Department of Health & Social Care

Equalities impact assessment: 10 Year Health Plan for England

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Introduction

This equality impact assessment (EQIA) assesses how the Department and Health and Social Care (the department) and NHS England have worked in partnership to address the requirements of the public sector equality duty (PSED), section 149(1) of the Equality Act 2010, and related provisions under section 149 more generally, in developing the 10 Year Health Plan. We recognise that developing the plan, its content and implementation are very important exercises of the functions of the department and NHS England.

This document also highlights if risks have been identified that need to be mitigated as proposals are implemented. The EQIA incorporates assessments for each chapter of the plan which explores the proposals through the lens of each protected characteristic.

The general information in this document and the supporting chapter assessments have informed the development of the plan and will also inform implementation. This has assisted decision-makers in making informed decisions about the plan and to continue to comply with the PSED on considering options for operational delivery of the policies proposed.

Addressing health inequalities duties

The Secretary of State for Health and Social Care and NHS England are also subject to separate duties in relation to health inequalities. The Secretary of State is subject to section 1C of the NHS Act 2006. Section 1C confirms that the Secretary of State must have regard to the need to reduce health inequalities between the people of England with respect to the benefits they can obtain from the health service in access and outcomes from health services, and this document demonstrates that such considerations have been taken into account throughout the 10 Year Plan development process.

By contrast, NHS England is subject to section 13G of the NHS Act 2006, which places a similar duty on NHS England in the exercise of its functions, to have regard to the need to reduce inequalities between persons with respect to their ability to access health services, and with respect to the outcomes achieved for them by the provision of health services.

For detailed guidance on the Equality Act 2010 or the PSED, resources are published by the Equality and Human Rights Commission (EHRC), particularly the EHRC's technical guidance on PSED which was last updated in 2023.

The structure of this EQIA

The first 3 sections of this EQIA give an overview of the basic legal framework and EHRC's technical guidance, and explains the main terms and summarise the obligations

associated with PSED. The ‘Protected characteristics and existing inequalities’ section provides information on inequalities in access and outcomes by reference to protected characteristic groups. It also provides information on the intersections between those protected by the Equality Act 2010 and people who face socioeconomic inequalities.

The final sections correspond to chapters 2 to 9 of the 10 Year Health Plan and provide more detailed analysis of the potential equality impacts on each protected characteristic.

The legislative context and the PSED

Equality Act 2010 and PSED’s 3 equality aims

The 3 elements of the general equality duty are often called equality aims and that term is used in this EQIA. The term ‘equality aim’ is not used in the Equality Act 1010. The EHRC advises that due regard should be given to all 3 equality aims in exercising a body’s functions:

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this act[1] (equality aim 1)
- advancing equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it (equality aim 2)
- fostering good relations between persons who share a relevant protected characteristic and persons who do not share it (equality aim 3)

In making the assessment provided in this EQIA, consideration has been given to the PSED’s 3 equality aims.

Understanding the Equality Act 2010, legal framework and the PSED

Addressing PSED means considering how to address all 3 equality aims. The general equality duty is supported by secondary legislation, non-statutory technical guidance, published by the EHRC and other non-statutory guidance also issued by the EHRC. This guidance has been considered in the development of this EQIA package.

[1] In relation to the PSED and marriage and civil partnership, only the first equality aim needs to be considered. Equality Act 2010, section 149(7) and the EHRC’s technical guidance on the PSED, paragraph 2.9.

To address the first equality aim, consideration needs to be given to who is protected by the Equality Act 2010 and how to eliminate unlawful or prohibited conduct. It is important to recognise that the Equality Act 2010 provides a legislative definition of each of the protected characteristics. In some cases, these definitions include specific exclusions or depart from the way that one would normally define a term. Furthermore, case law informs how terms in the Equality Act 2010 should be understood. Definitions and explanations of the protected characteristics can be found in section 4 of the Equality Act. The production of this EQIA demonstrates how the PSED has informed the development of the plan.

The EHRC technical guidance

The EHRC's technical guidance explains the equality duties and what action should be taken to comply with the PSED and the specific equality duties[2].

