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Guest Editorial

Fit for whose future? A critical omission of people with intellectual disability in the 2025 NHS 10 Year Health Plan for England

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Summary

The NHS 2025 Health Plan aims for radical reform but overlooks people with intellectual disability. This editorial highlights critical omissions in policy, services, research and rights protections. Without intentional inclusion, digital and community shifts risk deepening inequality. True progress demands co-produced strategies to ensure equitable care for this vulnerable population.

Keywords

Intellectual disability; life expectancy; mental health services; patients and service users; prevention.

The UK Government's 2025 Fit For The Future: 10 Year Health Plan for England ('the Plan') boldly promises to reinvent the National Health Service (NHS) through three strategic shifts: from hospitals to communities, analogue to digital and sickness to prevention.[1] Framed as a radical departure from a failing model, it emphasises equity, digital empowerment and genomic-driven personalisation. However, for people with intellectual disability, a population historically subject to entrenched health inequalities and poor outcomes, the Plan, while recognising that it is not a legislative framework, is a mix of promising rhetoric and notable silence.

While the Plan rightly acknowledges that the NHS 'works least well for those who already experience disadvantage', it fails to substantively engage with people with intellectual disability. There is only a singular dedicated mention of intellectual/learning disability in the entire document, despite this population having markedly elevated risk of premature mortality, diagnostic overshadowing, fragmented care and high physical and mental health morbidity.[2,3] In contrast, intellectual/learning disability is referred to 47 times in the main text of the preceding NHS Long Term Plan (2019).[4]

Silences that speak loudly

The lack of a targeted strategy for people with intellectual disabilities is striking. The NHS Long Term Plan (2019) committed to improving understanding of intellectual disability across the entirety of the NHS, increasing annual health checks, reducing inappropriate prescribing, tackling preventable deaths and delivering on the Transforming Care agenda.[4] Nonetheless, the 2025 vision is silent on these vital issues.[1]

There is no mention of specialist in-patient services or the ongoing need for evidence-based use of hospital beds, nor a plan for improving community alternatives.[5] Despite decades of policy commitments, a significant minority remain detained in inappropriate settings, often for years without clear therapeutic justification, including misuse of long-term segregation and seclusion. The 168-page document offers no roadmap for how the new integrated neighbourhood care models will include or replace these institutional pathways.

Another omission is policy guidance to support reduction of irrational polypharmacy, particularly the overuse of psychotropic medication. The programmes stopping over-medication of people with a learning disability and autistic people (STOMP) and supporting treatment and appropriate medication in paediatrics (STAMP) have shown that rationalisation of psychotropics is a significant challenge. Nevertheless, the Plan contains no reference to sustaining, expanding or embedding this work into community health frameworks.

Furthermore, the lack of discussion about the reform of the Mental Health Act, specifically the implications and consequences of removing intellectual/learning disability as a condition warranting admission to hospital for treatment under Section 3, is deeply concerning.[6] This legislative change has far-reaching implications for how care is commissioned and delivered for this vulnerable group, and its omission reflects a failure to engage with rights-based reform and the potential unintended consequences.[6]

In parallel, the Plan fails to engage with the ethical risks posed by imminent assisted dying legislation, offering no assurance of specific safeguards for people with intellectual disability who may have impaired decision-making capacity, be at heightened risk of coercion and be at risk of diagnostic overshadowing, where symptoms are erroneously attributed to their intellectual disability, with the actual cause of their suffering being undetected and untreated.

These silences are compounded by the Plan's failure to address the exclusion of people with intellectual disability from research and innovation.[7] There is no strategy to ensure inclusive research, equitable access to clinical trials or adaptations for participation in genomic or digital health initiatives. As a result, this group is at risk of being left behind and, in effect, will no longer 'exist' in the very future the Plan seeks to build.

Most strikingly, the patient and family/carer voice is absent. While the Plan draws on extensive public consultation, it is unclear how the perspectives of people with intellectual disability and their supporters were sought, included or incorporated. This undermines claims of co-production and belies the Plan's commitment to giving patients more choice and control. Without transparent and full engagement with people who face the greatest barriers, the system risks reinforcing inequality under the guise of reform. Relatedly, there is no easy-read version of the Plan, rendering it effectively inaccessible to many people with intellectual disability.

View of people with lived experience and their supporters

The Learning Disability Policy group, attended by representatives of national charities including MENCAP, Learning Disability England and Challenging Behaviour Foundation, met to discuss our concerns around the Plan, it's implementation and the next steps. There was unanimous disappointment at the lack of specific mention of intellectual disabilities in the Plan.

