quarter, with the remaining half coming from charitable income, commercial sources and payments by families.[111]

* Young people with special education needs and disabilities (SEND) are eligible for support from youth services until they are 25.

Local authority spending on services for young people declined by 77% in real terms between 2009/10 and 2022/23.[112] As well as reducing central funding, the government removed ringfences on several grants, including the Youth Opportunity Fund, which had previously been specified for youth work.[113] The government sets a statutory duty (with the guidance on this updated in 2023[114]) for local authorities to provide a "sufficient quantity" of educational and leisure-based activities for young people. [115] But the requirement for local authorities is still not clear: there is no minimum level of youth service provision.

In response to local authority funding cuts and commissioning choices, service providers have reduced provision of universal youth services and instead shifted to more targeted services for groups with specific needs, for example young people with special educational needs and disabilities (SEND).[116] According to research by Unison, 4,500 local authority youth work jobs were cut between 2012 and 2019.[117] There has also been growing regional disparity, with the most affluent areas in England having twice the level of youth work provision as the most deprived areas.[118]

There was a notable shift in the types of organisations delivering services over the 2010s. Local authorities cut substantial numbers of youth clubs across the country, with the average number per authority decreasing from 14 in 2011/12 to eight in 2018/19 – a 44.3% reduction.[119] This resulted in the voluntary and community sector taking a more prominent role in overseeing and delivering services to young people.[120] However, there have been concerns about volunteers' ability to effectively replace qualified youth workers and to maintain consistency in service quality.[121]

Impact

Assessments of the impact of youth work on young people are broadly positive, though the evidence base is relatively weak compared to other more structured interventions.

DCMS commissioned three projects to assess the impact of youth services called the Youth Evidence Base. One project analysed five longitudinal datasets to assess the impact of youth work on individuals over the life course. It found a "clear association" between regular youth club participation and improved education, health and wellbeing (as well as reduced negative behaviour such as crime) in the short term across the studies, and also found strong evidence that these effects were sustained into adulthood.[122]

Analysis of the Next Steps Study – a cohort study of people born in 1989 and 1990 – found a statistically significant increase in weekly sports participation and reduced alcohol consumption for youth club participants compared to a matched group at age 16.[123] Moreover, 46% of youth club participants had a higher education qualification at age 25, compared with 38% of the matched group.[124]

The Millennium Cohort Study (MCS), covering people born between 2000 and 2002, found positive short-term outcomes, with youth club participants having lower rates of unauthorised school absences and shoplifting than the matched group.[125] Youth club participation also had a statistically significantly link to good health, educational

qualifications and having a paid job later on at age 17.[126] The MCS mainly covered young people from more affluent backgrounds who already had good health and educational outcomes at the time they were in youth clubs – so there is an argument that youth club participation reinforced rather than caused positive effects later on.[127]

The second Youth Evidence Base report involved a systematic literature review of 77 studies from around the world, with a focus on youth work studies with an experimental or quasi-experimental design. Despite the relatively low quality of some of the literature, the review concluded there was "convincing evidence to show that youth activities have beneficial impacts for young people across a range of personal, social, educational, and economic outcomes". It found that the quality of interventions varied, but that evidence of impact was strongest for mentoring and summer employment schemes.[128] These findings are in line with earlier reviews by the Youth Futures Foundation into interventions to improve youth employment,[129] and by the Youth Endowment Fund into youth violence reduction programmes.[130]

The third study looked at the impact of youth work on local areas, analysing the effect of cuts to youth services on young people's outcomes a year later.[131] The study found that a reduction in youth work provision led to a statistically significant increase in cases of weapons possession, bike theft, shoplifting, and in the proportion of young offenders who reoffend.[132] It did not find evidence for short-term changes in either education or health outcomes linked to cuts in youth work, although the study only evaluated the impact of youth centre closures over a short period of time.[133]

A separate working paper analysed the impact of youth centre closures in London on young people's outcomes between 2010 and 2019. It found that the closure of a youth centre is linked to a 10% increase in the number of crimes, particularly drug-related offences, committed by 10- to 18-year-olds living nearby.[134] In addition, youth centre closures disproportionately affect outcomes for young people from disadvantaged backgrounds, since the centres are more likely to be located in deprived areas which lack alternative recreational services for young people.[135]

