Industry in Focus

A fairer future: how can the NHS tackle health and social inequities?

pwc

Contents

Executive summary

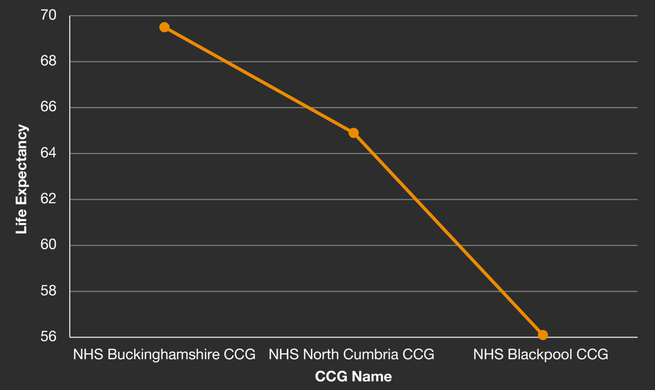
Equity is at the core of the NHS' founding principles. So why, 74 years after its creation, do people experience inequitable health outcomes?

Hailed as "the first health system in any Western society to offer free medical care to the entire population",[1] the NHS was designed, from inception, to be a universal service, free at the point of use, with access based on clinical need rather than an ability to pay.

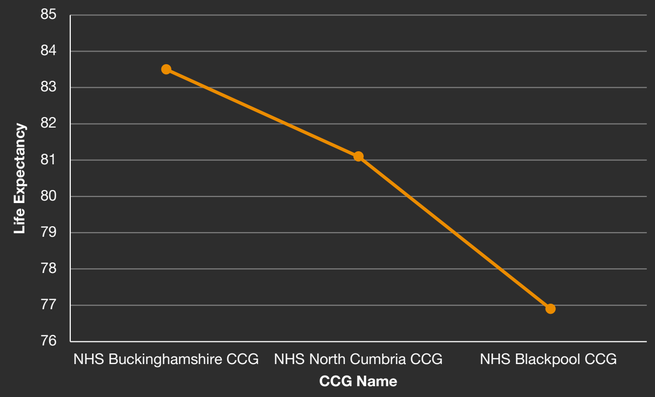
The NHS constitution states that it has "a wider social duty to promote equity through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population."[2]

Despite this fundamental commitment to equity, people in the different regions of England experience large variations in health outcomes.

Highest to median to lowest life expectancy per Clinical Commissioning Group (CCG)



Average healthy life expectancy by Clinical Commissioning Group (CCG)



1 Delamothe, Tony, 'Founding Principles', (2008)
2 Department of Health and Social Care, 'The NHS Constitution for England', (updated 2021)

Variations in health outcomes today – a snapshot

Age-adjusted mortality rates from COVID-19 are **two to three times higher** among black ethnic groups compared with white ethnic groups.[3]

The life expectancy of people with a learning disability is **23 to 27** years less than the rest of the population.[4]

The difference in healthy life expectancy between the most and least healthy places in England is **26.2 years**.

The life expectancy of men in the 10% most deprived areas of England was almost **a decade less** than those in the least deprived areas in 2017-19.[5]

Women in the 10% least deprived areas in England can expect to live almost **eight years longer** than those in the most deprived areas.

Even before the pandemic, **life expectancy was falling** in one in five communities for women and one in nine for men, mostly in urban areas of northern England.[6]

3 Office for National Statistics, 'Coronavirus (COVID-19) related deaths by ethnic group, England and Wales: 2 March 2020 to 15 May 2020', (2020)

4 The 2018 Learning Disabilities Mortality Review found the median age at death was 60 for men and 59 for women, for those (aged 4 and over) who died April 2017 to December 2018. This is significantly less than the median age of death of 83 for men and 86 for women in the general population.

5 Men in the least deprived 10% of areas in England could expect to live to 83.5 years, almost a decade longer than men in the 10% most deprived areas (74.1 years). See Office for National Statistics, 'Health state life expectancies by national deprivation deciles, England: 2017 to 2019', (2021)

6 Head, Emily, 'Life expectancy declining in many English communities even before pandemic', (2021)

Discrepancies in health outcomes are driven by more than just healthcare. The social determinants of health (SDoH) are "the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels."[7] Healthy People 2020, a US federal government initiative, organises the SDoH into five themes:

1. economic stability;
2. education;
3. health and healthcare;
4. neighbourhood and the built environment; and
5. social and community context.[8]

The Marmot Review, which assessed strategies to address health inequities in England in 2008, summed up the outcomes of these themes succinctly: "People with a higher socio-economic position in society have a greater array of life chances and more opportunities to lead a flourishing life. They also have better health. The two are linked."[9]

In fact, access to healthcare is estimated to influence up to 20% of total health outcomes[10], which is often taken to mean that the NHS has limited scope to significantly improve these inequities. But the NHS doesn't just provide healthcare. It is also one of the world's biggest employers, employing roughly one in 20 people in the UK. It also has huge economic power, with an annual budget of £136 billion in 2021/22[11] and a real estate portfolio estimated at more than £30 billion[12]. In other words, its impact reaches across all five SDoH themes. And even if it didn't, the 20% of outcomes influenced by access to healthcare represents a significant opportunity to maximise its impact on health equity.

This poses the question: Is the NHS maximising its impact on health equity? And, if not, what more could it do?

Defining health equity

Throughout this paper we use the World Health Organization's definition:

"Health equity is defined as the absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically or geographically."[13]

7 World Health Organization, *'Social determinants of health'*
8 https://wayback.archive-it.org/5774/20220413183449/ https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources
9 Marmot, Michael, Goldblatt, Peter, Allen, Jessica, et al, *'Fair Society, Healthy Lives (The Marmot Review)'*, (2010)

10 Hood, Carlyn M., Gennuso Keith P., Swain Geoffrey R., and Catlin Bridget B., *'County health rankings: Relationships between determinant factors and health outcomes'*, (2016)
11 The King's Fund, *'The NHS budget and how it has changed'*, (2022)
12 NHS Property Services

13 World Health Organization

Our work on health inequities

Over the last year we have conversed with experts and leaders, some of whom work within the NHS, researching how health inequities manifest in England and how they could be influenced by the NHS. These interviews also included individuals from across the public sector, charities and PwC's international colleagues. To complement this, we polled approximately 2,000 members of the public to understand broader perspectives on what role the NHS should play in reducing health inequities, asking their views of it as a provider, employer and buyer. Our respondents are from diverse backgrounds, varying by region, age, ethnicity, employment, income and education.

Our primary research polling is UK wide, for the NHS statistics, we have focused on NHS England as UK-wide data sets are not available. Many of our recommendations can be applied to the UK.

Since launching our summary report in June 2022, we have continued to receive input from across the NHS and wider communities.

We are pleased to now outline our findings and recommendations in greater detail.

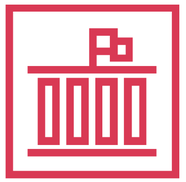
Barriers for the NHS in tackling inequities

During our research, it was suggested by various interviewees that it would be useful to establish a “clear diagnosis of the barriers to the NHS on overcoming the problem of inequities”. By analysing the issues described by our contributors, we identified **nine barriers** preventing the NHS from being more impactful in its role in tackling inequities. These are grouped into **three strategic themes** and used at the end of the executive summary to analyse the potential impact of our recommendations.

Structures and accountability

The scale of the NHS, and its tendency towards high degrees of central control, make it difficult to work in partnership across organisations at a local level. Among other problems, this makes it difficult to effect change and share knowledge that could make a positive difference to inequities.

Because health inequities are influenced by wider determinants and societal factors, which are difficult to immediately address, it is hard to hold individual organisations to account.



There is no accountability process to hold national leaders to their promises, putting a burden on system leadership to actively galvanise resources and capacity to introduce impactful changes in the face of competing priorities.

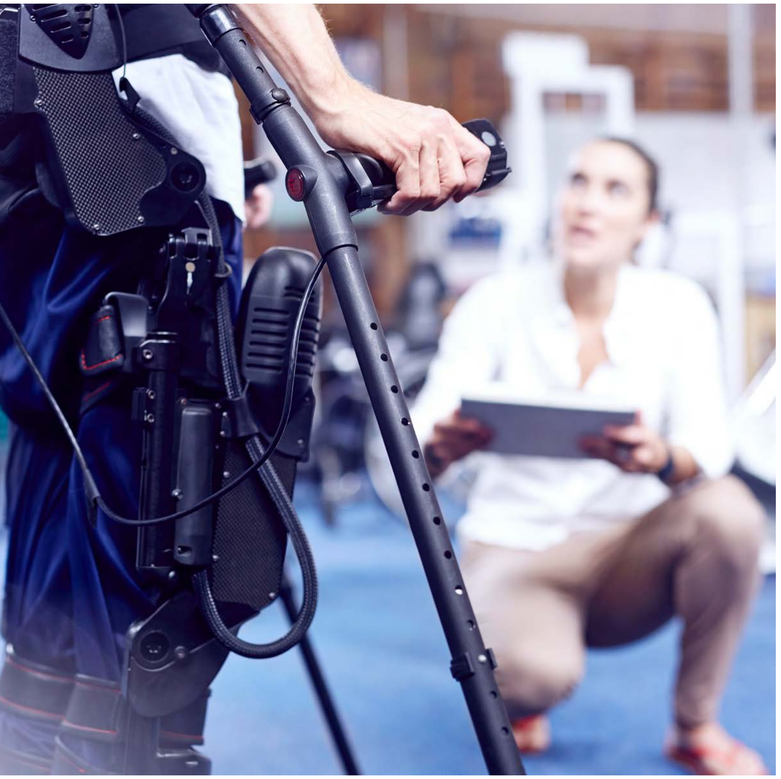
Resources and priorities

There are significant financial pressures on the NHS due to years of austerity and relative cuts to the service restricting its ability to invest in initiatives that reduce inequities.

