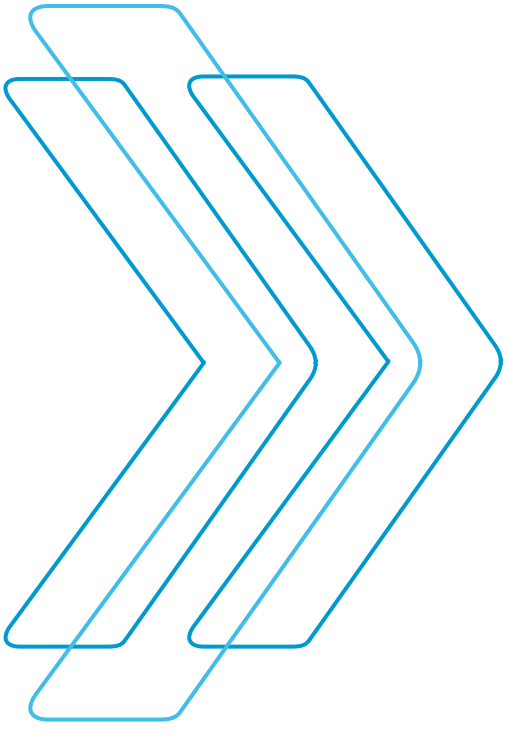
The King's Fund

Ideas that change health and care

The NHS's role in tackling poverty

Awareness, action and advocacy



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Key messages

- The NHS plays a key role in preventing poverty simply by existing to provide care for everyone, free at the point of use. But it can also do more to prevent, reduce and mitigate the effects of poverty. It has three spheres of action: the direct provision of health care services to people and communities; its wider economic and social role 'in place' by virtue of its size and scale in every community; and the leadership role it has in every community, which confers on it a status that can be used more broadly for poverty reduction.
- It is important to do more to address poverty now. The Covid-19 pandemic has exposed and worsened the impact of inequality in the UK, particularly for those at risk of, or in, poverty. The impacts on our communities' health and wellbeing will not end once the pandemic recedes.
- The NHS is not powerless in the face of poverty. Much of what can be done is not about increasing the burden on an already stretched NHS, but being more aware of the existing power and influence the NHS has to tackle poverty.
- There are practical actions the NHS can take as a direct service provider and commissioner of services, and more broadly, as an economic and social actor. But this requires active leadership and strong partnership working. It will not be effective without the NHS working in meaningful partnership with other sectors, communities and individuals in, or at risk of, poverty.
- Awareness of the issues relating to poverty is the cornerstone for action: the NHS needs a shared and consistent story on poverty and its role in tackling it. This is important for NHS staff, so that they can see and understand their role in doing so; for partners, so that they can see how the NHS can support them in joint actions; and for people experiencing poverty, because meaningful engagement is fundamental to developing NHS awareness.
- As a service provider, key actions the NHS can take include: meaningful engagement and co-production with people with lived experience of poverty; paying attention to inequalities as digital innovations roll out; making use of social prescribing and stronger integration between social

welfare and health services; and measuring meaningful outcomes and spreading good practice.

- As an economic and social partner 'in place', local NHS organisations can better use their status as anchor organisations in their communities to tackle poverty. For example, the NHS could maximise its role as a good employer and, on procurement, it could do much more to comply to the letter and with spirit of the Social Value Act. The NHS also has significant economic levers: there needs to be a wider recognition and focus on its fiscal multiplier effect across all local economies.
- The NHS has an important role as an advocate. It has a unique position and authority, and is held in high public regard. Workshop participants called for NHS leaders to take on a much stronger role as advocates. Using its voice and reputation, the NHS can influence and speak up and out for people and communities at risk of or experiencing poverty. Clinicians also require support from non-clinical leaders to ensure they feel safe to speak out about poverty without fear of negative consequences.
- NHS England and NHS Improvement has a key role as a national leader in supporting local actions to tackle poverty. The NHS's new local and regional partnerships, including primary care networks (PCNs) and integrated care systems (ICSs), also provide an opportunity for stronger leadership on tackling poverty.

1 Introduction

At the start of 2020, NHS England and NHS Improvement commissioned The King's Fund to provide independent support to consider how the NHS can better tackle poverty in England as part of the commitments it made to reducing health inequalities in the NHS Long Term Plan (NHS England 2019).

This discussion paper sets out findings from a process of engagement with stakeholders and wider literature and evidence, in particular:

- how more needs to be done to **raise awareness** of the NHS's role in tackling poverty
- what **further actions** the NHS can take
- how the NHS can be **a stronger advocate** for poverty reduction
- underpinning these three specific roles, the NHS has a **partnership** and **leadership role** that will help support them.

These findings are based on a series of four virtual workshops and a plenary session, hosted by The King's Fund during August and September 2020. Participants included stakeholders from a mix of NHS, voluntary, community and social enterprise (VCSE) organisations, local authorities, national government and arm's length bodies, and people with lived experience of poverty. Three workshops focused on specific types of area – urban places, towns and rural places, and coastal places – and the fourth explored the overall themes with the Voluntary, Community and Social Enterprise (VCSE) Health and Wellbeing Alliance (NHS England undated a). This work has also been supported by further research on poverty and health, updating the findings from a previous report from The King's Fund, *Tackling poverty: making more of the NHS in England* (Buck and Jabbal 2014) (*see* the Annex for more details).

Poverty: a rising tide

According to the Social Metrics Commission's 2020 report (Nussbaum 2020), a fifth of the population in the UK are experiencing poverty, based on data from 2018/19. While this overall figure has been largely stable over the past two decades, changes have occurred, including reduced poverty rates for

older people and lone families. Conversely, there has been a rise in the number of people in the deepest form of poverty: up to 7 per cent in 2018/19, from 5 per cent in 2000.

As we continue to reckon with the impact of the Covid-19 pandemic, its unequal economic consequences are becoming clearer. For example, most people in the bottom tenth of the earnings distribution are in sectors that have been forced to shut down, and 80 per cent are either in a shut-down sector or are unlikely to be able to do their job from home – compared with only a quarter of the highest-earning tenth (Blundell *et al* 2020). Poverty rates are predicted to rise by many hundreds of thousands at least. The Legatum Institute used the Social Metrics Commission measurement framework to model poverty, suggesting it could rise by 700,000 by winter 2020, while the the Institute for Public Policy Research (IPPR) predicted more than 1 million people would fall into poverty by the end of 2020 (Parkes and McNeil 2020).

The Institute for Fiscal Studies (IFS) has summarised the impact of Covid-19 on many forms of inequality, from income to health and access to education (Johnson *et al* 2021), while the Institute for Health Equity and the Health Foundation have drawn together a huge amount of information on changes in poverty and other wider determinants of health due to the pandemic in *Build back fairer: the Covid-19 Marmot Review* (Marmot *et al* 2020). Most recently, the Joseph Rowntree Foundation's UK poverty report 2020/21 has found that '…the health and economic effects of the coronavirus will be felt most by poorer households, and while we are all in the same storm, poorer households will face far greater headwinds' (Joseph Rowntree Foundation 2021, p 21).