In an earlier 2022 study, UK Youth and Frontier Economics estimated that the indirect economic benefits of youth work amounted to £3.2bn.[136] Of that, roughly £1.7bn results from better health outcomes for young people (with mental health the single largest area for savings) and reductions in substance abuse, obesity and teenage pregnancy rates.[137] The remainder comes from lower rates of knife crime and antisocial behaviour and increased employment and education attainment for youth work participants.[138] They consequently calculated a high return to investment for youth work for the government at £6.40 for every £1 of core funding. The contribution of youth work to a wide range of public policy objectives highlighted the importance of effective cross-sector collaboration.[139]

Potential lessons

- As a relatively early-stage, primary prevention intervention it is difficult to draw causal links between youth work and improved outcomes. This is especially the case for universal youth services like youth centres. The Youth Evidence Base literature review noted that many outcomes are hard to measure, are indirect, or relate to the avoidance of negative outcomes.[140]

- Youth work is not a single programme but an approach to working with a wide range of people. It provides an example of it being harder to evaluate alternative approaches to public services, than it would be for a more structured, targeted intervention. The systemic literature review noted that the evidence base is skewed towards larger, publicly funded structured programmes with formal evaluations.[141]

- It is also difficult to calculate the monetary savings from improved health and reduced crime linked to youth work owing to insufficient data. UK Youth and Frontier Economics acknowledged that they made several significant assumptions about the causal impact of youth work's wider social benefits on young people's outcomes,[142] although the more recent analysis of longitudinal studies – funded by DCMS – has strengthened these assumptions.

- The longitudinal study underscores how young people's socio-economic background was a key determinant of longer-term outcomes, as youth club participation had a bigger impact on the outcomes of young people from less affluent families.

- Youth work is an example of the siloed nature of government working: while DCMS has responsibility for supporting the youth sector and one-off capital funds, local authorities provide most of the revenue funding for local provision. Policy affecting young people and the youth sector is similarly fragmented, being split across several government departments including the Department for Education, Home Office and Department of Health and Social Care.[143] Despite local authorities providing the majority of statutory funding for youth services, they are rarely the beneficiaries of cashable savings.

- Youth work is comprised of a range of services that are delivered by providers in local areas and are generally tailored to the needs of the community. It is therefore a good example of the efficacy of giving local authorities and (increasingly in the absence of council funding) the voluntary sector[144] more flexibility in the design and delivery of preventative services in response to local needs.

- Shifting the source of funding for youth work away from the state towards either the voluntary sector or individuals can increase inequality of provision. This results in better-off areas receiving disproportionate amounts of funding and can entrench inequality of outcomes.

Case study 5 – Project CARA

Description

Project CARA (Conditioning and Relationship Abuse) is an early intervention programme aimed at people who receive a conditional caution for domestic abuse.[145] First-time domestic abuse offenders attend awareness-raising workshops as a condition of their caution, with the goal of preventing reoffending at a lower cost than if the case progressed through the criminal courts.[146] Currently nine police forces across England offer the programme, with awareness workshops overseen by, or delivered in partnership with, Hampton Trust.[147]

Implementation

CARA originated in 2010, when Hampshire Constabulary began exploring approaches to reduce reoffending in domestic abuse cases through issuing conditional cautions to first-time offenders.[148] Hampshire Constabulary commissioned Hampton Trust to design a workshop to raise awareness of domestic abuse and motivate first-time offenders to change their behaviour to prevent future recurrences.[149] Both organisations sought to include victims' feedback throughout the intervention, with their approval needed for the police to issue a caution to begin with.[150] Staff responsible for running the workshops direct victims to specialist support services and also seek their feedback on any positive changes in offenders' behaviour.[151]

The Hampshire CARA pilot launched in 2012 and became a model for later forces. To receive a conditional caution, individuals had to formally admit committing a domestic abuse offence, and agree to abide by the conditions imposed by the police caution. In return, they could not be arrested for a new offence or breach of conditions within the caution period, usually set at four months.[152] Offenders were then required to participate in two five-hour workshops, the second taking place four weeks after the first.[153] The workshops take place in groups but staff interact individually with offenders,[154] creating opportunities for peer learning among offenders reflecting on their personal situation and choices.[155] The workshop staff inform police as to whether participants have successfully completed both workshops and thus met the condition of their caution (provided that they did not reoffend during the caution period).[156]