Paragraph 2.39 of the EHRC's technical guidance on the PSED explains that 'due regard' means that: "in making decisions and in its other day-to-day activities a body subject to the duty must consciously consider the need to do the things set out in the general equality duty." The EHRC's guidance also confirms that a body: "subject to the duty must have due regard to each of the three aims set out in s.149(1) in relation to each of the relevant protected characteristics set out in s.149(7)." This guidance also refers to the importance of the 6 Brown principles:

- knowledge of the duty by decision makers
- conscious consideration of the duty at the proper time before final decisions are made
- substantive, real and rigorous consideration with an open mind
- that the duty is non-delegable
- the duty is continuing
- it is good practice for those exercising public functions to keep an accurate record showing what they had actually considered as this will facilitate transparency

With respect to the sixth principle the EHRC notes that proper record keeping encourages transparency and will discipline those carrying out the relevant function to undertake the duty conscientiously. The EHRC also notes that if "records are not kept, it may make it

[2] According to the EHRC "technical guidance is a non-statutory version of a code, however it will still provide a formal, authoritative, and comprehensive legal interpretation of the PSED and education sections of the act. It will also clarify the requirements of the legislation."

more difficult, evidentially, for a public authority to persuade a court that it has fulfilled the duty imposed by [section 149]." Paragraph 2.45 of the EHRC guidance also highlights the 3 additional principles set out below.

- the equality duty is an integral and important part of the mechanisms for ensuring the fulfilment of the aims of anti-discrimination legislation
- the duty is upon the decision maker personally. What matters is what he or she took into account and what he or she knew
- a body must assess the risk and extent of any adverse impact and the ways in which such risk may be eliminated before the adoption of a proposed policy

Detailed consideration has been given to identifying and considering how to address equality risks or challenges.

Addressing the EHRC's technical guidance

Equality aim 1 and equality aim 2 of the PSED are fully engaged by this process. The third equality aim of the PSED is fostering good relations between people who share a protected characteristic and those who do not. Paragraph 3.44 of the technical guidance provides a working definition for fostering good relations. This definition is: "the growth of relations and structures that acknowledge the diversity of society, and that seek to promote respect, equity and trust, and embrace diversity in all its forms". Paragraph 3.46 also explains that, fostering "good relations between people who share a particular protected characteristic and those who do not is intended to, for example:

- increase integration
- reduce the levels of prejudice and promote understanding between people who share a particular protected characteristic and people who do not share it
- increase diversity in civic and political participation (including volunteering) in the relevant community
- increase reported confidence and trust in institutions such as the body subject to the duty
- lead to a reduction in bullying, harassment, hate crime and violence against those who share a particular protected characteristic, both online and offline
- lead to a reduction in fear of crime both in respect of those who share a certain protected characteristic and those who do not"

This guidance has been considered in assessing when equality aim 3 is engaged in the development of the plan.

The relevance of the general equality duty and giving weight to the equality aims

As a 10 Year Health Plan for the NHS, the requirements of the Equality Act 2010 and most of the 9 protected characteristics are engaged as are the PSED's 3 equality aims. Evidence of inequalities in employment by reference to protected characteristics has been provided by the:

- NHS Workforce Disability Equality Standard (WDES) is a set of 10 specific measures (metrics) which enable NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff

- NHS Workforce Race Equality Standard (WRES) is a set of measures (metrics) which enable NHS organisations to compare the workplace and career experiences of staff from different ethnic groups

- NHS Staff Survey provides evidence by reference to a number of protected characteristics, specifically ethnic background, gender, religion, sexual orientation, disability and age as well as allowing individuals the ability to write in information with respect to other discrimination

The most recent NHS Staff Survey report was published in March 2025 and reported on the experiences of NHS Staff in relation to discrimination and equality. The WDES, WRES and NHS Staff Survey information and evidence have informed the EQIA and the plan itself where relevant.

The assessment process and ensuring ongoing due regard

Equalities issues were considered by the working groups established as part of the engagement process on the plan. Each working group was asked to consider equality issues - see the Tasking statements for the 10 Year Health Plan working groups. In addition, a dedicated working group (the vision working group titled 'I am treated in a fair and inclusive way irrespective of who I am') was specifically tasked with examining inequalities in greater depth, as well as vulnerable groups and individuals with protected characteristics. This working group had a lead role in considering health inequalities and equalities and reducing variation in outcomes. In addition, the importance of integrating this focus across all working groups was emphasised from the outset. This vision working group 4, held a dedicated session with the chairs of all the other working groups to clearly

set out the expectations and requirements for embedding these considerations into their thinking and final reports.

As part of the extensive engagement process in developing the plan there was meaningful engagement with those audiences who are all too often seldom heard and identifies what a range of different groups covered by the PSED and/or the health inequalities duties raised in relation to their assessments in relation to the 10 Year Health Plan. These audiences commented on what the plan should achieve, responded to the proposed shifts and shared issues and concerns.

As the 10 Year Health Plan draft developed, each policy proposal was reviewed looking at the issues through the lens of the potential impacts for different protected characteristic groups. This assessment drew on evidence and research about existing inequalities by reference to the protected characteristics. This process will also assist those implementing the proposals to understanding relevant inequalities by reference to protected characteristics and to properly address these as the proposals contained in the plan are developed and implemented.