There is a missed opportunity in the Plan to transcribe lessons learnt from the pandemic, where people with intellectual disability were disproportionately impacted on all levels. Significant changes to practice were made to offer alternative options, such as virtual consultations, enhanced choice and reduced reliance on traditional patient records. There is no suggestion to build forward from this.

Taken together, these omissions represent more than a missed opportunity. They reflect a systemic neglect of one of society's most neglected subpopulations who die, on average, 20 years earlier than the general population, as well as being almost twice as likely to have a death deemed avoidable. A plan that aspires to be ‘fit for the future’ must include everyone, especially the most vulnerable, and those who are arguably among the most reliant on the NHS. Currently, it does not meet this goal.

Opportunities in the Plan for people with intellectual disability

Nevertheless, embedded within the Plan are concepts with potential, if applied with intent. The vision for neighbourhood health centres and integrated community teams could bring more accessible, localised care. However, without mandated inclusion of specialists or co-produced service design, these risk becoming another layer of generic provision where people with intellectual disability fall through the cracks.

The commitment to personalised care planning, wider use of personal health budgets and the expansion of patient-held digital records could empower some but, simultaneously, it risks alienating others. Many people with intellectual disability are digitally excluded, and digital-first approaches must be critically scrutinised and, where possible, adapted to avoid exacerbating inequities; for example, this group are significantly more likely to report difficulties navigating the website of their general practice.[8] These issues of accessibility need to be considered in the movement towards an increasingly digital age of health service provision. Reasonable adjustments mandated under the Equality Act must be integral to digital and artificial intelligence rollouts.

The Plan's embrace of genomics and artificial intelligence offers promise of some clinical innovation, but again is without explicit frameworks or safeguards against exclusion specifically for vulnerable populations. Genomic medicine is particularly relevant to this patient group, as outlined in the RCPsych report on genetic testing.[9] Ensuring that people with intellectual disability have access to genetic testing as routine when in receipt of specialist services would seem to fit with the overall aims of the Plan, and yet is not mentioned. Genomic initiatives must avoid concerns of eugenic framing of disability, and artificial intelligence tools must be designed to avoid biases that disproportionately impact people with communication/cognitive differences.

Mental health in the margins

There is some recognition in the Plan of the importance of mental health, with proposed same-day emergency mental health departments and expanded school-based teams. However, there is no recognition of people with intellectual disability with co-occurring mental illness, arguably among the most complex and underserved groups in psychiatry. The intersection of intellectual disability and psychiatry is an area where clinical leadership is vital yet appears absent in strategic vision.

Workforce implications

The Plan's three shifts will lead to new service models more reliant on early intervention and prevention. This has significant workforce implications, with greater emphasis on multi-agency and partnership working and greater use of mainstream services with suitable adjustments. Priority will have to be given to workforce implications that are focused on improved physical health care, specifically to address the prevention of worsening of health inequalities seen in this vulnerable population.

A policy and research agenda for inclusion

If the future of the NHS rests on delivering care closer to home, shifting from sickness to prevention and embracing digital innovation, then people with intellectual disability must be intentionally included in both policy and research to avoid deepening of existing inequities. Delivering community-based care will require robust investment in specialist intellectual disability teams, embedded within neighbourhood health centres, with adequate staff training, managerial governance and care continuity. Prevention must move beyond rhetoric and adopt tailored approaches to address the known social determinants of poor health, such as poverty, housing instability, diagnostic over-shadowing and carer support, using co-designed tools and not top-down assumptions. It will need investment into social services. The shift to digital must be accompanied by targeted accessibility strategies, inclusive design standards and meaningful digital inclusion initiatives, and not simply app-based services that exclude by default.

Most urgently, a dedicated national research strategy for intellectual disability is needed, with people with intellectual disability as participants and not bystanders; without this, the promise of precision medicine, predictive analytics and personalised care will remain out of reach for those most in need. Policy without inclusion is inequity by design.

Table 1 provides a blueprint on how to make the Plan inclusive and transformative, by integrating intellectual disability within its core across all three of its strategic shifts.