Hampshire Constabulary continued CARA after the pilot finished and it has since been rolled out in another eight police forces, with 1,500 domestic abuse offenders receiving an intervention annually through the programme.[157]

Impact

Cambridge University conducted an evaluation of the intervention's Hampshire pilot, which ran between 2012 and 2015. For this, the researchers carried out a randomised controlled trial (RCT) comparing outcomes for participants with a matched group comprised of offenders who had also received a conditional domestic abuse caution, but who were not required to attend CARA workshops.[158] The evaluation found that reoffending for CARA workshop participants was 35% lower than the matched group one year after the intervention.[159] The pilot also found that 53% of abuse victims who engaged with Project CARA reported positive behavioural changes in offenders.[160]

While the study did not conduct a full cost-benefit analysis, it reported that the pilot cost £100 per participant and therefore regarded CARA as a potentially cost-effective intervention.[161]

The Home Office commissioned the University of Birmingham to carry out a second evaluation, comprising an impact analysis of workshops in Hampshire Constabulary and the West Midlands Police between December 2018 and November 2019.[162] The study compared reoffending by a sample of workshop participants with a matched control group and carried out a cost-benefit analysis for the two police forces. In its final report, the evaluation found that Project CARA substantially reduced domestic abuse recidivism, with the number of reoffenders among workshop participants 67% lower than the matched group six months after referral.[163] While the report found that Project CARA's impact lessened after 12 months, the number of reoffenders remained 54% lower than the control group.[164]

The same evaluation also estimated the economic benefit from CARA using the Home Office's estimated costs of crime.[165] These include costs incurred in anticipation of an offence (such as security measures); costs incurred as the consequence of a crime (like broken property); and the costs incurred by the police and criminal justice system in response to a crime.[166] The study subsequently estimated an economic benefit of £2.75 for each £1 that the West Midlands Police invested in CARA from reduced reoffending.[167] It estimated a much higher net benefit for Hampshire Constabulary at £11.10 for each £1 of initial spending, due to a greater reoffending rate for the control group there.[168]

Potential lessons

- While both evaluations of CARA were strongly positive about its effect on reoffending, their assessments were limited to the first 12 months after the intervention through the workshops. Consequently, it is unclear whether CARA contributes to a long-term reduction in domestic abuse.

- CARA is a successful example of cross-agency collaboration between police forces and an external service provider, in this instance Hampton Trust. The University of Birmingham's evaluation found good collaboration between Hampton Trust and Hampshire Constabulary throughout the pilot, with police effectively communicating information about offenders to workshop staff, who in turn gave updates to the police about the workshops.[169]

- A preventative intervention may not generate cashable savings for the government, but society-wide benefits mean it is still worth doing. With CARA, a proportion of cost savings – though it is not possible to determine how much – comes from avoiding costs that the criminal justice system would have incurred in response to a crime. But the majority of the costs of crime are borne by people and groups other than the state. As such, the benefits of CARA are spread widely across society, meaning that while spending on CARA may not deliver cashable savings for the government, it is still allocatively efficient to spend money on the programme.

Case study 6 – cash transfers

Background

People living in poverty tend to have worse outcomes on a range of issues including: health,[170] interactions with the criminal justice system,[171] likelihood of being taken into care,[172] need for adult social care[173] and difficulty accessing secure housing.[174] This in turn increases their need for acute public services.[175] That increased demand is costly: in 2016 the Joseph Rowntree Foundation (JRF) estimated that £69.2bn of annual UK public services expenditure was directly related to poverty.[176] Consequently, some interviewees argued to us that reducing poverty would be the most effective way to make a shift towards a more preventative approach.[177]

Transferring cash through the welfare system is one of the government's main policy levers to alleviate poverty. This case study looks at how changes to the welfare system since 2010 – in particular, the benefit cap, and the two-child cap on tax credits and universal credit – have affected poverty rates and, consequently, demand for acute public services.