The plan includes a wide range of proposals that are intended to have positive outcomes by reference to a range of protected characteristics including where there are important pre-existing inequalities. This represents a broad and determined effort to ensure the plan and the associated EQIA package identify and provide a framework for improving inequalities by reference to protected characteristics as the plan is implemented

The EQIA will be kept under review throughout the policy cycle, including through ongoing monitoring and evaluation following implementation. As the PSED is an ongoing duty, ongoing consideration will be given to the evidence and issues identified in this EQIA and the associated EQIA documentation. Those involved in the subsequent phases of policy design and implementation will be able to draw on these EQIA resources as part of that work.

Protected characteristics and existing inequalities

Several protected characteristic groups are currently impacted by challenges with access, quality or health outcomes. Some data on certain protected characteristics is limited, not routinely collected by the NHS or government bodies, or is underrepresented in academic research. Where necessary we have used alternative sources such as research from charities, community organisations and surveys to inform our assessment, though we note these may be smaller in size and/or be based on more limited evidence.

We have also outlined legal considerations for some of the protected characteristics and how this EQIA has interpreted the duty.

Age

In relation to services, the service delivery provisions on age in the Equality Act 2010 do not protect those under the age of 18 from age discrimination (section 28 of the Equality Act 2010. However, other provisions in the act (for example, disability and race) do prohibit other forms of discrimination for any age group, including those under the age of 18 and the PSED does provide for the advancement of equality of opportunity on the basis of age without the under 18 age limitation (section 149(7) of the Equality Act 2010). This EQIA therefore takes account of this broader interpretation of the PSED and also considers those under the age of 18.

Older adults

Age is a major factor in use of NHS services. The Centre for Ageing Better State of Ageing Report 2025 reported that there were 11 million people (19%) aged 65 and over in England and projected that the proportion will rise to 26% of the population aged 65 and over by 2065. This will significantly increase demand on NHS services. Older people, particularly those over 65, are consistently among the highest users of NHS services due to chronic conditions, frailty and/or increased or complex healthcare needs. According to Age UK, 86% of people over 85 in England live with at least one long-term health condition and as a result, are more affected on average by challenges with access, quality or outcomes[3]. Inequalities are also apparent in areas of deprivation. Older adults in more deprived areas were twice as likely to need help with daily activities compared to those in wealthier areas, and they also had higher levels of unmet care needs. NHS England's equality objectives for 2024 to 2025 and 2025 to 2026 specifically reference the need to address age-related health inequalities in elective care and communication access.

Children and young people

Children and young people in England have faced a growing number of health challenges, many of which have been exacerbated by the COVID-19 pandemic and ongoing social inequalities. The prevalence of mental health disorders among children and young people has significantly increased. In 2020, 1 in 6 children aged 5 to 16 were identified as having a probable mental disorder, up from 1 in 9 in 2017[4]. Factors such as isolation, disrupted education, and family stress during the pandemic contributed to this rise. The National

[3] Age UK (2023). State of Health and Care of Older People in England Accessed 24 June 2025
[4] NHS England. Mental Health of Children and Young People in England, 2020: wave 1 follow up to the 2017 survey

Child Measurement Programme for 2022 to 2023 raised that childhood obesity also remains a major concern, particularly in deprived areas. Children growing up in the most deprived areas of the UK are over twice as likely to be obese as children growing up in the least deprived areas. Poor diet reduced physical activity and limited access to green spaces have all played a role[5][6]. Other preventable conditions like asthma and epilepsy continue to affect many children, with the UK still reporting some of the highest mortality rates in Europe for these conditions[7].

Disability

It is important to note that disabled people are not a homogenous group, and different people will have different requirements, wants and needs. Disabled people are more likely to live with chronic illnesses, mental health conditions or impairments that require ongoing medical care[8]. The Department for Work and Pensions evidence on the employment of disabled people 2024 notes that disabled individuals report significantly poorer health outcomes and higher levels of anxiety, pain and functional limitations compared to non-disabled people. People with disabilities can also face physical, societal and systemic barriers to accessing care, leading to health issues worsening by the time they receive care[9]. According to the Department for Work and Pensions National Disability Strategy 2021, as a result of their higher NHS service usage, disabled people are more likely to experience fragmented care and report poor communication between services. Health inequalities can be exacerbated by intersections with other social factors. Disabled people face higher unemployment and deprivation rates. From the beginning of April to the end of June 2024, the disability employment rate was 53%, compared to 82% for non-disabled people[10]. In the most deprived areas of England, there were higher levels of disability in younger age groups compared with the least deprived areas - for example, 21.6% of 40 to 44 year olds were disabled in the most deprived areas compared with 8.1% in the least deprived areas[11].