There is therefore no doubt that the challenge of poverty will increase over the next few years. This means that the NHS's ability to act to mitigate these impacts – as a provider and anchor 'in place', a partner and an advocate – will be even more important. In October 2020, Ipsos MORI reported that for the first time, Britons were more worried about poverty and inequality than the state of the NHS (Ipsos MORI 2020).

The role of the NHS in tackling poverty

One of the main drivers behind the creation of the NHS was to protect the poorest in society from being bankrupted by the need to pay for care. It is easy to forget this role when we have been used to the NHS for so long. For example, the UK ranks by far the lowest for the proportion of people having

problems with medical bills against international comparators: 2 per cent, compared with 44 per cent in the United States, 35 per cent in France and 12 per cent in Sweden (The Commonwealth Fund 2018). The NHS, purely by its existence, therefore plays an important role in directly preventing poverty by avoiding potentially ruinous medical bills, as well as by keeping people well and able to work. But the NHS has more nuanced and varied roles in mitigating, preventing and reducing poverty. This report sets out how the NHS can do more, within its resources and with its partners, contributing to its wider role in improving the population's health and reducing inequalities in health.

Tackling poverty is the responsibility of multiple sectors (for example, social welfare, housing, education, economic development). By examining the NHS's role specifically, however, we can consider both its immediate role through the services it provides, and its wider role as an anchor institution and partner 'in place', working alongside and influencing other partners to take further action on tackling poverty.

The NHS Long Term Plan (NHS England 2019) makes various commitments to reducing inequalities in health, including those relating to poverty:

> *To support local planning and ensure national programmes are focused on health inequality reduction, the NHS will set out specific, measurable goals for narrowing inequalities, including those relating to poverty, through the service improvements set out in this Long Term Plan.*
>
> (NHS England 2019, p 40)

The plan also sets out how the NHS will support wider social goals beyond health care provision, including health and employment, the environment, and the role of the NHS as an anchor institution. The NHS Long Term Plan, and the government's wider 'levelling up' agenda to improve the prosperity of the nation and reduce regional economic inequality, therefore provide an important context for this work. Covid-19 has made this ever more important, as its impact on mortality and wider health has followed and widened the fault lines of inequality and poverty.

The NHS 'phase 3' implementation letter (NHS England and NHS Improvement 2020a) about the NHS's recovery from the first wave of Covid-19 was clear that the NHS needs to focus on tackling inequalities in the short term (as services return to normal). This requires strong leadership (including

a named executive team member with responsibility), monitoring and partnership with others. Doing more to address poverty in terms of the three As – awareness, action and advocacy– will contribute to this.

In the longer term, tackling poverty is aligned with the future 'fundamental purposes' of integrated care systems (NHS England and NHS Improvement 2020b) to: improve population health and health care; tackle unequal outcomes and access; enhance productivity and value for money; and help the NHS to support broader social and economic development.

What the NHS needs to do next: the three As – awareness, action and advocacy

The rest of this report sets out, in this context, how the NHS can work to tackle poverty, drawing strongly from the messages and views of NHS leaders and clinicians, stakeholders and people with lived experience who participated in the four workshops and wider conversations.

In the workshops we asked our participants what the NHS was doing well on poverty; what it could do more of; and what was needed to move forward. From these discussions we have drawn out examples and actions that leaders from across the NHS and its key stakeholders and partners consider to be the steps the NHS can take *practically* to move forward.

These steps are based on ideas, experiences and views as opposed to formal evidence, and reflect what those close to the ground think the NHS can and should move on quickly. This should also be supported by a concurrent focus on evaluation and academic work to inform practice.

The next steps for the NHS fall into three main areas – the three As – as summarised below. These are detailed in the following sections.

- Raising **awareness** – to make it clearer to decision-makers and practitioners in the NHS that their actions can, and do, make a difference to poverty. And raising awareness of poverty among its staff, to develop empathy and understanding of how poverty can affect how people take up or respond to care and services. We set out some specific areas where our workshop participants thought raising awareness was needed. As part of this, NHS England and NHS Improvement should set out a stronger narrative for how the NHS can, and does, tackle poverty.

- Practical **actions** – awareness is necessary but not sufficient. There are practical actions for the NHS as a direct service provider and commissioner of services; and more broadly as an economic and social actor. We draw on the areas and examples that our workshop participants thought particularly important.
- Being a strong **advocate** – workshop participants strongly wanted the NHS to support them and to speak out more about the effects of poverty on health, locally and at other levels of the system; they saw the NHS as a key voice for poverty given the high regard in which the NHS and those who work in it is held.

Finally, underpinning all of these are the partnerships and leadership required to deliver these three As, as detailed in the following sections.

2 Raising awareness

The NHS should develop a stronger, shared, consistent story on poverty and its role in tackling it – for NHS staff, so that they can see and understand their role in doing so, and for partners, so that they can see how the NHS can support them in joint actions. NHS England and NHS Improvement has a key role in developing and promoting awareness of a shared narrative on tackling poverty.

This echoes The King's Fund's earlier recommendations (Buck and Jabbal 2014) to NHS England to build a stronger narrative about the NHS's role in tackling poverty. This needs to be a positive story highlighting how much potential there is and how this will help meet wider goals of tackling health inequality and 'levelling up', and contribute to reducing future demands on public services, including the NHS itself.[1]

This narrative will help increase the understanding and awareness of poverty, its causes and consequences among all staff. In turn this will help to:

- embed considerations of poverty into local or national strategies, funding and decision-making
- promote true engagement with communities to understand their perspectives and holistic needs
- inform the design and delivery of specific services in a way that increases accessibility to those experiencing poverty
- enable staff to deliver more person-centred care, and to encourage cross-sector partnership to better meet people's holistic needs.

Below we set out three specific areas where workshop participants thought the NHS needed to increase awareness around poverty.

[1] For example, the University of York has estimated that NHS inpatient costs are £4.8 billion higher for those from more deprived groups (Asaria *et al* 2016) and the Joseph Rowntree Foundation has estimated that the costs of poverty are higher to the NHS than to any other public service, at £29 billion per year (Bramley *et al* 2016).

Enhancing engagement with people who experience poverty

Fundamental to developing awareness is meaningful engagement with people with lived experience of poverty, understanding what poverty means for them, their health, and how they use and access the NHS. A key feature of work that promotes awareness is its grounding in the grassroots and involving genuine participation or co-production with people in communities.

Our workshops and other research have highlighted that the voices and perspectives of people experiencing poverty are still not routinely heard in the NHS. The implication of this is not simply 'more engagement with people', as some communities report being 'over-consulted' (Weekes-Bernard undated). Rather, the NHS needs to further evolve its approach to how engagement is carried out, grounded in empathy and acknowledging where power is held in different contexts. This work also needs a sustained focus that recognises what are often longstanding and entrenched issues around poverty and therefore takes a long-term, systematic approach to tackling them. This must include greater understanding and work not only with those living in extreme poverty, to widen awareness of the experiences of millions living just or somewhat below the poverty line, but also with those facing the greatest risks of exclusion.