There is a workforce shortage in the health and social care sector. This means that staff act reactively to the impacts of inequities as opposed to proactively tackling its causes due to time constraints and pressures elsewhere across the system.

Political pressures affecting where resources are allocated mean that some communities are underserved, which perpetuates inequities.

Social and technological changes



The NHS' services are increasingly delivered digitally – a shift accelerated by the pandemic – but its benefits and risks are not evenly distributed throughout society.

The NHS fails to effectively utilise its data to tackle inequities.

By definition, under-represented groups have less of a voice in service design, so services aren't consistently designed with adaptations to boost equitable access such as transport access, physical design of facilities and mitigations for language barriers.

Our findings

Our findings show that a huge amount of work is already underway in many areas, with a notable gear change evident over the last 18 months. This follows commitments to prevent and address healthcare inequalities in the NHS Long Term Plan, and five strategic priorities being included in the NHS Operational Planning Guidance 2021/22.[14] Describing the extraordinary work happening every day across the NHS would be a monumental task, so we have focused our attention on a handful of areas where we believe tangible action could be taken. As such, we have identified nine key findings and ten recommendations, which are supplemented with case studies of good practice that could be replicated more broadly.

The NHS as a provider

1. **The formula used to distribute funding includes adjustments aimed at improving health equity,** but there are still some stark contrasts when comparing funding and outcomes. In addition, the move towards larger commissioning footprints risks significant variations being obscured at the local level.

   Although there is a negative correlation between funding and life expectancy/ healthy life expectancy (i.e. places with relatively poorer outcomes tend to receive higher funding per capita, owing in part to the health inequities adjustment in the funding formula), the relationship is not strong. There are several examples of places with relatively poor levels of funding and poor outcomes and vice versa, as shown in the table here.

	NHS Leicester City CCG	Percentile	NHS East Sussex CCG	Percentile
2019-20 funding allocation per capita (£)	1572.00	95%	1880.00	27%
Average female life expectancy at birth	82.00	73%	84.00	22%
Average male life expectancy at birth	77.30	92%	80.20	27%
Healthy life expectancy women	59.00	83%	63.00	51%
Healthy life expectancy men	59.00	86%	65.00	25%
Incomplete pathways per hundred people	20.18	52%	21.54	68%
52+ week waiters per hundred people	2.87	99%	0.37	11%
Population per GP	1870.00	74%	1911.00	77%
COVID-19 deaths per capita	158.00	56%	138.00	43%

Making comparisons like this has become more difficult as the number of CCGs in the country has decreased in recent years because of larger footprints obscuring differential investment and outcomes between areas. It will become increasingly difficult following the creation of ICBs earlier this year.

Although larger footprints have many advantages, averages across large geographies risk obscuring significant variations within them. As a result, historical disparities in services and funding could become entrenched.

For example, prior to the merger of CCGs in North West London, the Royal Borough of Kensington and Chelsea had some of the highest life expectancy statistics in the country, combined with funding per capita in the top 20% nationally. The funding for the post-merger North-West London CCG is in the bottom 20% and its outcomes are around the mean. This shifts the onus for allocating funding to overcome inequitable outcomes to ICB commissioning decisions rather than being driven systematically through the national funding formula.

14 See https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/our-approach-to-reducing-healthcare-inequalities/strategic-drivers/ for more detail

2. **There is more public support for equal access than there is for equity of outcomes**

   In our poll, 87% of UK adults believe that people should have equivalent access to NHS services regardless of where they live, while 56% think resources should be allocated according to where the need is greatest.

3. **The NHS does not consistently measure and report equity measures across key performance metrics**

   For instance A&E, cancer and elective wait times are not consistently broken down and reported along ethnic, social and economic lines.

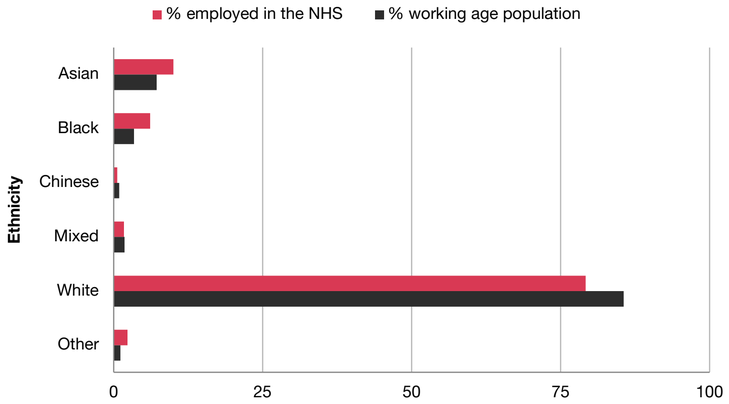
4. **Adopting new methods for delivering services has the potential to reduce or exacerbate inequity**

   For example, virtual consultations make access to services much easier for people with mobility or travel restrictions, but risk excluding those with language or technology barriers. This mustn't be used as an excuse to avoid virtual consultations becoming routine, but appropriate adaptations and alternatives need to be in place to ensure potential negative impacts are minimised.

The NHS as an employer

5. **The NHS compares well to other large employers in terms of workforce diversity**

NHS employment by race



As shown in the chart on this page, the ethnic diversity of the NHS workforce broadly reflects the working age population nationally.

6. **But minority groups are poorly represented at more senior grades**

   The NHS Workforce Race Equality Standard Leadership Strategy shows that, despite improvements in consecutive years, Black, Asian and minority ethnic representation at bands 8a upwards is 11.2% despite making up 18.9% of the total workforce.

   Even though NHS gender analysis suggests a roughly even split of men and women in senior roles, women, who make up 77% of the workforce, are much more likely to be in less well-paid roles.[15]

   Equivalent measurements related to representation from different social backgrounds are not routinely reported.

7. **Workforce wellbeing is being supported, but more could be done**

   Significant efforts have been made to increase support for staff wellbeing, particularly in relation to impact of the COVID-19 pandemic. But retention continues to be a challenge, and benefits and support for staff with some conditions and life events, such as bereavement, are inconsistent and often lag other leading employers.

15 NHS Employers, *'Gender in the NHS infographic'*, (2019)

The NHS as a buyer

8. **Legislation has shifted procurement focus to the social determinants of health**

   The Social Value Act of 2012 shifted the procurement mantra from ‘low cost’ to ‘value for money’, and now there is an increasing move towards measuring social value in procurement decisions. But this is early in its development, and links between local health and social equity objectives are not made consistently.

9. **There is scope to increase the use of the NHS’ buying power to put greater focus on local socio-economic determinants through the supply chain**

   A more focused and purposeful definition of value, linked to local health outcomes such as the SDoH (e.g. employment and air quality), would help the NHS make better use of the Social Value Act requirements in a way that specifically targets health equity.

Our recommendations

The NHS as a provider

1. Increase the size of the health inequities adjustment in the ICB funding allocation formula to direct greater funding towards places with lower overall outcomes.
2. Use more consistent messaging to improve public understanding of the discrepancies in outcomes between different population groups. Reporting these metrics should be treated with the same significance as the 18-week and four-hour wait metrics, among other commonly reported measures.
3. Ensure that all key performance measures are systematically analysed and reported in a way that indicates equitable service use – by age, gender, location, economic deprivation, employment, education and race.
4. Each integrated care system (ICS) and provider should establish a comprehensive strategy for improving health inequities that includes measurable targets. This should be supported by programme boards/ working groups within providers taking practical steps to improve performance.
5. Boost the profile of health Equality Impact Assessments (EIAs) associated with changes in working practices and use them to inform mitigating actions rather than justifying inaction.

The NHS as an employer

6. Develop a national NHS Social Mobility Strategy, with actions based on evidence of good practice from top-ranked employers in both public and private sectors.
7. Scale up initiatives already in place in some parts of the country to create greater connections with local communities, such as driving increased numbers of apprenticeship schemes and partnering with schools in disadvantaged areas to further diversify recruitment.
8. Increase the pace and scope of action on workforce wellbeing, such as offering transport, greater potential for flexible working, and targeted support for employees with disabilities, medical conditions and life events (e.g. childbirth, adoption and bereavements).

The NHS as a buyer

9. Link supply chain and buying strategies to local health needs – for example, by including impacts on local population health issues (e.g. air quality or employment) as a scored element in procurement exercises.
10. Place a requirement on the suppliers of products and services to take action related to health equity, such as making progress against diversity targets, ethical procurement and investing in employee wellbeing.

Big actions for the NHS nationally

These findings and recommendations apply across various layers of the NHS. At a national level they include a handful of key actions that can be taken in the short term to make a significant impact across the whole service:

1

Increase the size of the health inequities adjustment in the ICB funding allocation formula to direct greater funding towards places with lower overall outcomes.

2

Systematise data collection to the most granular community level possible – to allow accurate and evidence-driven action.

3

Require every ICS, place and trust to establish and resource a programme to use this data to inform tangible action at a local level.[16]

4

Establish standard measurements that will be reported regularly and used to hold ICSs to account for delivering progress. The lag between input and impact means that this will need to be a mix of input measures (e.g. variation in wait times between ethnic, social and economic groups, uptake of apprenticeships or the proportion of goods and services sourced locally) and output measures (e.g. comparing the healthy life expectancy metric with the national average or between different groups within the ICS).