[5] NHS. Obesity - Causes Accessed 24 June 2025
[6] Public Health England. 'Evidence review 8: improving access to green spaces (2020) on Local action on health inequalities: evidence papers. Accessed 24 June 2025
[7] Royal College of Paediatrics and Child Health (2020). State of Child Health Accessed 24 June 2025
[8] World Health Organization (2023). Fact sheet on disability 2023 Accessed 24 June 2025
[9] House of Lords (2024). Challenges faced by people with disabilities Accessed 24 June 2025
[10] ONS (2025). Labour market status of disabled people Accessed 24 June 2025
[11] ONS (2023). Disability by age, sex and deprivation, England and Wales: Census 2021 Accessed 30 June 2025

Race

There are persistent health inequalities affecting Black, Asian and other minority ethnic groups[12]. These communities often experience poorer health outcomes and may use NHS services more frequently for certain conditions. According to the UK Health Security Agency's 2025 Health inequalities in health protection report, emergency hospital admission rates for infectious diseases were significantly higher among certain ethnic minority groups (29, 27 and 15 times higher for the Asian other, Indian and Black African groups respectively, compared to the White British population). There are systematic challenges in the NHS and despite efforts, ethnic health gaps have not been closed - for example, 47% of Black and 34% of Asian patients report feeling they were treated differently in healthcare because of their ethnicity[13].

These disparities are compounded by socioeconomic disadvantage, poverty and geographical inequalities - for example, families living with a head of the household who is Black or from an ethnic minority group are between 2 and 3 times as likely to be in persistent poverty than families living with a head of the household who is White[14]. Many ethnic minority communities are concentrated in areas of higher deprivation, which can limit access to high quality healthcare and other resources that support good health. For example, people from the Pakistani ethnic group were over 3 times as likely as White British people to live in the most overall deprived 10% of neighbourhoods[15]. According to the 2011 Census, 80% of Bangladeshis, Pakistanis, Black Africans and Black Caribbeans lived in neighbourhoods with above average deprivation, compared with only 46% of the White British population[16]. However, it is recognised that it is important not to regard people from different ethnic minority groups as having the same experiences of discrimination or other inequalities in access[17]. However often the fact that ethnicity data is insufficiently disaggregated makes it difficult to understand these differences[18]. Research has shown that certain white ethnic minorities, such as Gypsy, Roma and Traveller communities[19], face significant disadvantages in areas like education, employment, and

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[12] The King's Fund (2023). 'The health of people from ethnic minority groups in England' https://www.kingsfund.org.uk/insight-and-analysis/long-reads/health-people-ethnic-minority-groups-england Accessed 24 June 2025

[13] Pineda-Moncusí M and others. Ethnicity Data Resource in Population-Wide Health Records: Completeness, Coverage and Granularity of Diversity Scientific Data 2024: volume 11, page 221.

[14] Social Metrics Commission (2024). Measuring poverty Accessed 30 June 2025

[15] GOV.UK (2020). People living in deprived neighbourhoods - Ethnicity facts and figures Accessed 30 June 2025

[16] Lloyd CD and others. An ethnic group specific deprivation index for measuring neighbourhood inequalities in England and Wales The Geographic Journal 2024: volume 190, issue 3, e12563. Accessed 30 June 2025

[17] EHRC (2020). Race report statistics

[18] GOV.UK (2020). Ethnicity data: how similar or different are aggregated ethnic groups Accessed 8 July 2025

[19] The Centre for Social Justice (2020). Facing the facts: ethnicity and disadvantage in Britain Accessed 8 July 2025

health and some disparities are also evident in relation to newer migrant communities including those from Eastern Europe.

Gender reassignment

Trans people are reported to face poorer health outcomes. After adjustment for age, ethnicity and deprivation, trans and non-binary adults reported higher prevalence for 10 out of the 15 long-term conditions[20]. They were around 3 times as likely to be living with dementia or to have a learning disability, and twice as likely to be experiencing mental health difficulties. They were almost 6 times as likely to be autistic. In the 2021 GP Patient Survey fewer trans patients reported being involved in decisions about care and treatment compared to other respondents (85% compared to 93.7%), and 88.2% of trans adults felt that their overall needs were met compared to 95.2% of other respondents.

Trans people face high levels of discrimination in employment and healthcare, often leading to economic marginalisation. The 'Work Fact Sheet - GB' (on the EHRC factsheets by domain page) highlights that trans individuals were more likely to be unemployed or in insecure work.

Pregnancy and maternity

It should be noted that the protected characteristic of pregnancy and maternity and the associated legislative provisions provided by section 17 of the Equality Act 2010 (Pregnancy and maternity discrimination: non-work cases) and section 18 (Pregnancy and maternity discrimination: work cases) are narrowly drafted to focus on specific aspects of pregnancy and maternity.