Implementation

As part of the 2010 spending review, the coalition government announced that it would cap the total amount of benefits that a household could receive.* After a slight delay, this change was implemented in September 2013, meaning that the maximum amount that a family could claim would be £26,000 per year, or £18,200 for a single person with no children.[178] Then in 2016 the Conservative government lowered the benefit cap for those outside London, to £20,000 and £13,400 for families and single people without children respectively.**[179] This limit was held flat in cash terms – in other words, eroding in real terms. It would not rise again until April 2023.[180]

In 2017, following the introduction of Universal Credit (UC), the government implemented a limit on the amount of extra support a family could receive, dependent on the number of children that they have. Families are not eligible for additional support for children through Universal Credit*** if they have more than two children and the third and subsequent children were born after 6 April 2017.[181]

Impact

Using benefits to alleviate poverty has been shown to be effective. For example, the Child Poverty Action Group states that child benefit's comparative simplicity, the regularity and stability of payments (which unlike means-tested benefits do not decrease if parents increase working hours), contributed to reducing poverty.[182]

It is hard to draw conclusions about the impact of the benefit cap on poverty, partly because it generates dynamic effects, with around 10% of people taking up paid work, moving onto other benefits or into cheaper housing.[183] A Department for Work

* The cap does not apply to those over state pension age, earning over a certain amount, or to some people with disabilities, health conditions or caring responsibilities.
** The original cap was the same across the country.
*** There are some exemptions to this, including for children that are part of a multiple birth (that is, twins, triplets etc.) and for adopted children.

and Pensions (DWP) evaluation of the policy focused on these outcomes, but did ask claimants about other impacts. Though not definitive, this evaluation strongly implies that the policy increased rates of poverty, with around half of respondents reporting that they reduced spending on essentials such as food and clothes, and substantial numbers also reporting reduced spending on children, and late or non-payment of bills.[184]

When the government cuts spending on welfare, poverty increases. Work from the Resolution Foundation shows that by 2023, nearly a quarter (420,000 or 24%) of all families with three or more children were negatively affected by the two-child limit.[185] That work estimates that those families lost £3,200 per year in benefits support for each child after their first two, with substantially higher poverty rates for families with three or more children.[186]

Unsurprisingly, the effect of limiting benefits to families with three or more children has been to disproportionately increase the poverty rate among that group. While the number of families with two children living in poverty declined between 2013/14 and 2022/23, the poverty rate of families with three or more children rose from 34% in 2013/14 to 46% in 2022/23. The Resolution Foundation forecasts that that trend will continue, with more than half (51%) of those families living in poverty by 2028/29.[187] This is unlikely to reverse. Both the Conservative[188] and Labour Party[189] have committed to keeping the two-child cap in place after the next election.

This increase in poverty has almost certainly increased demand for acute services. This is difficult to directly prove, but higher rates of poverty are associated with worse outcomes, which then require acute service intervention. In health and care, for example, those living in the most deprived parts of the country are four times more likely to be detained under the Mental Health Act, have a depression rate that is twice as high and have a mortality rate from bowel cancer that is 25% higher than those in the least deprived parts of the country.[190] Similarly, the Child Poverty Action Group reports that poverty has a detrimental effect on children's physical and mental health and educational outcomes, which persist into later life.[191]

So while there is no strong evidence showing a direct causal link between the generosity of welfare cash transfers and demand for acute services, this can be inferred given the good evidence both that benefit levels impact on poverty, and that poverty is a driver of demand for acute services.

Potential lessons

- Introducing a sustained preventative shift in public services requires considering the underlying drivers of demand for acute services, of which poverty is a leading factor. Increasing the generosity of key benefits may offer an effective way of addressing poverty and government should consider this alongside preventative public services.

- Reducing the rate of poverty will likely reduce demand for more acute public services. The Resolution Foundation estimates that abolishing the two-child limit and the benefit cap would cost the government £3bn in 2023/24.[192] It calculates that it would provide those families in the most deprived decile of the population with over £1,000 in additional income – a 5% increase – and would lift 490,000 children out of poverty.[193]

- There is no strong evidence on the relative cost effectiveness of using benefit payments to reduce poverty and in turn reduce demand for acute services compared to direct interventions through preventative services to limit acute demand among this group. But it is plausible that benefit payments could be more cost effective, since reducing poverty could reduce demand across a whole range of services. This is an area that would benefit from more robust evidence to inform future policy design.

Annex B: Spending patterns

In Chapter 2 we looked at the example of local authority spending on children's services. This annex expands on that analysis by looking at the trends in health and care spending and in homelessness services provided by local authorities. In all cases, spending has shifted away from prevention since 2010.

In the health and care system, spending on acute services has grown more quickly than on preventative services

Key health and care services sit at different points on the spectrum, from most preventative to most acute. As the name implies, NHS acute trusts deliver some of the most acute services in the country such as urgent and emergency, intensive and elective care.