One excellent example of this is Morecambe Bay's 'poverty truth commission', which has been led by the NHS to understand much more deeply the impact of poverty on health, and the role the NHS needs to play in tackling it across a coastal community in the north west(*see* box below). Including Morecambe Bay, there are currently 10 such commissions active across the UK and more are in development. The NHS needs to play a full part in these in their local areas and help support their development.

Raising awareness of and engagement with poverty between communities and the NHS: Morecambe Bay poverty truth commission

Some workshop participants described the impact of local 'poverty truth commissions', where developing a shared awareness in this way between different stakeholders was leading to action at a local level. One form of a 'fairness commission', these are based on a model used in several areas to bring together people experiencing poverty to work on an equal footing with local system leaders to address local issues.

One speaker described how their local poverty truth commission had shifted thinking on poverty and created momentum for change across a wide group of local stakeholders.

Source: Poverty Truth Network undated

Awareness training

A key aspect of awareness is ensuring that NHS staff have access to training about poverty to influence their relationship with those at risk of or currently experiencing poverty, and where they can seek to intervene for the individual, or in using their influence in planning in the NHS and more broadly. For example, training that supports staff in the following ways.

- Supports wider understanding by:
    - sharing relevant statistics and wider knowledge about poverty and its impacts on health, including personal decision-making and how to engage and adapt NHS services
    - helping to understand intersectionality and impacts on health. For example, the specific issues faced by people from ethnic minority groups, who are over-represented in low-income and overcrowded households (Khan 2020) and also face deeper health inequalities
    - showing how the NHS has influence across the life course and/or interventions at the point of contact. For example, the NHS has a unique opportunity to influence child poverty through intervention in maternity services, looking at a person's wider needs and attempting to break an intergenerational poverty cycle.
- Supports staff in their practice by:
    - developing resources that support staff practically – for example, on trauma-informed approaches and practice, such as that used in parts of the homelessness sector (Public Health Scotland 2020) to challenge negative stereotypes and facilitate a holistic approach to people experiencing poverty
    - recognising the impact of the stigma and shame that is often attached to experiencing poverty on people's subjective wellbeing and how this can affect treatment or care offered, or how the person may respond to how care is designed or offered (Shildrick and Rucell 2015)

  - recognising that staff need to be supported to resist widely held negative stereotypes about people who are poor, which are often reflected in the media and may be held by NHS staff, the wider public and even people who are experiencing poverty themselves. This means people are less likely to disclose how poverty is impacting on them, even when it affects their health or ability to access health services.

- Supports awareness and recognition that some NHS staff are also in poverty by:
  - recognising that some staff in the NHS itself experience poverty in their families and the NHS has a responsibility to address this. Poverty is not just an issue for the communities served by the NHS. For example, the NHS has a role in paying a meaningful living wage to its employees, and its leaders need to be aware of whether they pay the real living wage[2] and the implications of not doing so. Overall, despite some excellent exceptions, the NHS has a poor record on this – including but not solely with regard to subcontracted staff – although there is variation by area and type of institution; community trusts are most likely to be living wage employers compared to others (Dudding and Franklin 2020) (*see* section 3, Practical actions).

Access to the right data and its analysis

Participants in our workshops highlighted the need to develop better ways to identify people experiencing poverty or at risk of poverty, arguing that current measures do not support an individual clinician to identify whether they are dealing with a person experiencing poverty and therefore how they can develop more tailored care. The NHS does not routinely ask or collect data about incomes (or categories of income) in the same way as it does about other factors associated with disadvantage. Rather, it relies on proxy measures associated with postcodes. These cannot get an individualised understanding of who is accessing or not accessing services, their

[2] See www.livingwage.org.uk/what-real-living-wage on the real living wage, a voluntary standard based on an analysis of the cost of living, and its relationship to the legal minimum wage (set by the government, advised by the Low Pay Commission) and the legal national living wage (a measure based on a target to meet two-thirds of median earnings by 2024).

experiences, quality of care and outcomes. There is a case for NHS England and NHS Improvement to explore further the advantages and disadvantages (including issues of privacy) of collecting this information or working with other agencies to link data at the individual level.

This extends to the design of care pathways and the deeper analysis of data, explaining both needs and patient decisions. Population health management could be a huge strength here to help break the cycle of poor health (McManners 2020), helping design more appropriate pathways (which include non-health care intervention) to match the needs of those in poverty, potentially support pre-emptive intervention, and help improve how care is delivered.

In terms of planning services, at community level it was argued that current approaches to measuring poverty focus on postcode measures of deprivation, which are useful in urban contexts to plan and fund services but less helpful in less-densely populated rural and coastal settings. Understanding different issues in different geographies is key to tailoring provision – for example, taking into account that providing services in rural areas can be more expensive than in urban contexts (Palmer *et al* 2019).

NHS England and NHS Improvement should ensure that the measures it uses to identify need at individual and community levels (and feed into other decisions, such as funding formulae) are suitable and adapted to pick up the influence of poverty, and how that differs in different geographies; it should also support more specific population health management work on poverty. This would help raise awareness of poverty and the positive role of the NHS among clinicians and other decision-makers.

3 Practical actions

Beyond raising awareness, the NHS can take more practical actions to tackle poverty. This section sets out the key actions identified by workshop participants, supported with short case studies. These actions are based on three major routes: action through the delivery of services; through the NHS's wider economic and civic role locally and regionally; and through national-level fiscal analysis and allocation decisions.

Actions as a service provider

It is important to recognise that much of what the NHS can do to tackle poverty is simply part of its everyday work to deliver high-quality accessible services to all. However, as it develops and improves its services more generally, paying attention to poverty will enable it to better meet people's needs and thus improve health outcomes. Below are five specific ways the NHS can do more.

The development of services for those experiencing poverty

Workshop participants identified several key features of effective services for people experiencing poverty. While these are desirable features for any service, participants thought they were particularly critical for those experiencing poverty.

- Services need to be co-produced with people with lived experience of poverty whether they live in generally high or low deprivation areas. This is relevant to all services, regardless of the general wealth of the surrounding area.
- Attention should be paid to how poverty is experienced given other factors – for example, in majority populations, and in populations that are under-represented or in the minority in the area based on ethnicity.
- Services need to treat people holistically and provide swift access to support, which in turn can enable people to stay in work.
- Services need to be flexible, accessible, responsive and offer continuity of care.

Developing services in this way requires awareness of issues relating to poverty and is thus reliant on the meaningful engagement described in the previous section. Examples of services that have been developed in this way to respond to poverty are given in the boxes below. This includes the concept of 'poverty proofing' care pathways, borrowing from experience in the education sector.

'Poverty proofing' service pathways

During the workshops the concept of 'poverty proofing' was introduced. It is currently being used in some education settings to explore what barriers children experiencing poverty face, from their own perspectives. Participants were intrigued as to what an NHS equivalent might look like, to work with those in poverty to 'poverty-proof' all key aspects along the pathway, while acknowledging that the task of applying this to the complexity of a health care institution is not straightforward.