5

Develop a national NHS Social Mobility Strategy, with measurements and reporting akin to the Workforce Race Equality Standard (WRES).

16 This was reflected as one of the five strategic priorities for reducing health inequalities in the operational planning guidance of 2021/2022: "Priority 3: Ensuring datasets are complete and timely". See https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/our-approach-to-reducing-healthcare-inequalities/strategic-drivers/ for more details.

How these recommendations compare to the barriers faced by the NHS

Which barriers would our recommendations impact?

	Size of the NHS prevents partnership working	Hard to hold individual organisations accountable	Accountability of leadership	Financial pressures	Workforce shortages	Political pressures on resource allocation	Digital inequities	Underutilised data	Services aren't consistently designed with appropriate adaptations
The funding allocation formula should be progressively updated to direct greater funding towards places with lower overall outcomes				✓	✓	✓			✓
The public needs to be informed of discrepancies in outcomes between different groups		✓	✓				✓	✓	
All key performance measures across the NHS should be broken down, shared, and reported by age, gender, location, economic deprivation, employment, education and race		✓	✓				✓	✓	✓
Each ICS should establish a comprehensive strategy for improving health inequities, with measurable targets based on the data collection		✓	✓				✓	✓	✓
Boost the profile of health EIAs	✓	✓	✓				✓	✓	✓
Utilise the representative groups within the NHS to build understanding of the wider community and to inform better services		✓	✓	✓			✓	✓	✓
Increase the pace and scope of action on workforce wellbeing		✓	✓		✓				✓
Develop an NHS Social Mobility Strategy	✓			✓	✓				✓
The NHS should seek to link supply chain and buying strategy to local health needs, targeting "value" definitions at individual groups and issues where appropriate				✓		✓			
Require key suppliers to evidence similar standards with regards to employment practices				✓		✓			

Conclusion

Broader economic and policy issues will continue to act as headwinds to the NHS' efforts to improve health equity. These include competing internal priorities, such as urgent and emergency care performance, the elective backlog, workforce shortages and financial pressures. For the NHS to successfully achieve this objective, action on health equity can't compete with other priorities, but instead must be a foundational principle upon which the response to these other challenges are built.

Some themes are consistent across our examination of the NHS as a provider, employer and buyer. Two stand out:

1 **Maximising the value of data.**

The NHS collects and uses a huge amount of data but its analysis is inconsistent from an equity point of view. Improving this consistency would help better inform the public and point towards challenges and opportunities.

2 **Using the opportunity afforded by ICSs and ICBs.**

The development of ICSs and creation of ICBs represents an opportunity to cement the role of the NHS as a local anchor institution and accelerate its own action on health inequities, as well as influencing its partners more effectively.

We hear first-hand from our clients that health equity should be a higher priority in the NHS, an opinion that has been expedited by the pandemic. Public sentiment also resonates with this.

According to two thirds (68%) of UK adults, the pandemic has made health equity worse and 63% say the pandemic has had a negative impact on their access to health and/or social care services.

While there has been a recent doubling down on the issue, with the NHS showing great intent, increased focus and tangible action, this is inconsistent across the country.

The pandemic has shown that healthcare needs to be accessible and equitable to all, as the virus (and any future variants) affects everyone in society it did not affect everyone in the same way. The COVID-19 vaccination programme proved that enormous change can be achieved when resources, funding and leadership are focused on a clear, shared issue. Among the programme's many impressive features, it used data to inform a strategy to maximise its effectiveness and target resources where the biggest opportunities lie. If health equity could be treated with the same urgency and inventiveness, amazing things could be achieved.

"This report is rightly focusing on an area of significant impact for our underserved populations and the NHS. The evidence based approach is most welcome.

The solution focus in incredibly useful."

Dr Bola Owolabi
Director – National Healthcare Inequalities Improvement Programme

The NHS as a provider

On an average day NHS England delivers a staggering

841,096
GP appointments

68,019
A&E attendances

246,165
outpatient appointments

78,115
calls responded to for NHS111 and ambulance services

1.5 million[17] **people**
interact every day with the NHS across a huge range of services, which are free at the point of use

17 The King's Fund, *'Activity in the NHS'*, (2020)

If access to healthcare accounts for 20% of health outcomes, the NHS is arguably better placed than any other organisation in the world to maximise the equitable impact of this 20% because of its size. This section explores our findings and recommendations on key actions that the NHS can take to improve health equity through its services.

1. The formula used to distribute funding includes adjustments aimed at improving health equity…

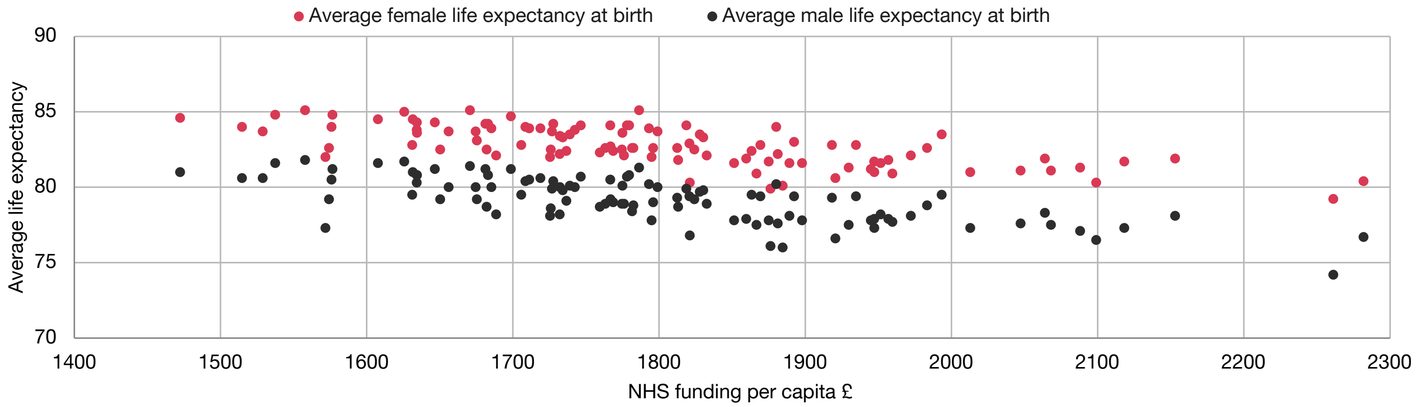
… but there are still some stark contrasts between places when comparing funding and outcomes. In addition, the move towards larger commissioning footprints risks significant local variations being obscured.

"Equal access to equal need"[18] is core to NHSE's stated approach to allocations. The target formula aims to reflect health inequities through a 'fair share' allocation for each area considering all of the following factors:

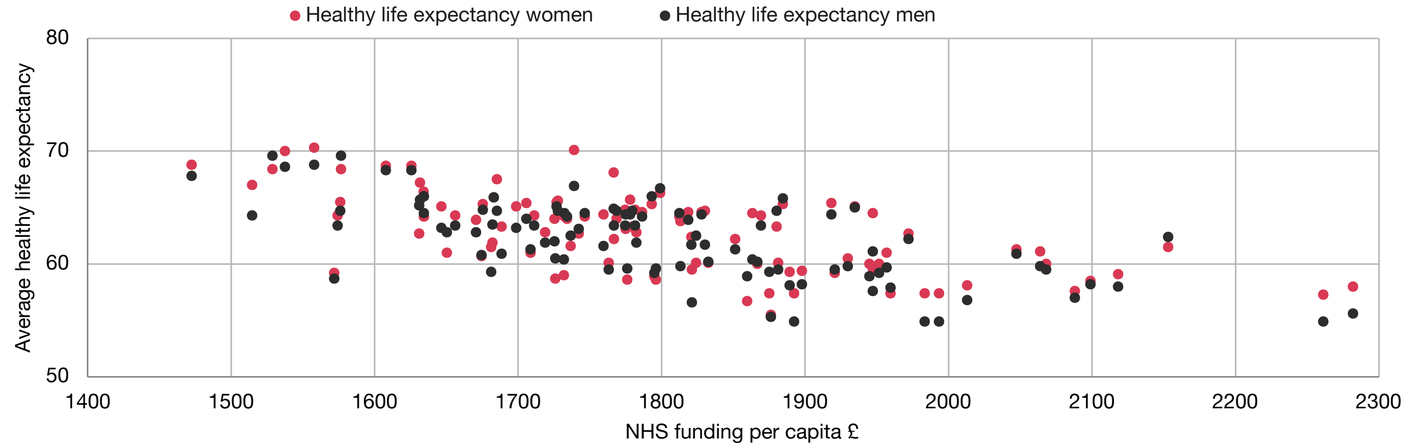
- "demography (age and sex);
- morbidity;
- deprivation; and
- the unavoidable cost of providing services in different areas."

The guidance puts emphasis on the needs of older populations, who are statistically more likely to consume health services. But this risks higher allocations being allocated to areas with an already high life expectancy. Although the link to deprivation goes some way towards counterbalancing this (there is a general downward trend in the scatter chart shown below), there isn't a strong link between outcomes (in terms of life expectancy and healthy life expectancy) and funding.

Funding per capita compared with life expectancy



Funding per capita compared with healthy life expectancy



18 NHS England, *'Equal Access, Equal Care Guidance for Prison Healthcare Staff treating Patients with Learning Disabilities'*, (2015)

Consequently, stark contrasts between places are apparent when looking at funding versus outcomes. For example, the table opposite compares Leicester, an area with long waits, low life expectancy and a healthy life expectancy 20 years lower than the richest parts of the country, to East Sussex, which receives nearly 20% more funding per capita despite favourable comparisons in outcomes. This suggests that the current funding allocation could be further strengthened to focus on closing the gap in outcomes.