General practice offers a mixture of acute and preventative services; it is the first port of call for many people when they are ill and GPs often refer patients on to acute services in hospitals. But general practice can also be preventative. If fully resourced, GPs can get to know their patients over a long period of time – known as 'continuity of care' – which can help them pick up on health problems early.[1] They can also provide advice about how to live a healthier lifestyle and refer patients to programmes such as the Diabetes Prevention Programme (see Case Study 2).

Mental health services similarly deliver a mixture of preventative and acute services. The NHS spent £12bn on mental health services in 2021/22.[2] Of that, £3.9bn (32.2%) was spent on inpatient services, crisis and liaison services, and perinatal care – three areas which can be thought of as more acute.[3] Simultaneously, £3.4bn was spent on core community services and talking therapies – two service areas which are more preventative.[4] The remaining £4.8bn (39.8%) was spent on children and young people's services, central services and "other services", which likely contain both acute and preventative spending. In its assessment of mental health services, the NAO argued that there is still "only limited investment in areas relating to prevention".[5]

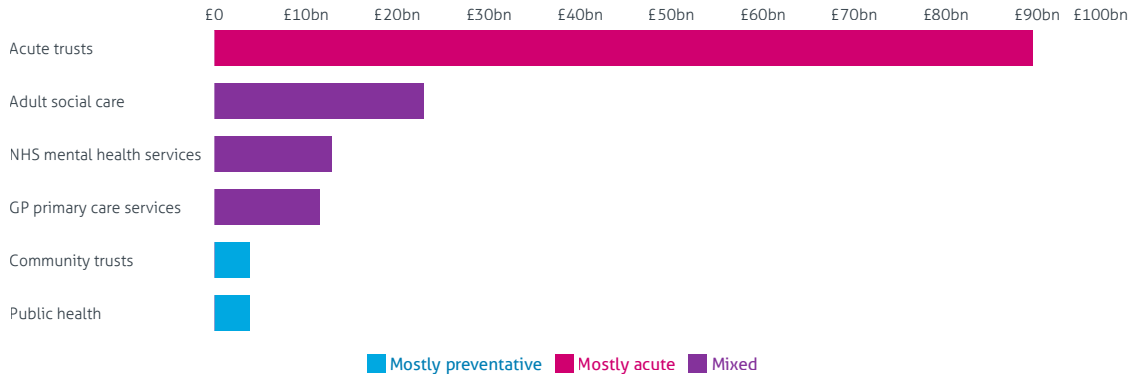
Adult social care is a more nuanced case. If done well, adult social care can help people to live independently and to stay out of hospital.[6] But, as previously discussed, local authorities are also only providing care when someone's need becomes so acute that it risks breaching the council's statutory duty.[7] This means there are elements of both acute and preventative provision within adult social care.

Community health is a collection of NHS services delivered outside of acute trusts. They can be delivered in people's homes through services such as health visiting, in community hospitals, in health clinics and in other places.[8] The range of services delivered in this setting are much more preventative than most delivered by acute trusts. During her time as minister of social care, Caroline Dinenage argued that "community health services, already helping hundreds of thousands of patients to receive care in their own homes, will be critical to [the government's prevention policy.]"[9]

Public health is arguably one of the most purely preventative services that the government offers. A parliamentary committee from 1988 defined public health as "the science and art of preventing disease, prolonging life and promoting health through organised efforts of society".[10] Public health interventions predominantly happen further upstream and are generally designed to reduce the likelihood of disease developing in the future.

The government currently spends far more on the more acute services in health and social care. In total, the government spent £144.5bn on acute trusts, adult social care, GP primary care services, mental health services, community trusts, public health and adult social care in 2022/23.*

Figure B.1 **Spending on the health and social care system, by type of service, 2022/23**