How to put theory to practice

Although some of the principles of Plan are relevant for people with intellectual disability, co-production at all levels will be vital when it comes to interpretation and implementation of the Plan for this population. It would be important to ensure meaningful co-production in policies and practices to address health inequalities, in developing clinical and multi-agency care pathways and in research. Some examples of these approaches are the outputs of national networks such as Cornwall Intellectual Disability Equitable Research (CIDER; https://www.plymouth.ac.uk/research/cider-cornwall-intellectual-disability-equitable-research), ResaArch in DevelopmentAl NeuropsychiaTry (RADiANT; https://radiant.nhs.uk/) and Centre for Autism, Neuro-Developmental Disorders and Intellectual Disability (CANDDID; https://www.canddid.nhs.uk/), who have

Table 1 Arguments and proposals to integrate intellectual disability into the National Health Service (NHS) 10 Year Health Plan (the Plan)

Key arguments for including intellectual disability in the Plan
Societal and political attitudes towards intellectual disability are still not sufficiently mature to ensure that the needs of people with intellectual disability would be met without being specified. Policy-makers at both the local and regional level will not necessarily be thinking about disability.
People with intellectual disability access all types of health and social care services, and all these services need to be aware of what needs to be done for them.
People with intellectual disability are a heterogeneous population, and there cannot be a generalised approach that would address all their needs.
National Health Service and social care systems and processes are geared to meeting the needs of the majority, but that always leaves those at the margins struggling to access services.
The model of neighbourhood care and its funding needs careful consideration, given the regional variation based on local resources, priorities, political attitudes and funding pressures. It risks further marginalisation of those at the margins.
Issues resulting from intersectionality, i.e. the specific needs of certain groups within the intellectual disability population (e.g. ethnic minorities, underserved communities etc.), must be addressed actively.
Intellectual disability is currently largely excluded from research and development in public health, preventative and social medicine.
Suggested key elements needed to integrate intellectual disability across the Plan's three strategic shifts
Embedding health leads for people with intellectual disability in neighbourhood health centres.
Introducing systems to monitor and identify any emerging disparities from implementation of the Plan over the coming years.
Committing to intersectional data collection and accountability on health inequalities and premature deaths.
Mandating reasonable adjustment training across community and digital health teams.
A coherent model of the delivery of improved physical healthcare.
Developing workforce models that support the emerging service models.
Using data science to understand social determinants and public health needs for this population.
Developing measurable targets for outcomes and access equity for people with intellectual disability.
Ensuring that digital tools are co-designed with, and for, people with intellectual disability and their carers.
Exploring technology in providing preventative strategies in complex health and social needs, using people with intellectual disabilities as a template.
Quality improvement and inclusive research programmes on key health and social concerns.
Focusing on co-designing neighbourhood health centre services with people with intellectual disability and their supporters.
Preventing digital exclusion by considering involving carers and people with intellectual disability in digital accessibility audits.
Ensuring satisfactory independent oversight by lived-experience advisory groups of clinical pathways for developments such as the Assisted Dying Bill and genomic policy, to mitigate potential concerns.
Moving from treatment to prevention, and from hospital to the community, could enhance the role of family carers in supporting upstream actions consistent with early intervention and prevention, if planned correctly.

made co-production central to all their research and service development initiatives.

CIDER, a university–NHS spin-out, leads co-produced national and international research into conditions overrepresented in people with intellectual disability (e.g. epilepsy, constipation), addressing iatrogenic harm and advancing genetics and technology for precision and personalised care. Its work has produced evidence-based guidelines, tools and best practice with lived-experience stakeholders. CANDDID specialises in co-development of psychosocial interventions and research with neurodivergent populations, including training professionals and setting service and research priorities. RADiANT, a network of clinicians, academics and experts by experience, promotes public education, staff training and research into five neurodevelopmental conditions, influencing clinical care, service design, policy critique and research methods.

While distinct, these three networks collaborate closely with each other and external stakeholders (e.g. charities, NHS England etc.) to identify and address barriers to inclusion such as funding constraints, tokenistic consultation, poor professional training, accessibility issues and negative attitudes among decision-makers. Their co-designed care pathways, easy-to-read consultations and research involving people with intellectual disability as co-investigators have improved service relevance, reduced health inequalities and built trust between communities and providers.[7] Collectively, they are well placed to exemplify meaningful delivery of the Plan for people with intellectual disability.

The NHS must not modernise by leaving behind the very people it has historically failed. The UK Government has called this a time for 'radical change: major surgery, not sticking plasters'. Nevertheless, in the case of intellectual disability, it has left the wound exposed. But it is not too late. The silence in this Plan can still become space for listening if policy-makers choose to hear. Inclusion, when it comes, must be bold, specific and resourced. People with intellectual disabilities, their families and those who work alongside them know what 'better care' could and should look like. The NHS must now open its future to their voices. For the NHS to be truly fit for the future, people with intellectual disability must be central, not marginal, to its transformation. Success for the Plan needs to be judged on how it has improved the lives and outcomes of the most vulnerable and disenfranchised people in society.

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