Source: Poverty Proofing the School Day undated

Making mental health services more accessible for those in poverty

One participant described an NHS–voluntary sector collaboration mental health service in north London. Using their INTEGRATE approach (a psychologically informed approach that focuses on multi-level interventions that create change in social environments and co-production of services), they work with people with and at risk of having poor mental health, including those in poverty. Part of this includes clinicians actively going into areas where people are less engaged – for example, youth centres, working men's clubs – taking services to people.

Source: MAC-UK undated

Using digital innovation to widen access

Digital innovation has come to the fore in the NHS during the Covid-19 pandemic. Digital innovations have great potential to transform and increase people's access to services (Mistry 2020). For example, workshop participants highlighted how electronic prescribing enables people from some travelling communities to pick up prescriptions when and where they want (and therefore maintain work on the move).

However, because of inequalities in access to technology, workshop participants also raised concerns about the potential of digital health services to entrench inequalities. The King's Fund's scoping review of digital exclusion in health (Honeyman *et al* 2020) commissioned by Public Health Wales argues that exclusion can happen directly (where health services are not designed with those with less access to digital technology in mind) and indirectly (where access to services that support the wider determinants of health, such as housing or employment support, become dependent on digital routes). We know that 1 in 10 people do not have access to the internet, and those who are older, poorer and with poorer self-reported health are all less likely to engage with digital technologies for health purposes. However, overall some inequalities are narrowing over time, for example the White ethnic group is now less likely than other ethinc groups to have used the internet in the past three months (Scobie and Schlepper 2018).

A key principle must therefore be to use a personalised approach to providing access to care for different individuals, as well as monitoring to ensure that no one gets 'left behind' due to digital exclusion. This reflects both the fact that many people are still excluded from digital channels because they cannot afford to access them, and that digital care – just as physical care – is not 'one size fits all' and needs to be adapted to people's needs. NHS Digital is working on widening digital inclusion and has published a useful guide for health services (NHS Digital 2019), including through understanding how to reach groups at risk of poverty such as homeless people, young carers, people with long-term conditions, isolated older people, and people in rented accommodation.

Local NHS organisations providing digital services need to ensure they have appropriate research and evaluation to monitor what works and spread good practice, and work with local partners to ensure that people are equipped with the skills and opportunities needed to access digital health care (The King's Fund undated).

Social prescribing and health justice partnerships

Social prescribing is a way to meet a person's wider needs by enabling GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services (Buck and Ewbank 2020). These may be of help to some of those in poverty, whose needs are more broadly social and around social welfare rather than medical. However, while social prescribing is gaining recognition and funding support in policy, it was not frequently discussed in the workshops. What was raised was the need for stronger

integration of social welfare services with health services directly, particularly 'health justice partnerships' (Beardon and Genn 2018) – that is, the provision of social welfare advice services in health settings (*see* box below).

NHS England and NHS Improvement should work with local health care commissioners to tailor more social prescribing services to be suitable for those in poverty (including funding the voluntary and community sector, which provides the intervention) and more actively support the formation of health justice partnerships.

Integrating social welfare advice services into clinical settings: health justice partnerships

Health justice partnerships are collaborations where social welfare advice services are integrated into health care settings. These often have specific aims to tackle poverty and are relevant for people in or at risk of poverty as they can provide support for a wide range of issues, including debt, housing and benefits. Having these services alongside health services helps provide a holistic service and address non-clinical demand.

The University College London Centre for Access to Justice identified 380 services of this type (the most common being local Citizens Advice) with around half in general practice (Beardon and Genn 2018). The remainder are in other health settings, with the most common issues addressed being welfare benefits, housing and debt issues. Some of these services are linked to social prescribing schemes but they often have only short-term funding, and are not often funded directly by health care commissioners.

One specific service mentioned by workshop participants was the Maternity Rights Advice Line, provided by Maternity Action. This is a helpline providing expert legal advice on employment rights and social security entitlements. This includes training for midwives and voluntary sector workers supporting vulnerable pregnant migrant women to access housing, income and health care entitlements. Services are delivered by in-house employment and immigration lawyers. The health justice partnership project is developing partnerships with maternity services to deliver integrated services.

Source: Maternity Action undated

Measuring what matters

Targets and outcomes against which the NHS is measured or evaluated can sometimes hinder its ability to tackle poverty. Workshop participants highlighted measures of cost and efficiency rather than social value (discussed in the next section); boards focusing solely on turnover and absence rates and not seeking to 'get behind them' to look more deeply at social mobility and workforce experiences of poverty; and Care Quality Commission (CQC) inspection criteria that can shift attention away from poverty-focused work.

NHS England and NHS Improvement should further promote and develop metrics that are appropriate for identifying meaningful outcomes from work aiming to address poverty.

Spreading good practice

Workshop participants highlighted several examples of ad hoc or pilot projects responding to and helping address poverty with potential for scaling up and sharing learning. In our workshops we saw connections being made between participants in different parts of the country who shared some similar issues.

The King's Fund report *Tackling poverty: making more of the NHS in England* (Buck and Jabbal 2014) recommended that NHS England should disseminate a catalogue of good practice. NHS England and NHS Improvement still have a role to promote good practice in mitigating and preventing poverty, which already exists in the NHS, by making sure these projects are well evaluated and learning is shared. It could develop and promote rigorous assessment of what works, including through working with the National Institute for Health Research (NIHR), and use its national reach to help spread good practice in different settings and locations.

As an economic and social partner in a place

The NHS's wider impacts on poverty through its direct role as a commissioner, procurer of goods and services, employer, land owner, educator, trainer, and through its contribution to local economic strategies and priorities are more widely recognised now. The King's Fund has recently set out four ways that the NHS supports economic development, and therefore poverty reduction, through: local direct employment; its pay and wage rates; connection to the wider economy; and its roles in developing skills and opportunities (Maguire 2020). These are all areas where the NHS can act more cohesively as an anchor institution or partner in place. But workshop participants wanted the

NHS to move further, faster and more consistently in this area to maximise its impact on poverty.

Increasing the number of NHS institutions recognising and using their anchor status

Local NHS organisations can better use their status as anchor organisations in their communities to tackle poverty. Anchor institutions (*see* box below) recognise that their unique role in local communities and economies extends beyond the delivery of their core service. In our workshops, the discussion of the anchor role centred on the mechanisms of employment and training. There was far less discussion on the wider anchor roles, including through commissioning of health care directly and wider supporting goods and services, and the wider civic, social and environmental roles the NHS can play 'in place'.

NHS organisations as anchor institutions

As the Health Foundation (Reed *et al* 2019) states, 'anchor institutions' are large, public sector organisations that are unlikely to relocate and have a significant stake in a geographical area. The size, scale and reach of the NHS means it influences the health and wellbeing of communities simply by being there; and, unlike many businesses, it will be there in perpetuity, meaning it has a stake in the long term as well as the short. This confers advantages and duties.