This type of comparison has become more difficult to make over recent years, as the number of CCGs is lower due to mergers of organisations and the creation of ICBs. The outcomes are a double-edged sword, creating both risk and opportunity.

> “The current challenge is that the NHS is not being brave and disproportionately investing.”
>
> Interviewee

The risk is that the lack of visibility on variations in funding, combined with the relative ease of “rolling forward” funding structures from one year to the next, leads to these local differences being entrenched rather than challenged.

The opportunity lies in ICBs taking greater action at a local level by actively investing in the areas of greatest need. This will require a sophisticated understanding of relative outcomes between different populations within an ICS footprint, combined with an ability to analyse and compare spending patterns across the geography and population.

	NHS Leicester City CCG	Percentile	NHS East Sussex CCG	Percentile
2019-20 funding allocation per capita (£)	1572.00	95%	1880.00	27%
Average female life expectancy at birth	82.00	73%	84.00	22%
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Incomplete pathways per hundred people	20.18	52%	21.54	68%
52+ week waiters per hundred people	2.87	99%	0.37	11%
Population per GP	1870.00	74%	1911.00	77%
COVID-19 deaths per capita	158.00	56%	138.00	43%

At present, the funding formula uses the annual average GP registered list to allocate finance[19]. This may further exacerbate the issue by discriminating against areas where people are less likely to be registered with a GP, which tends to encompass more vulnerable populations.

The inverse care law[20] states that the availability of good medical or social care tends to vary inversely with the needs of the population served. Funding allocations should be used at both national and local levels to counteract this.

> “There needs to be a structural shift from funding activity to funding outcomes.”
>
> Interviewee

Recommendation:
Increase the size of the health inequities adjustment in the ICB funding allocation formula to direct greater funding towards places with lower overall outcomes.

19 NHS, *‘Technical Guide to Allocation Formulae and Pace of Change’*, (first published 2019)
20 The King’s Fund, ‘Inverse care law’, (2001)

Case study

Good practice at Leicester, Leicestershire and Rutland (LLR) ICB

In order to reduce health inequities, there has been focus on specific investment, deep data diving, engaging partners, education, setting and then measuring targets.

Leicester, Leicestershire and Rutland (LLR) ICB have created a **financial framework** to address inequities with agreed investment in transforming trust priority areas and investment based on need.

Additionally, LLR has begun a **partnership** between the **NHS, local authorities and local universities** to review health inequities at the system level.

The ICS wants to make sure that all decision-makers have the **expertise, insight, skills and understanding** of health inequity and how to reduce it; this is achieved through **mandatory training** and local or regional robust training packages relevant to roles.

LLR wants to **understand the full effect of the COVID-19 pandemic** on health inequities across its population. This includes ensuring that vaccine uptake is equitable and that there is a primary prevention focus to recovery. Relating specifically to ‘protected characteristics’ under the Equality Act, LLR is acting to improve **completeness and consistency of their data** to better understand and mitigate against health inequities. Another action to reduce inequities is the creation of a **health equity dashboard,** which ensures **accountability** against plans and targets to remove health inequity through all work completed in LLR. Another way of tackling inequity has been the creation of a **Health Equity Audit** undertaken for projects delivered at all levels of commissioning, service redesign and evaluation within the ICS.

2. There is more public support for equal access than there is for equity of outcomes

Investing more resources in areas with the poorest outcomes seems rational if our aim is to improve health equity. But our survey suggests that public support might not be as strong, with their preference instead skewing towards equal access and experience.

Our polling found that 87% of UK adults believe that people should have equivalent access to NHS services regardless of where they live, while 56% think resources should be allocated to where the need is greatest.

We believe that this may be driven by a gap in understanding the scale of health inequities. It may also be the result of a perceived “postcode lottery” in the standard of service experienced.

When asked whether they believed their access to health and/or social care support provided by the NHS differed depending on their location of residence, 40% of respondents answered yes, while only 18% disagreed.

But, as already outlined, this is **not** the result of a strategic decision to invest resources in places with the greatest need. Several of our interviewees expressed a view that the NHS behaves as a reactive service provider that meets demand as pressure arises rather than adopting a longer-term way of operating that prioritises equal access and/or outcomes.

Recommendation:
Use more consistent messaging to improve public understanding of the discrepancies in outcomes between different population groups. Reporting these metrics should be treated with the same significance as the 18-week or four-hour wait metrics, among other commonly reported measures.

Case study

Child Health Services Sweden

The Swedish government launched a programme where children gain access to a tailored healthcare service until the age of five.

Goal: To improve children's physical, psychological and social health by identifying potential issues early and intervening if necessary.

Impact: Children's health in Sweden is good generally, particularly on a global comparison.

Outcomes: This health service has a crucial role in balancing social health differences and sustainable health development.

Sweden offers a Child Health Services (CHS), which is free of charge for all children up to the age of five and has an estimated participation rate of nearly 100%. Its aim is to improve children's physical, psychological and social health by identifying potential issues early and intervening if necessary. As a result, the standard of children's health in Sweden is generally good, particularly when compared with other countries.

The model: The CHS programme operates under a trio of tiers that integrate enabling interventions. These are used to various degrees for different time frames in order to support the factors that promote health and mitigate physical, psychological and social health issues.

1. **First Universal Tier** is offered to all children and designed to promote health and development as well as preventing: diseases, injuries and physical, psychological and social problems.
2. **Second Tier** provides additional interventions accessible to all children on a needs basis and designed to strengthen the determinants that promote health while preventing physical, psychological and social problems.
3. **Third Tier** is for additional interventions provided on a needs basis from/in collaboration with different healthcare providers, social services or other resources.

Case study

Good practice at Royal Free London NHS Foundation Trust

Royal Free London NHS Foundation Trust (RFL) is aiming to reduce inequities in health by looking at data management, being an anchor institution, setting embedded inequities for measurement and identifying urgent actions.

RFL has partnered with the HealthEItent programme to create a single integrated care record for residents across North Central London (NCL). Through population health management, HealthEIntent provides an opportunity to take a data-driven approach to understand factors that drive poor health outcomes in population sub-groups and inform how to mitigate preventatively.

As an **anchor institution**, RFL wants to positively contribute to the health of the community through providing good employment opportunities, purchasing locally where they can via procurement and reducing NHS carbon emissions and air pollution through sustainability initiatives. To measure success, they will examine the percentage of new staff who live in NCL, the percentage spend from local suppliers, and aim to cut patient transport service mileage by 25% by 2025.

RFL have identified **four main embedded inequities** in their system and produced KPIs to measure the success at tackling them. Embedded inequities include the wider determinants of health, health and behavior lifestyles, the places and communities we live in, integrated health and care system. For example, when looking at health and behaviour lifestyles, they will measure: staff wellbeing, improved recording of BMI, alcohol and smoking status, and reducing alcohol-related hospital admissions.

In terms of **urgent actions,** RFL recognise that they need to strengthen leadership and accountability, collaborate locally in planning and delivering, and develop digitally enabled care pathways increasing inclusion. Additionally, they realise that they must protect the most vulnerable people from COVID-19, protect those suffering from mental ill health and accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes.

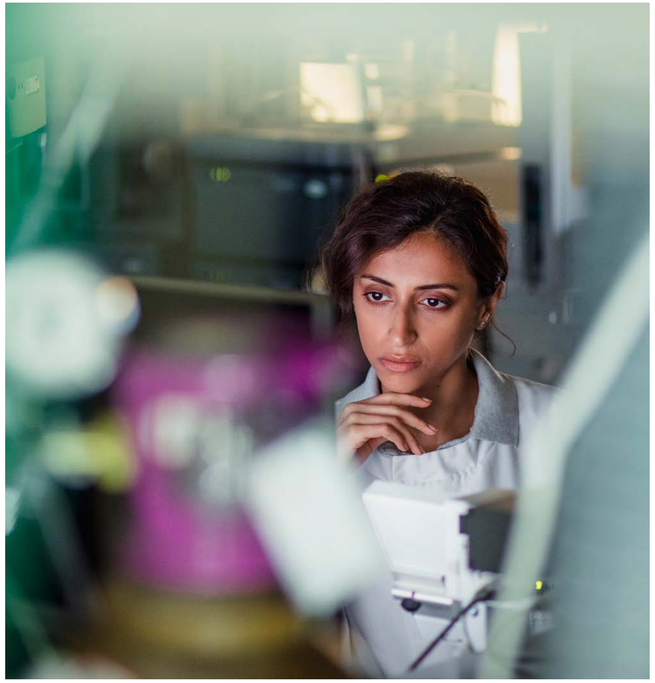
3. The NHS does not consistently measure and report equity measures across key performance metrics

NHSE's 10 priorities for 2022/23 recognise the growing importance of using data and analytics to "redesign care pathways and measure outcomes with a focus on improving access and health equity for underserved communities". The NHS currently uses metrics to measure data on A&E waits, cancer waits, elective waits and operating within its financial budget. These are the key metrics against which the NHS' performance is measured and have a significant impact on where leadership and management time is directed. But across all these metrics, there isn't consistent routine analysis and reporting of the varying impacts on people from different parts of society. Furthermore, interviews conducted with senior stakeholders highlighted underutilisation in the reporting and monitoring of data on health equity despite the vast amount of information available to the NHS.