The non-work provisions in section 18 focus on matters such as breast feeding and other unfavourable treatment of someone in a non-work setting that has given birth within 26 weeks. Provisions in the 10 Year Health Plan that impact on women and children are therefore considered under the protected characteristic of sex.

Pregnancy and maternity inequalities are predominantly covered by the protected characteristic of sex. There are persistent and deeply concerning inequalities in pregnancy and maternity services across England, with reports of fragmented and inconsistent care. In the Care Quality Commission (CQC) Maternity Survey 2024, only 58% of respondents said they were 'always' given the information and explanations needed in hospital after birth. Inequalities are often exacerbated in areas of intersectionality. Black women are

[20] Saunders CL and others. Demographic Characteristics, Long-Term Health Conditions and Healthcare Experiences of 6333 Trans and Non-Binary Adults in England: Nationally Representative Evidence from the 2021 GP Patient Survey BMJ Open 2023: issue 13, e068099

nearly 4 times more likely to die during or in the first year after pregnancy than White women, and women from Asian ethnic groups also face significantly higher risks[21]. Black women are 40% more likely to experience miscarriage than White women. Women living in deprived areas face higher rates of stillbirths, neonatal deaths, and low birth weight babies. Access to high-quality care is often limited in these areas, and women report feeling less supported and informed throughout their maternity journey.

Sex

In making the assessment provided in this part of the EQIA, consideration has been given to the PSED's 3 equality aims. The Equality Act 2010 provisions recognise that developing services in a manner that neglects the fact that women remain the primary carers of babies and children could amount to sex discrimination contrary to the act's indirect discrimination requirements. While some of the provisions in relation to children are addressed under the protected characteristic of age, other provisions in relation to children are addressed here under the protected characteristic of sex. However, it is equally important to recognise that boys and men also face specific health inequalities.

Women and girls

Women are generally more likely to use healthcare services, particularly women between the ages of 20 to 39 due to the use of maternity services[22]. NHS England's equality objectives include improving access and communication. Women and girls in the UK continue to face significant health inequalities that affect their physical, mental, and reproductive wellbeing.

This gap is partly due to underrepresentation in clinical research, misdiagnosis, and delays in treatment, especially for conditions like endometriosis and autoimmune diseases. Gynaecology waiting lists have doubled since the COVID-19 pandemic, leaving many women in pain and without timely care[23]. Women are more likely to be in low paid, part time or insecure work, and face a persistent gender pay gap. In 2024, The Fawcett Society gender pay gap briefing identified that the mean gender pay gap for full-time hourly earnings in the UK rose to 11.3%, up from 10.7% the previous year. There are regional disparities, women in the North of England face shorter healthy life expectancy, lower wages, and higher rates of domestic violence and mental illness compared to those in the

[21] House of Lords Library (2023). Maternal mortality rates in the Black community Accessed 29 June 2025
[22] NHS England. Maternity services monthly statistics Accessed 29 June 2025
[23] Royal College of Obstetricians and Gynaecologists (2022). Left for too long Accessed 24 June 2025

South. Girls born in the North East can expect to live in good health until just 59.7 years, compared to 65 and over years in the South East[24].

Men and boys

There are also persistent and emerging health inequalities that affect boys and men in England. Suicide remains the leading cause of death among men under 50 in the UK and is 3 times more common among men than women[25]. Men, particularly those who are living in the most deprived areas of the UK, are significantly less likely to seek help for mental health issues due to stigma and societal expectations around masculinity[26]. Men are also more likely to engage in risky health behaviours such as smoking, excessive alcohol use, and poor diet, and make fewer general practice appointments than women, including NHS Health Checks[27]. This can lead to both early onset and late diagnoses of preventable conditions. There are also regional inequalities, with men in deprived regions have lower rates of uptake for cancer screening and GP registration[28].

Sexual orientation

People who are not heterosexual are reported to face greater health inequalities than those who identify as heterosexual, including poorer experiences and outcomes. A 2020 review found that among men aged 50 and over, being gay, bisexual, or another non-heterosexual orientation is associated with a heightened risk of long-term illness and health-related limitations[29]. Lesbian, gay and bisexual (LGB) individuals are at significantly higher risk of poor mental health, including depression, anxiety and suicidal ideation[30]. ONS research found that the age-standardised rate of intentional self-harm for people who identified with an LGB+ orientation (gay or lesbian, bisexual or other sexual orientation) was 1,508.9 per 100,000 people in England and Wales between March 2021 and