Questions remain as to how the NHS can best be supported and challenged to think differently about the social and economic value it brings to local populations. To be an effective anchor, NHS organisations need to act coherently using all the levers they have, including: employment; procurement and commissioning for social value; the use of capital and estates; environmental sustainability; and as a better partner across a place.

This suggests that there is a need to be clearer on what it means to be an anchor institution and to support NHS organisations to live up more fully to this role. The establishment of the NHS Anchors Learning Network (Health Foundation undated) funded jointly by NHS England and NHS Improvement and the Health Foundation will have an important role in fulfilling that need.

Maximising the role of the NHS as an employer

The NHS is the country's largest employer, employing 1.5 million people or 1.1 million full-time equivalents (Rolewicz and Palmer 2020). While many of

these are medical roles, the vast majority are non-medical. The NHS therefore has a powerful presence in every community as a source of direct employment and income, and it is a relatively larger employer in poorer parts of the country than in wealthier areas.

It is not surprising then that participants highlighted the NHS's role as a good employer, with opportunities for stable jobs and career advancement for individuals and a source of important income at family and community levels. The NHS has a responsibility to be a good employer, as well as a big one.

The Centre for Progressive Policy has recently looked at how NHS trusts live up to this, benchmarking them against other employers and against each other (Dudding and Franklin 2020). In particular they explored to what extent the NHS is a good employer on pay and benefits, terms of employment, training and progression, working conditions, work-life balance, voice and representation, and diversity in employment. The box below shows some of the results. The NHS does poorly at paying the real living wage and social mobility, both of which are important for short- and long-term poverty.

Is the NHS a good employer?

The NHS ranks 9th out of 26 large employers on an index of good employment (Dudding and Franklin 2020). It does well on some aspects, including chief executive officer (CEO) pay ratio and better staff approval ratings. To some extent, the NHS acts to equalise pay across the country since it has a universal pay scale; therefore being employed by the NHS in a poorer part of the country helps to raise relative incomes. However, it does worse at signing up to accreditation schemes and on the real living wage and social mobility – issues of particular relevance to poverty.

Further, there is huge variation across the NHS (four trusts at the top end do as well as the best large employer, four at the bottom do as badly as the poorest performing employer). Community trusts tend to score better than mental health trusts, while ambulance trusts perform poorest as a group.

Workshop participants had many other ideas about how the NHS could be a better employer for those in poverty, or as an employer 'in' poorer communities. For example:

- In highly seasonal coastal tourism areas, many people work during the summer and then struggle in the winter. The NHS could work with local educational and training institutions to offer training and development in

fallow economic times, boosting local incomes and offering younger people opportunities in the short term and skills development in the longer term.

- More broadly, there were various examples of projects in early stages of development where local NHS organisations, education providers and other partners are working together to provide training opportunities and pathways bespoke to the local context, and the roles and skills that are needed. The NHS needs to be more active in developing opportunities for 'good' jobs.
- The NHS could do more to ensure that maternity employment retention rates are monitored internally, and work with the voluntary sector to support expectant mothers' rights to employment – for example, with organisations like Maternity Action, which help support expectant mothers around their rights, including to continued employment.
- Racism and discrimination among the NHS workforce can also impact negatively on people in poverty. Understanding this in more depth and taking action to address it are important, and the new NHS Race and Health Observatory (NHS England 2020) could have an important role in supporting change.
- The NHS could to more to ensure that flexible working is available to people with caring responsibilities to enable them to continue working alongside caring.

NHS England and NHS Improvement commissioned the Learning and Work Institute to identify initiatives the NHS could rapidly develop to address the employment impacts of Covid-19 and support social mobility. The report (Aldridge 2021) identified a number of actions that support economic recovery and poverty reduction.

In conclusion, there are many ways the NHS can help reduce poverty through its role as an employer, and some of these are set out above. NHS England and NHS Improvement can support all NHS organisations to go further on being good employers by expecting them all to be real living wage employers for all staff, including those subcontracted, and to reduce the unjustifiable variation between the best and the worst performing organisations.

Commissioning and procurement: making better use of the Social Value Act

As stated earlier, the Social Value Act was not mentioned in any detail in our workshops. A few participants highlighted the NHS's role in procurement –

some of the lowest-paid and most insecure staff are indirectly employed and the NHS can do immense good by pushing good practices through their supply chains and using social value in procurement.

A key challenge to the NHS acting as an anchor is the imperative of efficiency and, alongside this, the pressure to cut costs (Devins *et al* 2017). Creating the space, or 'permission', to act as an anchor requires a much broader notion of value than simply keeping within budget or ensuring a cost-effective use of treatment resources. This means a more enveloping notion of social value; the Social Value Act (Department for Digital, Culture, Media and Sport *et al* 2018) provides one framework for this, but social value needs to be embedded in commissioning more widely (*see* box below).

Commissioning for social value is important in principle and, if done well, is likely to help the NHS tackle poverty. The government has introduced new stipulations that mean, from the beginning of 2021, a strengthening of social value in the assessment of bids for government contracts (Cabinet Office and Department for Digital, Culture, Media and Sport 2020). Given this, and the findings that many NHS commissioners are not using social value in their commissioning, more action from NHS England and NHS Improvement is needed to ensure that the NHS maximises social value through its commissioning. The recent White Paper on the future of the NHS (Department of Health and Social Care 2021) did not refer directly to social value, as integrated care systems develop and the NHS moves away from competition and tendering based solely on the price of services, there should be a stronger focus on the social value that NHS spending creates.

The Social Value Act and the NHS: a route to tackling poverty

The Social Value Act came into force in 2013 and requires all public sector commissioners – including local authorities and health sector bodies – to consider economic, social and environmental effects in the procurement of services and contracts.

Early exploration of how the Act could be used by the NHS (Allen and Allen 2015) suggested it was an important way to help the NHS understand the broader effects of its commissioning and wider elements of social value, beyond cost minimisation. For example, the Act's provisions enable the NHS to: employ local residents or target groups such as young unemployed people, to build local supply chains; procure with the voluntary, community and social enterprise (VCSE) sector, and work with schools and young people; require contractors to pay a living wage; and to minimise negative

environmental impacts. All of these could be used to help the NHS tackle poverty.

A 2017 survey (Redding and Butler 2017) showed that while almost 6 in 10 clinical commissioning groups (CCGs) stated that they had a social value policy, only around 1 in 8 were judged to be highly committed, evidenced and active in ensuring that their commissioning delivered social value. More organisations and systems need to develop approaches such as Cheshire and Merseyside's social value charter, which includes: a social value network and champions, supported by a training programme open to NHS organisations, local authorities and the VCSE sector; case studies; development of kitemarking; and a guide on how social value can be embedded across the commissioning cycle.

Source: NHS England undated b.