The COVID-19 pandemic exhibited how routine analysis of such metrics through different lenses at a national level can have a powerful influence on how resources are directed to those with the greatest need. The Health Foundation[21] found that people under 65 living in the most deprived areas of the UK were over **3.7 times** more likely to die from COVID-19 than those in the richest areas. And age-adjusted mortality rates from COVID-19 are **two to three times higher** among Black ethnic groups compared with white ethnic groups. Understanding[22] these differences allowed the national strategy to be adjusted appropriately. Campaigns, for instance, were designed to target communities and areas with low vaccine uptake. And people at higher **risk of serious illness** were given advice on isolation and staying safe.

When examining key pressures on NHS waiting lists, the equity of access issue is stark. Calderdale and Huddersfield Foundation Trust conducted analysis into its elective waiting lists and discovered that "people from minority ethnic backgrounds were waiting on average three weeks longer than white patients for 'priority two' operations – which must be done within one month"[23]. Additionally, "the figures for last October (2021) also revealed people from the most deprived communities were waiting 2.5 weeks longer than those from the least deprived areas."[24] They used this data to cut disparities significantly by 2021, identifying that quantifying problems is the first step towards resolving them.[25]

> "We need to use the measurement of data to accurately and powerfully measure the problems in communities, the NHS has an awful amount of unused data. Powerful dashboards on health needs to work toward equality are possible."
>
> Interviewee

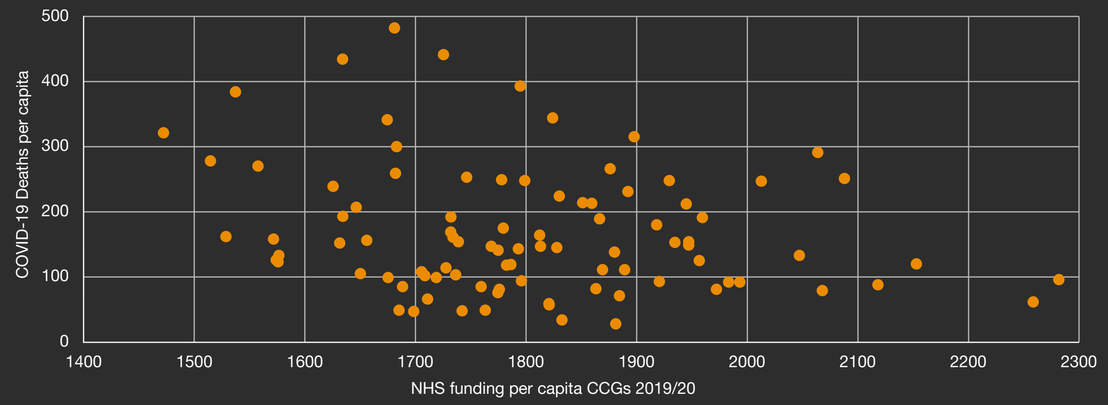


> "We don't prioritise our data collection well; and we don't use the data when we do have what we need."
>
> Interviewee

21 Office for National Statistics, '*Coronavirus (COVID-19) related deaths by ethnic group, England and Wales: 2 March 2020 to 15 May 2020*', (2020)
22 Ibid

23 HSJ, '*Daily Insight: No quick cure for procurement*', (2022)
24 Ibid
25 Hynett, Leo, '*Addressing inequities in Elective Surgery Waits*', (2022)

COVID-19 Deaths per capita compared to funding



Understanding data can clearly have an impact on our ability to transform service delivery for the better. Going forward, it would be interesting to assess how access is changed for people based on data – for instance, at what point do people tend to prefer virtual over face-to-face interaction; are people more likely to attend screening clinics held locally in places they're going anyway (e.g. supermarket car parks or religious buildings). And could data be used in a targeted way to create behavioural nudges towards healthier lifestyle choices?

Our poll found that 72% of respondents believe it is important that data and information on health equity within their respective geographies should be shared publicly.

Recommendation:
Each ICS and provider should establish a comprehensive strategy for improving health equity that includes measurable targets. This should be supported by programme boards/working groups within providers taking practical steps to improve performance.

Recommendation:
Ensure that all key performance measures are systematically analysed and reported in a way that indicates equitable service use – by age, gender, location, economic deprivation, employment, education and race.

Case study

Good practice at Calderdale and Huddersfield Foundation Trust

Calderdale and Huddersfield NHS Foundation Trust has worked on reducing health inequities in patients with learning disabilities by including the board, using data and intelligence, and through extensive education and training of staff members.

In order to address inequity in health for people with learning disabilities, Calderdale and Huddersfield has presented to the board dedicated sessions and a task and finish group, which was established to advance learning disability **priorities**. Learning disability data is **reported to the board** on a monthly basis.

Using data, the trust has been able to create a **flagging system** within patient records, design a **disability dashboard** and produce **data models** to compare against the general population. Through **deep diving** into patient transport, cancer and missing appointment data as well as completing audits on reasonable adjustments, targeted action could commence on **prioritising those waiting for surgery** and ultimately **reducing the backlog of waiting lists** for elective care.

In addition to this, **learning disability champions** have been assigned, easy reading **training** provided and **Makaton sessions** made available to all staff to support communication with patients. **Mandatory e-learning packages** have been developed, including leaflets and videos to be completed on induction to the NHS.

Case study

Good practice at West Yorkshire ICS

To tackle inequities, West Yorkshire has set up a fellowship programme, involves the community to share experiences, and uses complex data and intelligence to reduce health inequities.

West Yorkshire has launched the **Health Equity Fellowship Programme** with the appointing of **30 fellows** that will support work to tackle inequities and make West Yorkshire an equity informed system. The benefits of this include **transferable learning** from projects that can be shared across the system, **system connections** to reduce inequities, projects taking positive action to reduce inequities, and 30 additional members of the workforce with training in public health.

West Yorkshire wants to be informed by the **expertise of people with lived experience**, for example those with learning or mental health disabilities. West Yorkshire is working with specific population groups regarding **planning and priorities** such as those living with serious mental illness, unpaid carers, veterans and those in contact with the justice system.

Through the use of **intelligence and data**, inequities can be identified that exist in the population that relate to risk factors for ill health, early diagnosis, disease prevalence and health outcomes. Intelligence provides guidance to understand what people need to be engaged with and how the approach to improve their outcomes can be changed.

4. Adopting new methods for delivering services has the potential to reduce or exacerbate health inequity

The recent rapid scaling of new methods such as remote GP, outpatient consultations and virtual wards, to name a few, could improve access for patients in remote areas or those with mobility issues. They can also significantly reduce the environmental and social impacts of staff and patient travel. But these methods also pose the risk of excluding people without access to, or who have difficulties using, technology. [26]

In our poll, 28% of people found it difficult to access the care they need from NHS services due to difficulties with technology, but 73% believe that the NHS should continue to improve the availability of online and virtual services for patients.

Support for this increases positively with income. Moreover, during the interviews, leaders within the NHS frequently mentioned that within their areas communities had differing and often competing needs by location – for example, urban vs rural vs coastal, or between demographic groups.

In these circumstances, health EIAs are crucial for finding the correct method of care for each patient, whether using traditional or modern methods. The EIAs must underpin tangible action that harnesses the benefits of new ways of working while limiting any potentially negative impacts. NHSE is recognising and acting on their importance by piloting Algorithmic Impact Assessments[27] in healthcare, ensuring that AI can support transformation while eradicating potential inbuilt biases.

Recommendation:
Boost the profile of health equity impact assessments associated with changes in working practices and use them to inform mitigating actions rather than justifying inaction.

26 This was reflected as one of the five strategic priorities for reducing health inequalities in the operational planning guidance of 2021/2022: "Priority 2: Mitigating against 'digital exclusion'". See https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/our-approach-to-reducing-healthcare-inequalities/strategic-drivers/ for more details.

27 Gov.uk, *'UK to pilot world-leading approach to improve ethical adoption of AI in healthcare'*, (2022)

Case study

The Australian Digital Health Agency – Telestroke

PwC Australia supported development of a telestroke model of care in NSW.

Goal: To provide equity of access to stroke specialists, diagnosis and treatment.

Impact: People in more remote and regional areas can have easier access to the care they need.

Outcomes: The model will save lives and improve post-stroke outcomes. Telestroke is being hailed as a model for care during COVID-19 and beyond in its use of telehealth technology to virtually assess and treat stroke patients in regional and rural NSW.

PwC are supporting the Australian Digital Health Agency (ADHA) to develop a new telestroke model of care in New South Wales (NSW). This includes providing the NSW Ministry of Health, pillars, statewide services, NSW Ambulance and local health districts with guidance to implement world-class, hyperacute care for patients with suspected stroke regardless of their location. This is extremely important for populations living in remote and regional areas who may find it difficult to access the services and care they need.

Every year around 19,000 NSW residents have a stroke. The state is also home to 12 of Australia's top 20 hotspots for stroke incidence, 10 of which are in regional and rural areas. Regional Australians are also 19% more likely to have a stroke than their city counterparts and are more likely to die or be left with serious disability due to a lack of access to time-critical stroke treatment and specialist care.

The model: The NSW Telestroke service consists of a single virtual services 'hosted' by a facility and services from a roster of specialist stroke physicians. **Telestroke referring sites are telestroke-enabled services that refer stroke patients to the NSW Telestroke Service.** The model is facilitated by early notification of FAST+ (Face, Arm, Speech, Time) patients by NSW Ambulance using standardised assessment protocols. The patient is triaged and assessed on-site using a standardised protocol prior to calling NSW Telestroke.
The model uses a unified platform that supports communication across hospital and district boundaries:

- Enables remote viewing of electronic medical records, real-time scanning review of images and live patient assessment through screen sharing and collaboration functions.
- Supports teams to include patients, carers and additional clinicians in the consultation and decision-making process.