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[24] Health Equity North (2024). Woman of the North: Inequality, health and work Accessed 24 June 2025
[25] House of Commons Library (2025). Suicide statistics Accessed 24 June 2025
[26] Samaritans (2020). Out of sight, out of mind: Why less well-off middle-aged men don't get the support they need Accessed 29 June 2025
[27] L Tanner and others. NHS Health Check Programme: A Rapid Review Update BMJ Open 2002: issue 12, e052832.
[28] The Kings Fund (2024). Illustrating the relationship between poverty and NHS services Accessed 30 June 2025
[29] Kneale D, Thomas J and French R. Inequalities in Health and Care among Lesbian, Gay and Bisexual People Aged 50 and over in the United Kingdom: A Systematic Review and Meta-Analysis of Sources of Individual Participant Data The Journals of Gerontology 2020: volume 75, issue 8, pages 1,758 to 1,771.
[30] The term LGB is used throughout this document when referring to sexual orientation. Where cited sources use broader terms such as LGBT, LGBT+, or LGBTQ+, those terms are retained to reflect the original language of the source.

December 2023, compared with 598.4 per 100,000 people who described themselves as straight or heterosexual[31].

Religion and belief

This protected characteristic covers both religion and people of faith or no faith and people with or without philosophical beliefs covered by the Equality Act 2010. There is a possibility some people of faith might prefer more anonymised services for certain conditions so consideration should be given to community feedback in the design of services. No adverse impacts of this policy have been identified in relation to people of no faith or religious beliefs.

Engagement with seldom heard voices

As part of the 10 Year Health Plan development, the public engagement exercise, Change NHS, was launched on 21 October 2024. It was the biggest national conversation about the future of about the health service in its history. The engagement concluded in June 2025 with over 270,000 contributions in total. This included events with over 3,000 staff and members of the public in every NHS region of England, including children and young people. There were 1.9 million visits to the Change NHS website, over 250,000 online contributions and over 1,600 partner organisations who all shared their experiences and ideas for change. In addition, over 17,000 people who joined over 650 community events hosted by partner organisations. The insights gathered are referenced as evidence within the EQIA.

Change NHS also included a large-scale programme of local, place-based engagement, designed to reach audiences who are often seldom heard in government consultations. A co-creation group was established by NHS England and the Department of Health and Social Care (DHSC) to design a ‘workshop in a box’ (WIAB). The WIAB enabled local organisations to deliver workshops in their community on the 10 Year Health Plan. As with the public deliberative events, the aims were to understand:

- what success for the 10 Year Plan looks like
- responses to the 3 shifts
- opportunities, priorities and any ‘red lines’ for the delivery of the shifts

[31] ONS. Self-harm and suicide by sexual orientation, England and Wales: March 2021 to December 2023 Accessed 30 June 2025

In total, 685 WIABs were delivered between 18 November 2024 and 14 February 2025. Workshops reached a total of 17,601 participants from a wide range of audiences. Audiences included the public, workforce, other stakeholders and Core20PLUS5 audiences such as people with multiple long-term health conditions, people from an ethnic minority and people with learning disabilities and/or autism.

The groups included a wide range of participants whose experiences relate to or have implications for the protected characteristics set out in the Equality Act 2010 and health inequalities more generally. These groups are set out below:

- age: children and young people
- disability: people affected by cancer, people affected by stroke, people with a learning disability and/or autism, people with multiple long-term health conditions
- gender reassignment and sexual orientation, LGBTQIA+ community, including transgender and non-binary people
- pregnancy and maternity, people with experience of maternity services
- race and ethnicity, asylum seekers, refugees, and/or newer migrants, Gypsy, Roma and Traveller communities, people from an ethnic minority and victims of modern slavery

This engagement activity provided extremely valuable information about the views from different protected characteristic groups and issues that were highlighted by a variety of groups and so proved intersectional in nature. While broadly welcoming of the 3 shifts - hospital to community, analogue to digital and treatment to prevention - some concerns were also identified.

Equalities insights from seldom heard audiences

This section brings together a high-level insight of the findings from engagement with a wide range of seldom heard groups to inform the development of the 10 Year Health Plan. Understanding the perspectives of people who often face barriers to accessing and benefiting from healthcare is essential to creating a system that is inclusive, person-centred and equitable.