A wider recognition of the NHS's fiscal multiplier effect in local economies

There was also no explicit discussion of the 'fiscal multiplier effect' of NHS spending. This is the *indirect* economic effect of NHS spending: it is an additional impact above and beyond how the NHS commissions and its direct actions. NHS spending, like all other spending, induces additional economic activity and therefore wealth generation. But different industries do this to different degrees, and in different ways. In a study that covered economic activity across the European Union (EU), the World Health Organization (WHO) found that health care spending ranked 9th out of 62 industries in terms of the scale of additional economic activity induced by an industry's own spending on others (Boyce and Brown 2019). There have been few analyses of the NHS's fiscal multiplier effects on the wider economy (*see* boxes below for two examples). There need to be more analyses to help understand how to maximise the NHS's indirect effect on the economy in a way that is more likely to tackle poverty at the local level.

The fiscal multiplier effect of the NHS – the Aneurin Bevan University Health Board

The Aneurin Bevan University Health Board provides care for a population of 600,000 people in south-east Wales. A study (Morgan *et al* 2017) looked at direct commissioning from 25 industry sectors, and further induced demand through those sectors.

In 2009/10, total expenditure for the health board was £952 million, with employment of 10,754 full-time equivalents (FTEs) and value-added of £406 million. Of this, £528 million was spent on the supply chain (the remainder includes wages and depreciation). More than two-thirds (70 per cent) of supply chain spending was on the health sector (including social care) in and outside Wales; 24 per cent of supply chain spending was spent in the local area, the vast majority (90 per cent) of which was on health and social care activity.

The study found the Aneurin Bevan University Health Board expenditure induced further spending in the Welsh economy of £746 million (a multiplier of 1.78); a further 8,754 FTE jobs (a multiplier of 1.82); and a further £324 million of value-added (a multiplier of 1.80).

Source: Morgan *et al* 2017

The fiscal multiplier effect of the NHS – the Black Country

A study (Frith 2017) of the economic impact of NHS spending in the Black Country – covered by four clinical commissioning groups (Dudley, Sandwell and West Birmingham, Walsall, and Wolverhampton) and seven NHS trusts – showed an annual spend in 2014/15 of around £2 billion. 52 per cent was spent on employee wages and pensions and other benefits, and the remainder on goods and services. There was a gross value-added of NHS spending of £1.1 billion and a total of 30,800 FTE jobs are supported by this spending in the Black Country.

The study found NHS spending in the Black Country induced further spending, including a further 10,000 FTE jobs (a multiplier of 1.32) and a further £457 million of gross value-added (a multiplier of 1.43).

The NHS is more labour intensive than other significant sectors; for every £1 million spent in the NHS, 15 jobs are supported, compared to 6 in production industries.

Source: Frith 2017

National analysis and allocations

Much of the action that the NHS can take clearly needs to be local. National leadership and support can help support this work (*see* sections 4 and 5). But more concerted national action is needed too; the development of the anchors network is a case in point. Two other areas are worth mentioning here.

First, is the collation, analysis and use of data and measurement to support the NHS's role in tackling poverty. Again, the national population health management work is a good example of this. So too is the commitment to monitor health inequalities more systematically and coherently as part of the NHS's recovery from Covid-19, as set out in the 'phase 3' letter referred to earlier (NHS England and NHS Improvement 2020a). But the NHS's national leadership can go further. One step would be to explore the case for developing and rolling out definitions of poverty, and 'at risk of' poverty, in existing datasets at individual level and testing how well postcode data can approximate individual poverty risks.

Second, is to be more active through NHS allocation policy – that is, how the overall resource for the NHS is allocated to local areas. There is a long history of this, and the National Audit Office has assessed NHS resource allocation as one of the clearest and fairest among government departments (National Audit Office 2011). Allocation formulas are constantly reviewed under the aegis of the Advisory Committee on Resource Allocation. Topics that need to be assessed as part of this process include: the direct and indirect impacts of Covid-19 on poverty and future health; how these impacts may differ by geography, all other things being equal (Bambra *et al* 2020); primary care allocations (Boomla *et al* 2014); and related issues such as how common measures of deprivation used in the formulas can mask rural poverty (which were raised in our workshops) (Burke and Jones 2019); and the increased costs of providing rural services (Palmer *et al* 2019). Allocation informed by these additional issues could more effectively channel resources to areas of need.

4 Advocacy: using the NHS's voice to tackle poverty

The NHS's role as an advocate is important because it has a unique position and authority in terms of its standing in the eyes of the public, and therefore has potential to influence other sectors.

Workshop participants called for the NHS to take on a much stronger role as an advocate, using its voice and reputation to both influence and speak out for people and communities at risk of or experiencing poverty, and to work more closely with organisations and sectors tackling poverty. They saw that one of the most powerful things the NHS could do was to simply 'show up' and use its influence and voice in local places, partnerships and public debates.

Advocacy from national leadership

NHS England and NHS Improvement could harness their organisational power to speak out on a range of issues to influence work on poverty. One component of this is to work with the Department for Health and Social Care and across government to advocate for a cross-government health inequalities strategy, which recognises the wider determinants of health inequalities and connects goals for reducing poverty and improving health outcomes to the government's 'levelling up' agenda.

Workshop participants described what they felt was the current lack of recognition of the role of the Department for Work and Pensions in developing policies that impact on people's health and wellbeing. Again, this indicates a role for cross-government working, with a role for the Department for Health and Social Care.

Advocacy from the NHS workforce

The advocacy of clinicians at local level is powerful, for individual patients and for broader change in the conditions that lead to poor health for patients and the public. This is part of a long tradition: as Virchow, a nineteenth century

physician and one of the first to recognise the wider determinants of health, put it:

> *Medicine is a social science, and politics is nothing else but medicine on a large scale. Medicine, as a social science, as the science of human beings, has the obligation to point out problems and to attempt their theoretical solution: the politician, the practical anthropologist, must find the means for their actual solution… The physicians are the natural attorneys of the poor, and social problems fall to a large extent within their jurisdiction.*
>
> (Quoted in Maletz 2011)

Many clinicians are acting in this way, including through the examples and ways outlined earlier, but our workshop participants – including clinicians from the NHS – wanted to see this more consistently.

For example, the Health Creation Alliance supports the role of health creation through voice and advocacy (Health Creation Alliance undated); and both Fairhealth (Fairhealth undated) and the Deep End Group (Wolf undated) movements are supporting and exploring the role of general practice in improving the wider social determinants of health. The advocacy role of health professionals was outlined in the 2013 report from the Institute for Health Equity (in collaboration with many other partners) on the role of health professionals in working for health equity (*see* box below). Many Royal Colleges and other organisations are signed up to the Marmot principles (Allen *et al* 2013).

NHS staff are increasingly using their individual and collective voice to speak out on national debates about poverty. We saw an example of this in October 2020 when more than 2,000 paediatricians signed an open letter calling on the UK government to provide free school meals for children from low-income households during the school holidays (Royal College of Paediatrics and Child Health 2020).