Summary of recommendations

1

Increase the size of the health inequities adjustment in the ICB funding allocation formula to direct greater funding towards places with lower overall outcomes.

2

Use more consistent messaging to improve public understanding of the discrepancies in outcomes between different population groups. Reporting these should be treated with the same significance as the 18-week and four-hour wait metrics, among other commonly reported measures.

3

Ensure that all key performance measures are systematically analysed and reported in a way that indicates equitable service use – by age, sex, location, economic deprivation, employment, education and race.

4

Each ICS and provider should establish a comprehensive strategy for improving health inequities that includes measurable targets. This should be supported by programme boards/working groups within providers taking practical steps to improve performance.

5

Boost the profile of health EIAs associated with changes in working practices and use them to inform mitigating actions rather than justifying inaction.

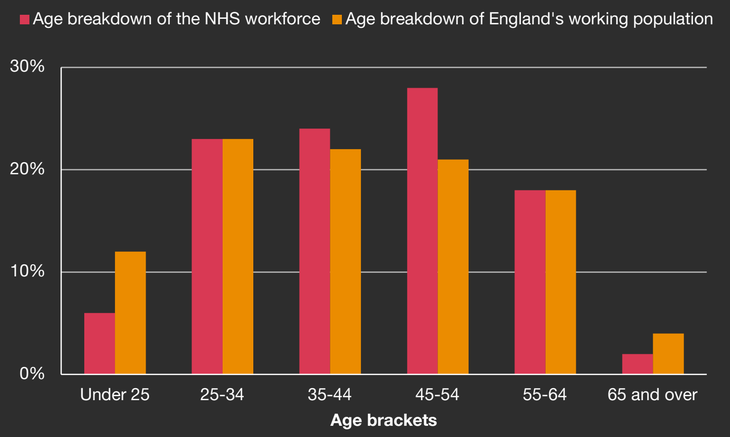
The NHS as an employer

Introduction

The NHS employs 1.4 million people[28], equating to roughly one out of every 25 working people. In 2019/20, the total cost of its staff was £56.1 billion[29], equivalent to 46.6% of its total budget.[30] The NHS also offers 350 types of career, extending far beyond the suspected roles of doctors and nurses to occupations such as porters, cleaners, ambulance staff, healthcare assistants[31] and so on.

Despite the range of employment opportunities provided by the NHS there is currently a workforce shortage that has been exacerbated by the pandemic. The 'big leave' phenomenon saw a total of 140,000 staff, equivalent to one in nine, leave their active service in the year to September 2021. The NHS also faces a demographic staffing challenge: 6% of the workforce is under 25, with the average age standing in the mid-40s.[32] Without action, future workforce pressures are likely to increase as a large proportion of the workforce approaches retirement age.

Age breakdown of the NHS workforce and England's working population



Source: NHS Employers

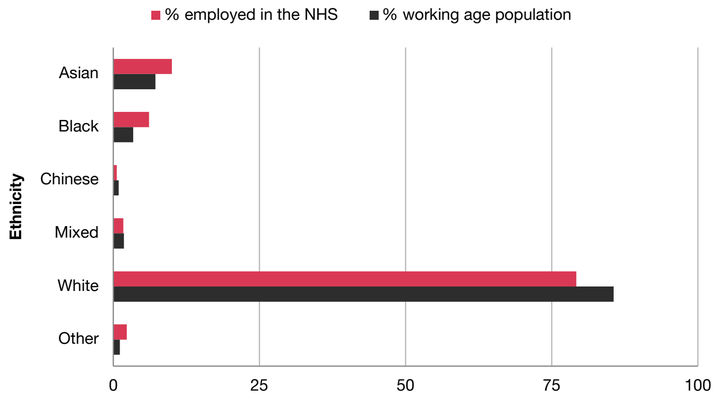
Health and social care systems can learn from the people and communities they employ, as well as directly influencing their health through employment – which is one of the significant social and economic factors influencing health outcomes beyond providing access to healthcare. Given its size as an employer, the NHS has a huge opportunity to directly influence health equity while tackling its significant and growing workforce capacity challenges.
This section outlines our findings and recommendations on key actions that the NHS can take to improve health equity through its role as an employer.

28 NHS, *'NHS Workforce Race Equality Standard'*, (2022)
29 Gov.uk, *'DHSC evidence for the NHSPRB: pay round 2021 to 2022'*, (2021)
30 Ibid, (note: these statistics don't include the salaries for GPs or employees from the Department of Health and Social Care and other national bodies, such as NHS England and NHS Improvement)
31 The King's Fund, *'NHS workforce'*, (2020)
32 NHS Employers, *'Age in the NHS infographic'*, (2019)

1. The NHS compares well to other large employers on diversity and representation across its workforce

The NHS is a diverse organisation that tends to be highly representative of the local populations it serves. Nationally, a study found that 77.9% of NHS staff were white and 22.1%[33] were from all other ethnic groups combined. This profile is slightly more diverse than the national population, in which white ethnicities stand at 85.6%.

Number and percentage of NHS staff (2020) and percentage of working age population (2011) by ethnicity



Within the NHS workforce, 2.7% of people describe their sexual orientation as LGB+, 69.8% as heterosexual and 27.5%[34] chose not to disclose. In 2019, meanwhile, 7% of job applicants were LGB+ candidates and 7% of new starters were LGB+, an increase from 2017/18 (4%) and 2016/17 (2.8%). However, 30% of new starters chose not to share their sexual orientation, which could allude to them not feeling that the NHS is an organisation that would welcome their sexuality. In the general population, 3.1% of people aged 16 and over identify as LGB+,[35] a proportion that has been increasing over time. Allowing for the proportion of staff who haven't shared their sexual orientation, this suggests that the NHS is representative of the general population and is likely to have greater LGB+ representation among its workforce than average.

Our public polling supports the view that the NHS performs well on representation, with 77% of respondents feeling that they often or sometimes receive care and support from a diverse workforce of healthcare professionals when using its services.

The NHS' record on disability representation is less positive. In 2021, 3.7% of the workforce had declared a disability through the NHS Electronic Staff Record.[36] This is an increase of 0.3% on the previous year, but there is clearly still work to do to become more representative, as 20% of the UK's working age population report a disability.[37] Work is ongoing in this area under the Workforce Disability Equality Standard (WDES) and the NHS is making progress on representation across the workforce, on boards and during recruitment.

This work is helping to reduce disparities in experience, improve implementation of reasonable adjustments to make it easier for disabled colleagues to carry out their roles, and reduce the likelihood of entering formal capability processes.

The NHS' performance on social mobility is less easy to measure. Data on the workforce's socio-economic backgrounds is not reported in the same way as other diversity measures. Studies have shown that medical professions tend to have a lower representation of people from working class backgrounds.[38] However, such data is unlikely to offer a full reflection of the NHS given the huge breadth of professions it relies on.

33 Gov.uk, '*NHS Workforce*', (2021)

34 NHS Digital, '*Sexual orientation*'
35 Office for National Statistics, '*Sexual orientation, UK: 2020*', (2022)
36 NHS, '*Workforce Disability Equality Standard*', (2022)
37 Powell, Andrew, '*Disabled people in Employment*', (2021)

38 Social Mobility Commission, '*State of the Nation 2016: Social Mobility in Great Britain*', (2016)

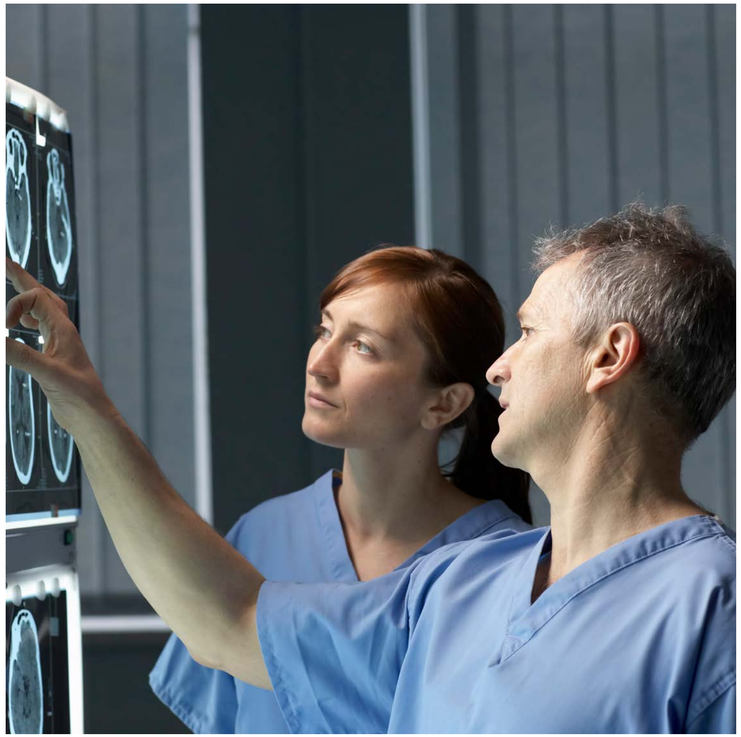
Its rankings by external organisations point to shortcomings too. The NHS' presence is missing from the Social Mobility Employer Index 2021. It ranked ninth out of 26 UK employers on the CPP[39] Good Employer Index, but its impacts on social mobility were highlighted as a shortcoming. The NHS can therefore learn from other organisations represented in these indices to improve representation throughout the employment lifecycle. A strategy and reporting similar to the Workforce Race Equality Standard (WRES) and WDES on this topic would help.