These insights are particularly important for the EQIA. They provide direct evidence of how different groups experience health and care services, including where there are existing inequalities, risks of exclusion, or specific needs that may otherwise be overlooked. This information supports the plan in:

- identifying and addressing systemic barriers to access and outcomes
- mitigating the potential for unintended negative impacts
- ensuring services are designed to be inclusive of all communities
- fulfilling the public sector equality duty under the Equality Act 2010

Shared priorities

Despite differences in background and experience, there was broad agreement among seldom heard groups about what the 10 Year Health Plan should deliver. Common priorities included:

- improved access to healthcare, including shorter waiting times and clearer routes through services
- inclusive and culturally competent care, with better communication, interpretation, and staff training
- better mental health provision, particularly for children, young people, and marginalised communities
- joined up and co-ordinated services
- clear, accessible information, tailored to different communication and literacy needs
- careful use of digital and AI tools, with safeguards against exclusion, bias and depersonalisation

Participants also reflected on the plan's 3 strategic shifts (from hospital to community care, from treatment to prevention, and from analogue to digital). While many supported these shifts in principle, there were consistent concerns across groups about how they would be implemented in practice. These included fears that digital tools could deepen exclusion, that community-based care might not be accessible to all, and that prevention would not be achieved without significant investment and cultural change.

Findings for different seldom heard groups

Ethnic minority participants described experiences of unequal treatment, lack of representation and culturally insensitive care. They wanted reassurance that digital systems and AI would be carefully designed so that they would not reinforce existing biases. They called for stronger staff training, inclusive service design, and greater community engagement to build trust. They recognised that digital tools could offer

improved access but highlighted the importance of these being implemented in a way that reduce - and ideally eliminate - bias and have strong safeguards to ensure privacy and accessibility. Several participants also stressed the need for prevention models not to overlook the structural inequalities that drive poor health outcomes in their communities.

Children and young people consistently raised the need for improved access to mental health support, particularly in schools and early intervention services. They reported challenges accessing GP appointments, long waiting times and a sense of stigma around seeking mental health care. Digital tools were generally well received, particularly where they helped reduce barriers to access, but there were concerns about data privacy and how effectively these tools were explained and supported. Many welcomed the focus on prevention.

LGBT participants described not always feeling understood or accepted in healthcare settings, with concerns about stigma and a lack of tailored mental health support. Many spoke about unequal treatment and highlighted the importance of holistic care that recognises emotional and social wellbeing. While digital tools were welcomed by some, others raised concerns about bias in digital systems and risks to privacy, especially in smaller communities. Some participants were cautious about a community-based model of care, particularly if local services lacked LGBT competence.

People with a learning disability and/or autism reported low satisfaction with services and called for care that was more flexible, accessible, and informed by lived experience. Participants emphasised the value of face-to-face, person-centred interactions and highlighted the importance of communication formats that are visual, easy to understand and adapted to individual needs. Digital exclusion was a concern, with many reporting difficulties using online systems. While some appreciated the convenience of virtual appointments, most preferred care models that prioritised relationships, continuity and flexibility. There was particular concern about how digital-first or fragmented community services would meet their needs effectively.

People affected by cancer stressed the importance of equitable access to timely and high-quality care. They raised concerns about delays in screening, inconsistent GP awareness of symptoms and limited access to emergency or specialist treatment. While some appreciated the use of digital tools such as virtual wards and online follow-ups, others were concerned about losing access to in-person support. Many welcomed the shift towards prevention but felt this would require significant improvement in early diagnosis pathways and public awareness.

People affected by stroke highlighted challenges navigating the system and accessing follow-up care, including psychological support. There were mixed views on virtual and community-based care - for example, some saw benefits in reduced travel and more local support, while others worried about continuity and expertise. Participants were generally

supportive of prevention efforts, such as regular health checks, but questioned whether these could be delivered equitably and at scale.

People with multiple long-term conditions described fragmented, poorly co-ordinated care that failed to respond to their needs holistically. They expressed strong support for more joined up, community-based services, but emphasised the importance of continuity, access to specialists and personalised care. Digital records and communication tools were welcomed by some, though concerns remained about usability, privacy, and whether these tools would be accessible to all. There was also some uncertainty about how well prevention-focused models would meet the needs of those already living with complex conditions.

Asylum seekers, refugees and newer migrants described difficulties navigating the health system, often linked to language barriers and fragmented services. While digital exclusion was a concern, there was interest in digital tools that support translation and interpretation. Many in this group supported prevention-focused approaches, provided information was clear and accessible.

Gypsy, Roma and Traveller communities expressed low levels of trust in health services. They highlighted the importance of cultural awareness training for staff, access to local and community-based services, and improved interpretation support. While some saw potential benefits in digital tools, concerns were raised about privacy, data security and the risk of further exclusion. Participants were cautiously supportive of community-based care, but only if it was culturally sensitive and did not reduce access to more specialist services.

Victims of modern slavery described multiple barriers to accessing healthcare, including language difficulties, digital exclusion and fear or mistrust of authorities. Participants emphasised the need for trauma-informed, respectful and face-to-face care. While digital tools could improve information access, many individuals in this group required one-to-one support to safely navigate services. They were concerned that increasing reliance on digital channels or remote care could create new barriers, especially without tailored outreach or advocacy.