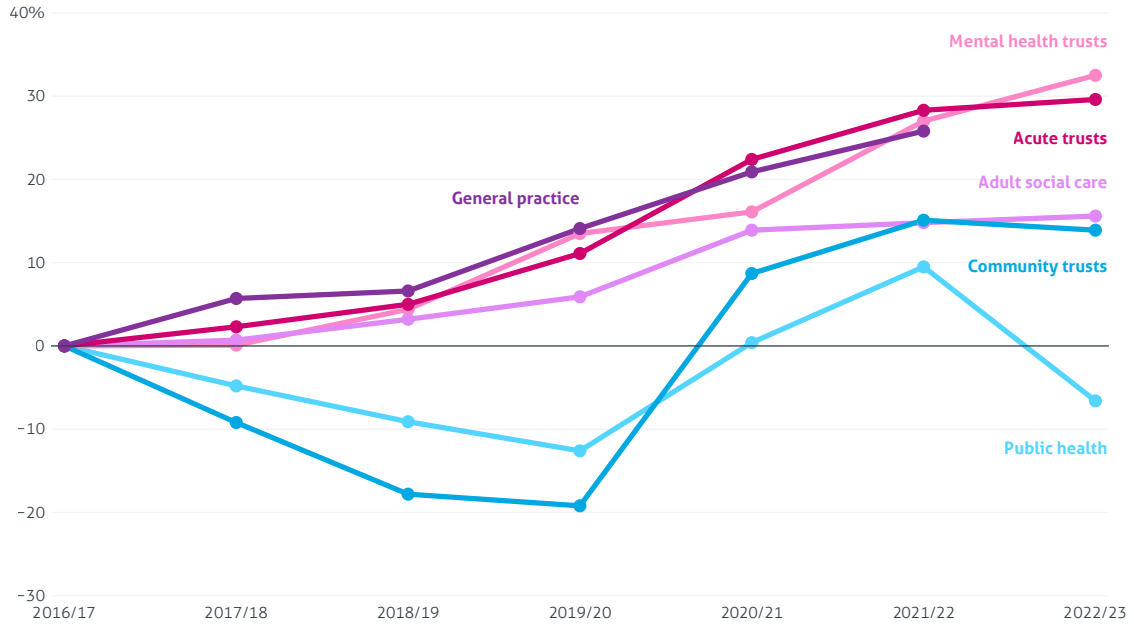


Source: Institute for Government analysis of NHS England, 'Annual report and accounts' ('Operating expenses' table), 2022/23, NHS England, 'Consolidated NHS provider accounts' ('Analysis by type of trust' table), DLUHC, 'Local authority revenue outturns: RO3', 2022/23 and NHS Digital, 'Adult Social Care Activity and Finance Report, England 2022-23' ('Appendix B, Table 5'). Notes: 'GP primary care services' in this chart is a different spending metric than shown in other charts in this report. We use this metric to show the most recent, non-Covid year for all services. 'NHS mental health services' shows spending from 2021/22, put into 2022/23 prices. This is because this is the most recent year for which there is data.

Of that £144.5bn, the NHS spent £89.5bn (62%) on acute hospitals. The next largest area of spending was adult social care, which received only £22.9bn (15.9%) of spending in 2022/23. Third was mental health services, where spending was £12.8bn (8.9%). Spending was lowest on community trusts and public health where the NHS and local government respectively spent £3.9bn on each of those services in 2022/23 – 2.7% of the total spent.

* NHS mental health service spending (£12bn) is for 2021/22, as this is the most recent year for which there is data. That spending has been converted into 2022/23 prices (£12.8bn) to make it comparable to other spending amounts. This is the amount shown in the chart and referred to from now on.

Figure B.2 **Change in spending on health and care services, by service, since 2016/17 (real terms)**



Source: Institute for Government analysis of NHS England, 'Consolidated NHS provider accounts' ('Analysis by type of trust' table), DLUHC, 'Local authority revenue outturns: RO3', 2022/23, NHS Digital, 'Adult Social Care Activity and Finance Report, England 2022-23' ('Appendix B, Table 5') and NHS England, 'Investment in General Practice, 2017/18 to 2021/22' ('Table 3a'). Notes: The time series starts from 2016/17 because this is the first year for which we have data for all metrics. 2021/22 is the most recent year for GP spending data. This includes Covid spending in 2020/21 and 2021/22.

Since 2016/17, spending on mental health and acute hospital trusts rose by 32.5% and 29.6% respectively in real terms – more than on general practice, adult social care or public health. This is despite the fact that spending on NHS trusts likely outpaced spending on the other areas of the health and care sector in the years between 2009/10 and 2016/17. This is difficult to prove, as individual data for acute, mental health and community trust spending is only available from 2016/17 onwards. But if spending on acute and mental health trusts followed the pattern of spending on all hospitals, it would certainly have increased meaningfully between 2009/10 and 2016/17.[11]

Spending on adult social care grew less quickly between 2016/17 and 2022/23, despite a real-terms cut of 9.3% between 2009/10 and 2014/15.