Our polling found that over a third of people ranked development, training and employment opportunities for the local population as the most important thing the NHS should prioritise in the recruitment and training of its workforce.

Throughout our investigation, interviewees suggested that a whole system approach is necessary. Currently, there is ongoing work and allying with local education establishments. One example is the NHS Ambassadors scheme, within which volunteers collaborate with schools, colleges and universities to lead the development of local social mobility action plans that align efforts and resources behind programmes for change. Building on and broadening these initiatives, combined with a better understanding of the NHS' impact on social mobility at a national level, would help the NHS to develop its impact on the health of the population it serves while supporting efforts to tackle its challenges on workforce supply.

> "Health inequality in the NHS is very focussed on its provision of services. Not the role it plays as an employer. Conversations about the NHS as an employer tend to focus on getting people to apply/recruitment…rather than optimisation of the existing workforce."
>
> Interviewee

> "The NHS needs to focus on the optimisation of its existing workforce and make better use of existing networks to gather perspectives."
>
> Interviewee



39 Dudding, John, Franklin, Ben, *'Simply the best?'*, (2020)

2. But minority groups are poorly represented at more senior grades

Although the NHS workforce broadly reflects the ethnic diversity of the population it serves, this correlation becomes much less strong at senior levels.

As outlined in the WRES in 2021, the total number of Black, Asian and minority ethnic staff at very senior manager level has increased by 48.3% since 2018, from 201 to 298.[40] In addition, 12.6% of board members are from a Black, Asian or minority ethnic background, which is a sizeable disparity considering that this group makes up 22.4% of the total NHS workforce. The NHS People Plan states that for Leadership Diversity every NHS trust, Foundation Trust and CCG must publish their progress against the Model Employer Goals to achieve the "ambitious challenge of ensuring leadership is representative of the overall Black, Asian and minority ethnic workforce by 2028".[41]

But in 98.6% of trusts, a lower proportion of Black, Asian and minority ethnic staff believed that their Trust provides equal opportunities for career progression or promotion compared to white staff, and progression and hiring statistics continue to lag for Black, Asian and minority ethnic groups.

Recommendation:
Develop a national NHS Social Mobility Strategy, with actions based on evidence of good practice from top-ranked employers in both public and private sectors.

Recommendation:
Scale up initiatives already in place in some parts of the country to create greater connections with local communities, such as driving increased numbers of apprenticeship schemes and partnering with schools in disadvantaged areas to further diversify recruitment.

40 NHS, 'NHS Workforce Race Equality Standard', (2022)
41 NHS England and NHS Improvement, 'A Model Employer: Increasing black and minority ethnic representation at senior levels across the NHS', (first published 2019)

Case study

Bristol Race Ecosystem

The Bristol Race Ecosystem (BRE) demonstrates that having senior leadership supporting, advocating and providing rationale for change to ensure equal access to talent is crucial.

BRE is a collaboration between Black SouthWest Network and the University of Bristol in order to support and establish the development of more evidence-based approaches to ultimately influence policy on race disparity. The ecosystem utilised under-represented staff groups to come together in a race equality group to understand the barriers to accessing healthcare systems and internal NHS progression. The work consisted of minority ethnic staff commissioning a report with a series of recommendations.

They wrote to everyone in Bristol NHS commissioned services and asked employers questions such as, ‘what risk assessments are you doing and are you sharing these risk assessments.’ There was an immediate response from services that outlined the changes they would be making and sharing with leadership. Having similar initiatives throughout NHS organisations would add significant value to the local NHS service design, operation and offering, setting the foundations for change.

Case study

PwC NZ Hauora Team – health and wellbeing practice

PwC ZC developed a market leading health and wellbeing practice for New Zealand.

Goal: Use firm's in-depth experience and understanding on health and wellbeing to bring a unique perspective to reimagine hauora (Māori understanding of health).

Impact: Reduce health inequities present in indigneous communities that were excluded from current government policy.

Outcomes:

- Strengthened population health using early intervention and health promotion.
- Used equity-driven, data-informed decision-making from new technologies.
- Designed three frameworks for the ambulance, community health access and largest primary health organisation, which could be used to assess an organisation against equity, Māori (Mana Tititi) or Pacific values.

NZ's life expectancy for different ethnicities reveals a stark gap. For Māori and non-Māori, this figure at birth was 7.5 years for men and 7.3 years for women in 2017-19.

PwC NZ worked with several key government agencies, NGOs and private health organisations to respond to COVID-19. Our practice spans the health ecosystem from policy to implementation and covers health equity, Te Tiriti o Waitangi, investment strategies, operational models, outcome frameworks, commissioning frameworks, models of care, service design, digital health, infrastructure, and strategy and policy.

Intervention entails

1. Structural – tackling the root causes of health inequities, that is, the social, economic, cultural and historical factors that fundamentally determine health.
2. Intermediary pathways – targeting material, psychosocial and behavioural factors that mediate the impact of structural factors on health.
3. Health and disability services – undertaking specific actions within health and disability services.
4. Impact – minimising the impact of disability and illness on socioeconomic position.

Challenges

- Unequal access to healthcare.
- Racial and ethnic discrimination.
- Lack of access to quality education.
- Income and wealth gaps.
- Inadequate housing or lack of housing.

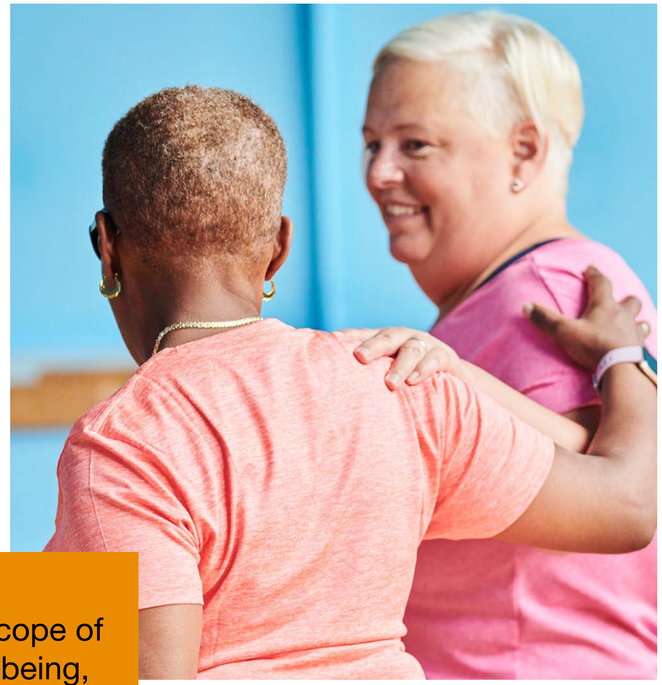
3. Workforce wellbeing is being supported, but more could be done

The NHS has recognised the need to focus on staff wellbeing due to the immense workforce pressures exacerbated by COVID-19.[42] But, as already outlined, the NHS still faces challenges attracting and retaining sufficient staff to meet future demand.

In addition to its importance for workforce retention and attraction, wellbeing significantly affects health equity. Minority groups are more likely to experience discrimination, abuse and bullying at work. This is as true in the NHS as elsewhere. For example, the 2020 NHS staff survey found that 13.7% of gay and lesbian staff reported discrimination from patients or the public, and 11.8% reported discrimination from their colleagues.[43] The Royal College of Nursing also reported that Black employees were more likely to report physical abuse than those from other ethnic backgrounds.

During the COVID-19 pandemic, considerable emphasis was placed on wellbeing services provided to NHS staff, including, as outlined in the NHS People Plan, a telephony support service, bereavement support, access to wellbeing and mental health apps, and specific support for Black, Asian and Minority Ethnic staff. This needs to be built upon if the NHS is to maximise its impact on the health equity among its workforce and deal with its staffing challenges.

One health issue that affects the workforce unequally, and for which employers can make a difference, is menopause. Recent evidence suggests that women who reported at least one problematic menopausal symptom at the age of 50 were 43% more likely to have left their jobs by the age of 55 and 23% more likely to have reduced their hours, while 31% of women have taken time off work due to symptoms.[44] This is hugely significant for the NHS, where women make up 77% of the workforce and 48% of them are over 45. There is an opportunity to provide support to help reduce this disproportionate impact, and in the process improve workforce retention. Having spoken to Peppy Health during our research, we understand that the take-up of employee support for menopause has been much stronger among private sector employers than in the NHS. Our conservative estimate is that the opportunity of improving support for workers experiencing symptoms could be the equivalent of an additional 9,000 NHS workers per year.



Recommendation:
Increase the pace and scope of action on workforce wellbeing, such as offering transport, greater potential for flexible working, and targeted support for employees with disabilities, medical conditions and life events (e.g. childbirth, adoption and bereavements).

42 NHS England, *WE ARE THE NHS: People Plan 2020/21 - action for us all, (2020)*
43 NHS Employers, *'Supporting your LGBTQ+ workforce'*, (2020)
44 UK Parliament, 'Menopause and the workplace', (2022)

Summary of recommendations

1

Develop a national NHS Social Mobility Strategy, with actions based on evidence of good practice from top-ranked employers in both public and private sectors.

2

Scale up initiatives already in place in some parts of the country to create greater connections with local communities, such as driving increased numbers of apprenticeship schemes and partnering with schools in disadvantaged areas to further diversify recruitment.