The NHS workforce as advocates for equity – the advocacy role of health professionals

The Institute for Health Equity (Allen *et al* 2013) set out several key roles for health professionals as advocates for health equity:

- Individual health professionals and health care organisations should, where appropriate, act as advocates for individual patients and their families.
- Individual health professionals and health care organisations such as local NHS trusts should act as advocates for their local community, seeking to improve the social and economic conditions and reduce inequalities in their local area.
- Individual health professionals, students, health care organisations such as NHS trusts, and professional bodies such as Medical Royal Colleges and the British Medical Association should advocate for a greater focus on the social determinants of health in practice and education.
- Individual health professionals, students and professional bodies such as Medical Royal Colleges should advocate for policy changes that would improve the social and economic conditions in which people live, and particularly those that would reduce inequalities in these conditions. They should target this advocacy at central government, and bodies such as the NHS Commissioning Board (now NHS England).

In that report, the following bodies agreed to commit to greater advocacy around health equity through specific commitments: Academy of Medical Royal Colleges; Royal College of Physicians, British Dietetic Association; Royal College of Paediatrics and Child Health; Royal College of Speech and Language Therapists; Royal College of Obstetricians and Gynaecologists; British Association of Occupational Therapists; Royal College of Occupational Therapists; Royal College of Nursing; British Medical Association; Medsin; and British Association of Music Therapy.

Source: Allen *et al* 2013

5 The NHS: a better partner and leader for tackling poverty

None of the mechanisms described here are a panacea for the NHS's role in tackling poverty. But used well, they can all help to strengthen the NHS's approach to poverty. All of them come together, in different ways, in 'place'. The NHS is not an island and needs to work more closely with others to address poverty across the three As.

Cross-sector partnerships for tackling poverty

Workshop participants emphasised the importance of local NHS organisations working in partnership to tackle poverty. These partnerships require the NHS to be aware of its contribution to tackling poverty, with this understanding facilitating greater and deeper engagement with communities and partnership working – for example, to design 'wraparound' care and support. Our workshop participants stressed the following:

- clear, consistent and shared understandings between the NHS and other sectors on terms such as health inequalities, poverty, community engagement – and a process to develop these shared understandings that values the contributions of all partners
- building relationships and trust to develop partnerships
- recognising the levers other organisations hold to address poverty, and what local NHS services can do to support this work
- ensuring that grassroots-level partnership working between 'frontline staff' is supported and resourced from the top.

The voluntary, community and social enterprise sector

In particular, local NHS organisations need to be aware of the role of the VCSE sector in this work and treat them as core partners rather than an afterthought or 'add on' to services. It also relies on different sectors having knowledge of how each other works and the organisational 'languages' used.

Participants suggested a need for local NHS organisations to ensure effective communication about how best to address poverty between the NHS and VCSE sectors by learning how the VCSE sector works, as well as sharing NHS processes and language with VCSE leaders.

Local NHS leaders need to facilitate their staff to have capacity to engage with their local VCSE sector, and need to ensure that appropriate measures are used to evaluate impact. Awareness in this context goes both ways – upskilling VCSE leaders to engage in the 'NHS world' as well as ensuring that NHS leaders and staff have an understanding of the VCSE sector and how it works (NHS Confederation 2020).

For example, in November 2020, the Thriving Communities programme was launched. This includes a £30 million fund for NHS Charities Together community partnership grants (NHS Charities Together undated) and aims to help local NHS charities develop community partnerships to reduce health inequalities, support people impacted by Covid-19 and improve prevention. Every integrated care system (ICS) and sustainability and transformation partnership (STP) has an allocation of funding, and lead NHS charities are being recruited now in every ICS/STP area who will work with local VCSE groups and organisations to develop community partnerships, using their funding allocation.

NHS England and NHS Improvement have an VCSE Leadership programme which supports the integration of VCSE into ICS governance and planning and programme delivery (NHS Confederation 2020). The King's Fund and The National Lottery Community Fund are also working in this space, supporting genuine partnership working in local areas between the voluntary and community sector, the NHS and local authorities to improve the health and wellbeing of local communities. Six areas have received grants to develop capacity for working together and support community organisations' participation and will also receive support to work together in new ways and to foster stronger relationships. As the programme progresses, The King's Fund and The National Lottery Community Fund will also work with the Healthy Communities Together Partnerships to identify and disseminate learning from their experience (The King's Fund 2020).

Local economic and education partnerships

Historically, the NHS has been poor at engaging with strategic partnerships at regional and local levels. Two key areas to develop to address poverty are strategic economic partnerships and educational partnerships.

The renewed focus on place by the NHS through STPs, ICSs and PCNs and the government's 'levelling up' agenda create an opportunity to develop deeper economic partnerships between the NHS and other stakeholders to help tackle poverty. The NHS needs to be a stronger partner in local economic and industrial strategies, including contributing to the government's Industrial Strategy (Reed *et al* 2019) and its focus on skills, infrastructure, innovation and inclusive economic growth. This will not only enable the NHS to influence these strategies to support its own needs (for example, for a skilled workforce); but also enable its partners to draw on NHS economic power to develop more inclusive and poverty-reducing growth. The box below sets out how the NHS Confederation is supporting the NHS to engage with local enterprise partnerships.

Other key partners include universities and other local education institutions, including NHS and academic collaborations through Academic Health Science Networks (AHSN Network 2019). In particular, universities have taken the lead on understanding and acting on their role as anchor institutions (Harris and Holley 2016) – something the NHS needs to learn from. Secondly, meeting workforce needs is one of the biggest challenges facing NHS leaders. As the NHS Confederation states (Wood and Alway 2020), by better embedding colleges into core NHS workforce development, and better using their local recruitment and training power, they can 'play a timely and important role in the government's 'levelling up' agenda, narrowing regional inequalities and increasing prosperity by supporting local people into clear and high-quality local career pathways'.

The NHS and local enterprise partnerships

Responsibility for developing local economic plans rests with the 38 local enterprise partnerships (LEPs) in England, working closely with the emerging combined authorities and a range of other partners. The NHS can benefit from being part of LEPs (for example, from expertise) and from efforts to move towards more equal and inclusive economies, which will tackle poverty and ultimately improve population health. The NHS Confederation (2017) set out a five-point plan for engaging with LEPs.

- Understand the extent of existing relationships between local NHS colleagues (clinical commissioning groups, trusts, local education and training boards, academic health science networks) and your respective LEP(s).

- Discuss informally with colleagues from local authorities (including public health), further education, higher education and the third sector, the level (and success) of their interaction and engagement with the LEP.
- Review existing public LEP strategies around skills and employment, highlighting both points of potential alignment and issues absent.
- Collate relevant local health (and care) data. LEPs require a clear evidence base for their priority investment areas. The data should highlight both the employment base, skills gaps and needs, and demographics.
- Agree local senior leadership and representation when approaching the LEP(s), perhaps through the new STP leadership. This person should be able to communicate on behalf of a good proportion of the health economy, rather than just a particular institution.

The NHS Confederation supports NHS organisations and systems to engage with economic partners and leaders of LEPs, and has produced a range of guides, reports and case studies. It also provides a free local economic growth bulletin for NHS organisations and others.