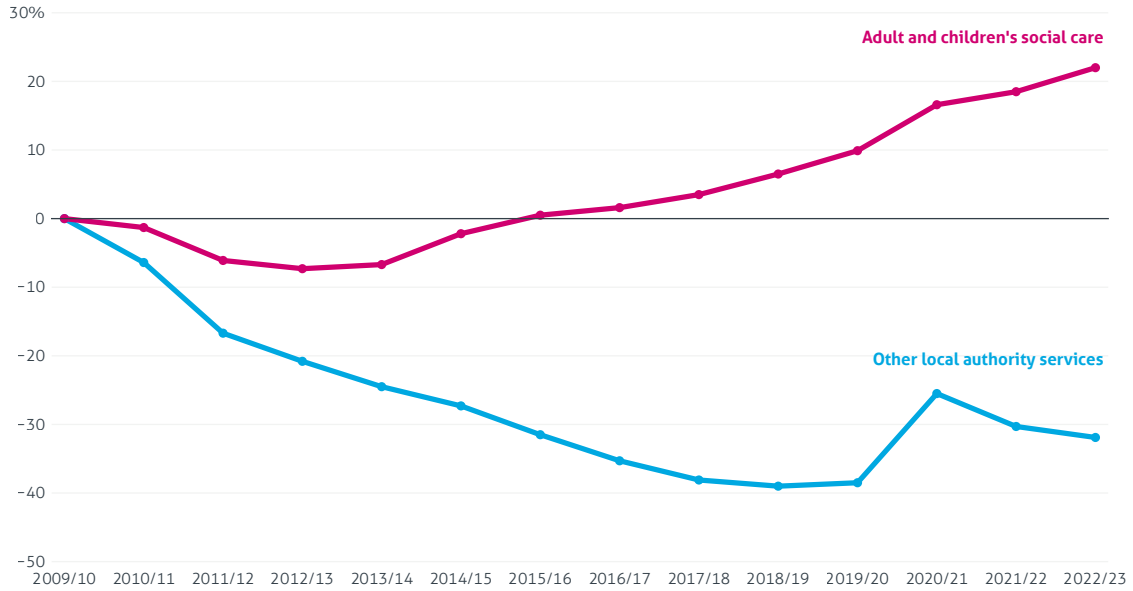
General practice more or less tracked acute trust spending increases between 2016/17 and 2021/22 (the last year for which we have data) but that service also experienced funding cuts between 2009/10 and 2013/14,[12] meaning that – as with adult social care – it is likely behind the funding increases that acute trusts have benefited from since 2009/10.

At the most preventative end of the spectrum, spending on community trusts grew by 13.9% in real terms between 2016/17 and 2022/23, following a period before the pandemic in which spending had fallen – to a low of -19.2% beneath 2016/17 levels in 2019/20. The government actually spent 6.6% *less* in real terms on public health in 2022/23 than it did in 2016/17. Overall, it seems probable that the balance of spending has shifted further towards the acute end of the health and care spectrum over the last decade.

Local authorities are spending an increasing proportion of their budgets on acute services

Central government cut grant funding to local government by 31% in real terms between 2009/10 and 2021/22.[13] Some of that loss was offset by rising income from council tax rises and sales, fees and charges, but the result was that local authority spending power fell by 10.2% by 2021/22. At the same time, demand increased, putting pressure on acute, statutory services such as adult social care. Falling funding and rising demand for statutory services led local authorities to cut non-statutory services, many of which are preventative.[14]

Figure B.3 **Change in local authority spending, by service, since 2009/10 (real terms)**



Source: Institute for Government analysis of DLUHC, 'Local authority revenue outturns', 2009/10-2021/22 and NHS Digital, 'Adult Social Care Activity and Finance Report, England 2023-24' ('Appendix B, Table 5'). Notes: Data from the revenue outturns shows total expenditure. This includes spending on Covid-related activity in 2020/21 and 2021/22.