3

Increase the pace and scope of action on workforce wellbeing, such as offering transport, greater potential for flexible working, and targeted support for employees with disabilities, medical conditions and life events (e.g. childbirth, adoption and bereavements).

The NHS as a buyer

Introduction

In 2020/21, NHSE received £131 billion to commission healthcare services. From this, it allocated £102 billion to 106 CCGs, with the remainder used to directly commission services such as specialised care.[45] Addressing health inequities effectively within the NHS will require commissioning and procuring strategies to consider and place emphasis on the 'value for money' that is derived from procurement activities and the impact this is having on local communities, groups and individuals. The NHS Supply Chain, a key component of the NHS procurement function, which manages the sourcing, delivery and supply of healthcare products and services for NHS trusts and healthcare organisations across England and Wales, is well positioned to do this.

The NHS Supply Chain manages more than 8 million orders per year from over 930 suppliers, and aims to carry out 80% of all NHS purchases by volume by the end of 2022.[46]

In England, the Department of Health and Social Care spent about £70 billion on procurement in England in 2018/19, up from £68.3bn in the previous year.[47]

Approximately, £18 billion of this was spent on purchasing medicines annually and nearly £6 billion on 'hospital consumables'.[48]

45 NHS England, *'10 ways businesses can help to reduce health inequities infographic'*, (2022)
46 Johnstone, Richard, 'Jin Sahota interview: How government procurement reforms are unlocking millions for the NHS', (2019)
47 NHS Commissioning Report, *'Our 2020/21 Annual Report: Health and high quality care for all, now and for future generations'*, (2022)
48 https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf

1. Legislation has shifted procurement's focus to the social determinants of health

The Social Value Act came into force in 2013 and requires "people who commission public services to think about how they can also secure wider social, economic and environmental benefits".[49] This legislation supports commissioners in their procurement activities (whether for products or services) and to understand the potential impact that decision-making can have on their local communities.

In 2021, the Social Value Act was refreshed with a shift in its procurement mantra from 'low cost' to 'value for money'. This has provided a robust platform from which NHS organisations can start tackling their local health inequities through the use and measurement of 'value' to influence their respective supply chains, and to align this with their strategic thinking and subsequent policies. Implementing this will require strategic clarity and sophisticated analysis of value that might be achieved in the trade-offs between cost and the impacts of products and services on the local economy and environment.

49 Gov.uk, *'Social Value Act: information and resources'*, (updated 2022)

Case study

Australia – InnoWell

The University of Sydney

Goal: Use technology to produce a platform that aids medical providers monitoring patients.

Outcomes: There is currently limited information about the success of treatments and programmes offered by healthcare providers. InnoWell changes that, by providing valuable insights about how successful particular approaches are, which helps with making informed decisions and effectively allocating resources in the future.

Every year in Australia one in five people experience mental issues, that is nearly 4 million people. But only half of these individuals will receive help/support for mental health, and it's not uncommon for people to wait weeks or months before they are able to see a mental health professional. Despite many people working tirelessly in the sector, there is currently not a system which can provide care when people need it, intensifying the trauma of what people are experiencing.

The model:

This innovative venture harnesses technology to aid medical professionals and health providers to connect and monitor individuals that are utilising their services. This in turn enables them to have a deeper understanding of where the person is at and monitor their progress. This is crucial information for health providers, as it can be used to triage patients so those who are most in need are prioritised and seen first. They are then able to track how effective the treatments and programmes are to make more informed decisions in the future.

If a health service uses InnoWell, individuals arranging an appointment for the first time get provided access to the technology platform to answer scientifically backed questions targeted at assessing their mental health needs. This information is used to triage people's needs and match them with the right professional. Clinicians can view responses enabling them to have a clear understanding of their current condition prior to their first appointment.

2. There is scope to increase the use of the NHS' buying power to put greater focus on local socio-economic determinants through the supply chain

Role of the NHS

There is an opportunity to influence health equity by embedding the local socio-economic and environmental impacts of purchasing decisions in NHS decision-making in line with the legislation referenced previously.

The NHS's Supply Chain 2021/22 business plan places a strong emphasis on sustainability.[50]

Among this is the role of small and medium-sized enterprises (SMEs), local communities and supply chains. Setting targets related to how much business is done through SMEs will continue to be important in sustaining local economies, which in turn has an impact on public health through links to employment.

Our polling has demonstrated significant support for this approach, with 53% of respondents believing that the NHS should purchase goods and services from local businesses

50 NHS Supply Chain, *'Our 2022 – 2023 Business Plan'*

Case study

Preston – keeping money in the local economy

Preston has created a project to keep money in the local economy, which has led to better social and economic outcomes. This has positively impacted local procurement activities.

In Preston, a project to keep money local, and in turn build community wealth, has actively contributed to driving positive economic and social outcomes with parallels that can and should be drawn for NHS procurement. The fundamental aim of this project was to use local economic assets to develop the economy using methods that add social value for Preston's citizens, communities, organisations and businesses.

In total, £200 million was spent and recirculated across local suppliers simply as a result of changes in procurement behaviour and policy. The impact of this work has been significant, with a repeat spend analysis finding that the procurement spend retained within Preston had risen by £74 million (from £38.3 million to £112.3 million over four years). Over the past eight years, this has had a positive multiplier effect on local jobs, wellbeing, health and economic growth.

The NHS Supply Chain Business Plan also supports the delivery of value-based procurement. It has been working with trusts to identify and test such opportunities through pilots focused on areas such as wound care, ward-based consumables and cardiology. Numerous benefits were realised, including: better quality products, improved outcomes and system savings from reductions in the average length of stay (~3 days), more patients being treated in their own homes, improved operational efficiency and reduced infection rates.

Importantly, there is also a continued focus on addressing human rights and labour standards throughout local and international supply chains. This includes identifying the products and services with the most risk of poor labour standards and introducing mandatory supplier assessments for the Modern Slavery and Labour Standard.

Role of suppliers

Emphasis should also be placed on the suppliers of the products and services themselves to help address and reduce health inequities. Businesses can directly influence health in many ways, whether through employment, procurement, resource allocation, estates use or capital investments. To this end, earlier this year NHSE published its 10-point framework for organisations with ambitions to play their part in tackling health inequities.[51] Its key components include:

Embedding health inequities into strategy and operations – including environmental, social and governance (ESG) principles.

- Working in partnership with the NHS and ICSs – this can enhance the social determinants of health and support national and local health inequities priorities.
- Working in partnership with communities to design products and services – this way of working involves people who use the products and services on offer and engages groups of people at the earliest stages of design, development and evaluation.

This framework is helpful, but the NHS has an opportunity to boost its uptake by including measurable action in line with its recommendations in its procurement decisions.

Recommendation:
Link supply chain and buying strategies to local health needs, for example by including impacts on local population health issues (e.g. air quality or employment) as a scored element in procurement exercises.

Recommendation:
Place a requirement on the suppliers of products and services to take action related to health equity, such as making progress against diversity targets, ethical procurement, and investing in employee wellbeing.

51 NHS England, *'10 ways businesses can help to reduce health inequities infographic'*, (2022)

Conclusion

Our analysis comes at a time of great social, political and economic headwinds. Dealing with urgent and emergency care performance, the elective backlog, persistent workforce shortages, and financial pressure will require huge amounts of focus, effort and creativity across the entire NHS. To have any success, action on health equity can't compete with other priorities – it must be a foundational principle upon which the response to these other challenges is built.

Two common threads are consistent throughout our analysis of the NHS across its varied roles as a healthcare provider, employer and buyer, and how it can influence health equity.

1 Maximising the value of data.

The NHS can do more with its data. While it already collects and uses vast amounts of data, ensuring that it is analysed through the lens of equity could have a tremendous impact. Making this a more consistent exercise could help create a better dialogue with the public about funding allocations as well as improving insights on challenges and opportunities.

2 Using the opportunity afforded by ICSs and ICBs.

These represent an opportunity to cement the role of the NHS as a local anchor institution, tackle health inequity and more effectively influence its partners to do the same. The greater footprints of ICBs can unlock myriad advantages, as long as leaders ensure that disparities aren't hidden among the data.

Despite health equity being one of the NHS' founding principles, our research demonstrates that this should be a higher priority, an opinion that has been expedited by the pandemic. Public sentiment echoes this. Two thirds (61%) of UK adults say that the pandemic has made health equity worse and a similar number (63%) believe it has had a negative impact on their access to health and/or social care services.

Tangible action is being taken, but this is inconsistent across the country – and that risks compounding already existing disparities. The data tells a worrying story about health outcomes on gender, race and income lines, among other social groups.

For the NHS to make the biggest impact it can on improving the 20% of total health outcomes it directly influences, not to mention the health of its employees and the local economies it buys from, equity needs to be placed at the forefront of both how it is organised and how it operates.

The COVID-19 pandemic has served as a pertinent reminder of why accessible and equitable healthcare is vital. The pandemic also demonstrated that when there is a clear, urgent issue, enormous change is possible in a short amount of time.

Just think of what could be achieved with health equity given the same urgency.

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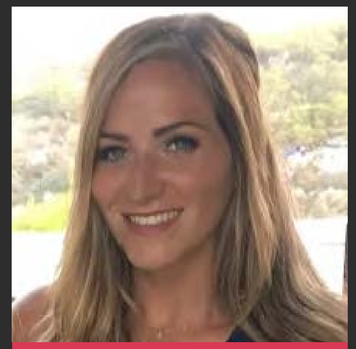

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RITM9647323