Source: NHS Confederation undated

The NHS and leadership for tackling poverty

Our workshop and plenary participants, which included senior NHS leaders, made several key points about leadership of – and from – the NHS in terms of institutional and personal leadership on tackling poverty.

Institutional leadership

NHS England and NHS Improvement has a key role as a leader in supporting local actions to tackle poverty, including delivering the commitment in the NHS Long Term Plan to:

> *…support local planning and ensure national programmes are focused on health inequality reduction, the NHS will set out specific, measurable goals for narrowing inequalities, including those relating to poverty, through the service improvements set out in this Long Term Plan.*
>
> (NHS England 2019, p 40)

The momentum established with the phase 3 recovery letter's focus on inequality reduction is an opportunity to do this, including its welcome decision to set out:

- several practical actions (including prioritising treatment for those experiencing, or at risk of inequalities)
- improved measuring and monitoring
- and stronger leadership for tackling health inequalities (including accountable members of NHS organisations' executive teams).

NHS leaders at all levels should recognise that poverty is an issue that the NHS can and should act on. This awareness is needed to facilitate their staff and provide the time and resources needed for meaningful engagement. This also involves recognising the value of giving staff time and space to think about and to engage with wider issues beyond immediate clinical need.

Workshop participants expected that the NHS would show strong institutional leadership by increasingly naming 'poverty' directly, and avoid it being subsumed under the catch-all of 'inequality', in order to increase awareness, develop action, and to fulfil the NHS's role in advocacy, particularly through local NHS executive leads for health inequalities.

Participants also expected stronger leadership on tackling poverty from the NHS's new local and regional institutions and partnerships, including PCNs and ICSs.

These institutions will form the core of the NHS for years to come. For example, one participant described a local PCN that is active with the local council, is engaged with wider determinants of health and is working with the local medical school on recruitment. It is within these partnerships' power to make a transformational difference to poverty through the design and delivery of services, greater attention to wider economic and civic roles, and through partnership with communities and other sectors. The four core purposes of ICSs, as set out by NHS England and NHS Improvement (2020b), are consistent with this: improving population health and healthcare; tackling unequal outcomes and access; enhancing productivity and value for money; and helping the NHS to support broader social and economic development. But this requires their leadership to be proactive and not reactive, to reach out, inquire, and support and learn from others. In short, this is leadership that combines an understanding and willingness to use the power of the NHS

with the humility to serve the goal of tackling poverty, which ultimately will also improve the health of the population the NHS is there to serve.

Personal leadership

NHS leaders at the workshops and plenary session themselves recognised that they do not have all the answers, and that they need to: reach out into the communities they serve; learn from those with lived experience of poverty; and draw on the understanding and experience of other stakeholders who have greater expertise. Morecambe Bay's poverty truth commission (*see* box on p 13) is a good example of this.

Finally, participants highlighted the importance of moral leadership and the role of advocacy within that. Health leaders, particularly clinicians, can be powerful moral advocates. They see the damage of poverty daily and their voice is extremely powerful. Participants wanted these leaders to do more to speak up and speak out. But for clinicians to work in this way also requires support from non-clinical leaders, and ensuring that staff feel safe to speak out about poverty without fear of implications for their roles. Many clinicians feel able to speak in this way, and do, but we also heard about those for whom it was less easy. It is therefore important for their professional organisations and employers to support them to do so, in the way that those signing up to the Institute for Health Equity's commitments on health equity (*see* box on p 30) have shown.

6 Conclusion

Poverty has always been inextricably linked with health. Indeed, this is one of the reasons why the NHS was founded, to insulate individuals and families from the potentially catastrophic costs of health care. Since 1948 the nature of poverty, and who is at risk and in poverty, has continued to change. Similarly, life expectancies and health problems faced by the population have altered. The NHS too has evolved: there has been a growing focus on more personalised and integrated care, and most recently the recognition that the NHS can influence poverty, and therefore health, through its impact as an economic and civic actor as well as through the direct delivery of care.

The experience of Covid-19 has reinforced the role of the NHS in society, but also the need for all public services to do more to prevent, reduce and mitigate the impacts of inequality and poverty. The NHS already has a significant role in this. It means people are not forced into penury due to health care costs, something that is not the case in some other countries. Part of this is about forward planning. The impacts of poverty related to Covid-19 will increasingly shape the demand for care over the coming years, and the NHS needs to be prepared. But this is also about more than that.

We have learnt much through research, and from our workshop participants, about how the NHS is being and can be more proactive, within whatever resources it has. In particular, more focus is needed on the three As of awareness, action and advocacy: awareness of poverty and how this changes people's needs and interactions with services; action in the design of care but also through the impact of the NHS as an economic and civic power; and advocacy for tacking poverty, given that the NHS and its staff have such powerful and influential positions in society. Our workshops and wider research give practical ways, examples and ideas that can be adopted and supported more widely across the NHS. But this requires active leadership and strong partnership working to do so. It is hard, and will not happen without commitment, and it will not be effective without the NHS working with other sectors, communities and individuals in, or at risk of, poverty.

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8 Annex: our approach to this work

This report is based on work commissioned by NHS England and NHS Improvement in early 2020. It is based on five elements:

- previous work by The King's Fund on *Tackling poverty: making more of the role of the NHS in England* (Buck and Jabbal 2014)
- a literature review undertaken by The King's Fund Library, which updated the above paper
- a series of workshops with health and poverty stakeholders, with a focus on the role of the NHS in different geographies (urban centres, town and rural, and coastal) and a workshop specifically with voluntary and community sector representatives
- a plenary session with NHS and other leaders to share results and reflections
- wider information and studies given Covid-19, its effects on poverty and health to date, and the likely longer-term impacts.

The updated literature review largely confirmed the findings from the original King's Fund paper with some updating of sources and practice. Because it did not challenge the fundamental findings, it is not reported in detail in this paper, although many of the updated studies that informed it are referenced.

Deprivation is closely related to health outcomes and inequality and 'place' is important in poverty. Northern and Midlands post-industrial towns, urban 'fringes' and coastal areas have all been highlighted as falling behind on various measures including child poverty, unemployment and health status (Local Trust 2019). We therefore saw it as important to frame our workshops around place, to explore the differences but also the similarities of how health and poverty are connected, and what that means for the role of the NHS. In practice, however, many of the issues, solutions and ideas expressed were similar across geographies; we have highlighted particular aspects in the text which seemed important – for example, whether common deprivation measures mask poverty in rural communities.

Three workshops were therefore undertaken with stakeholders from the NHS, poverty groups, and others with a particular focus on: urban and city environments; rural and market towns; and coastal areas. A further workshop was held with representatives from the VCSE Health and Wellbeing Alliance (NHS England undated), which represents communities with protected characteristics or those that experience health inequalities. In total, across these four workshops, more than 60 participants attended from a mix of NHS, VCSE, local authorities, government and arm's length bodies, and people with lived experience of poverty. Finally, we held a plenary workshop to reflect on the findings from these four workshops and consider the wider implications of these for the NHS.

This report is informed by all five elements above and our drawing together of the key common themes and 'asks' of the NHS from workshop participants.

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