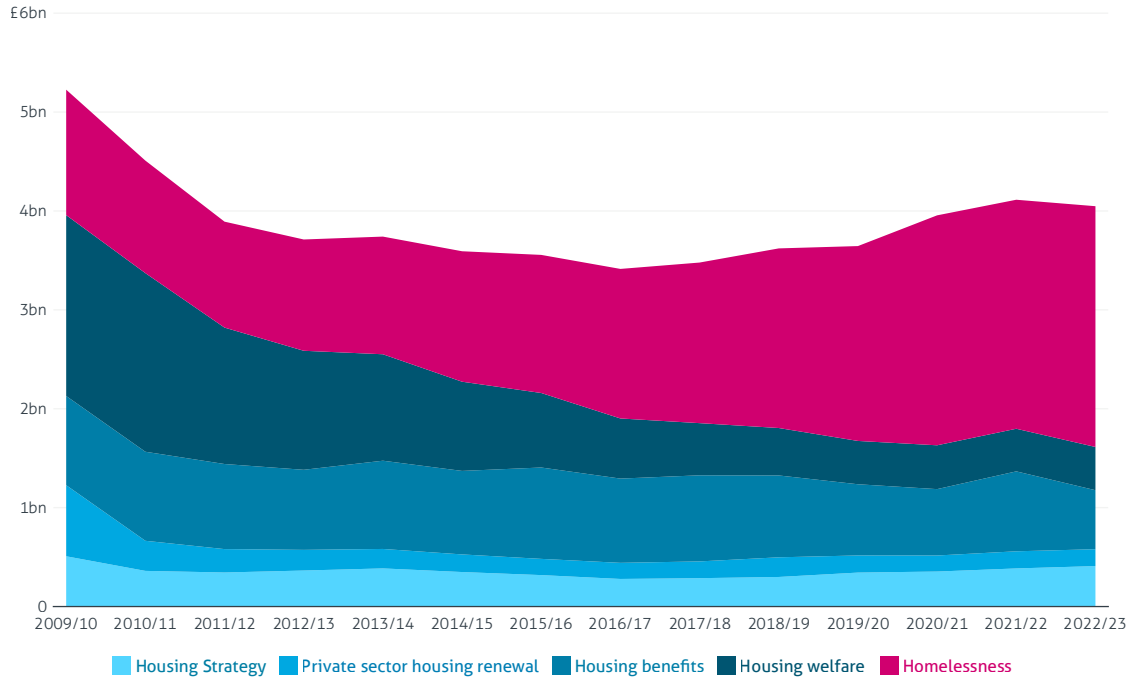
Spending cuts did not fall equally across all services. Spending on social care – for both children and adults – increased by 22% in real terms between 2009/10 and 2022/23. In the same time period, spending on other local authority-provided services fell by 31.9% in real terms. That spending includes a range of non-acute services such as libraries and cultural services – which includes things like museums, theatres and arts development – which were cut much more severely, by 47.4% and 36.1% respectively in real terms. Meanwhile, spending on the more acute, demand-led services were relatively protected. These are also services which local authorities have a more stringent statutory duty to provide. The result is that local authorities spent two thirds (66.9%) of their budget on adult and children's social care in 2022/23, compared to just over a half (53%) in 2009/10.

Councils are spending more on homelessness relief than preventing homelessness

As with the children's services described in Chapter 2, local authorities are spending much more on acute housing services – predominantly homelessness services – than they were at the start of the last decade. And as with children's services, the reasons for this are complex and multifaceted. These include: a change in statutory responsibilities for local authorities, rising poverty, decreasing generosity of the local housing allowance, a fall in the number of rental properties[15] and, likely, a reduction in upstream preventative spending.

The result of all these factors is that local authority spending on homelessness services – which are generally acute – almost doubled between 2009/10 and 2022/23 in real terms (an increase of 91.9%). In contrast, spending on housing welfare fell by 76.3% in real terms. Housing welfare is predominantly made up of the Supporting People Programme (SPP) which was designed to help people live independently and aims to "prevent crises such as hospitalisation, institutional care or homelessness, by providing early support when it is most effective".[16] In other words, SPP is an explicitly preventative programme. The result is that local authorities spent 60.1% of their housing budget on homelessness in 2022/23 compared to 24.3% in 2009/10.

Figure B.4 **Total local authority spending on non-Housing Revenue Account housing services, by type of service, 2009/10–2022/23 (2022/23 prices)**



Source: Institute for Government analysis of DLUHC, 'Local authority revenue expenditure and financing in England: individual local authority data – RO4', 2009/10-2019/20. Notes: This is total expenditure within a local authority's general fund, and therefore excludes spending that falls within the Housing Revenue Account.

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Annex B

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