People with experience of maternity care reported inconsistent and fragmented care, with concerns about safety, continuity and cultural sensitivity. Many felt that services were not joined up, and that communication across teams and providers was poor. Participants supported the idea of more local, community-based maternity support, but stressed that this must not come at the expense of access to specialist expertise. There was also concern that digital models or new tools might not adequately support people during vulnerable or high-risk pregnancies, particularly where safeguarding or language needs were involved.

Summary of policy and intended outcomes

The 10 Year Health Plan maps out a new model of care, making sure the NHS is fit for the future. It aims to capitalise on new technology, medicine and innovation to deliver better care for all patients.

From hospital to community: the neighbourhood health service, designed around you

At the heart of the new approach from hospital to community is the development of the neighbourhood health service, which aims to redesign care so that it is simpler, more joined up and more responsive to the needs of individuals throughout their lives. This shift will follow the principle that care should happen as locally as it can, in a patient's home if possible, and only in hospital if necessary.

Policies to drive this transformation include shifting investment towards out-of-hospital care, expanding coverage of care plans and personal health budgets, establishing neighbourhood health centres in every community and increasing the role of community pharmacy. Outpatient services and urgent and emergency care will also be redesigned, delivering more care in the community, in people's homes or in neighbourhood health centres, along with increased access to NHS dentistry and more dedicated mental health care.

Patients will benefit from more accessible and personalised care. Tackling health inequalities will also be prioritised through new care models, investment in local infrastructure and greater access through digital and face-to-face routes. Carers and families will be more formally recognised as part of care teams, allowing for more support and better information sharing. Staff will experience a shift towards team-based, neighbourhood care delivery. GP workloads will be supported through new roles and the streamlining of administration and expanded multidisciplinary teams will create more varied and opportunistic career paths across community services.

From analogue to digital: power in your hands

The shift from analogue to digital will use new technology to create the most digitally accessible health system in the world. This will ensure rapid access for those in generally good health and free up physical access for those with the most complex needs, providing patients with greater choice over how they interact with the health system.

Policies include:

- giving patients co-ordinated and personalised care and control over their data through a single patient record

- a remodelled NHS App with new tools and platforms to get advice for non-urgent care, book appointments and tests and hold consultations

- manage medicines, vaccinations and long-term conditions and manage a child, loved one or relative's care

Patients will benefit from easy and convenient access to health services, improved ability to manage their own and loved ones' care, better patient agency and ability to make informed choices on the care they receive and more responsive and personalised care, particularly for those with complex or acute needs.

Staff will experience more reliable, updated technology, the opportunity to communicate with patients more flexibly, more time to care and focus on the patient through reduced administrative burden and improved confidence in decision making through better access to patient health records.

From sickness to prevention: power to make the healthy choice

The plan sets out ambitions to halve the gap in healthy life expectancy between the richest and poorest regions, while increasing it for everyone, and raise the healthiest generation of children ever. The healthcare system will reach patients earlier, catch illness before it spreads and prevent it in the first place, by making the healthy choice the easy choice.

This will be achieved by working with businesses, employers, investors, local authorities and mayors to create a healthier country. The plan will deliver on the Tobacco and Vapes Bill, end the obesity epidemic through advertising and sales restrictions and introduce mandatory healthy food sales reporting for large companies in the food sector. Free school meals will be expanded and the Healthy Start scheme updated, new standards will be introduced for alcohol labelling, more support will be provided for people to find and stay in work, HPV vaccine uptake will be increased and lung cancer screening will be fully rolled out for those that have a history of smoking. A new genomics population health service and universal newborn genomic testing will enable early identification and intervention for at risk individuals.

Patients will benefit from support and incentives to make healthier lifestyle decisions, better awareness of health risks of alcohol consumption, smoking and vaping, improvements to wider determinants of health such as air quality, better support from employers and improved access to early diagnosis through screening services and genomics.

A devolved and diverse NHS: a new operating model

The ambitions laid out in the plan will be achieved through a new NHS operating model, shifting power from the centre to local systems, providers and patients. This will empower the front line and allow for greater equity for patients by giving greater choice and control over services.

In order to achieve this, a new system of earned autonomy will be introduced, with a new failure regime where local services consistently underperform. This will let underperformance in areas with the worst health outcomes be prioritised. The NHS foundation trust model will be reinvented will improved freedoms and flexibilities, higher standards for leaders will be set, along with new mechanisms to ensure the NHS is reactive to patient preference, voice and choice.

Patients will benefit from an increased focus on patient power, voice and choice with more user involvement to ensure services meet community needs, clearer information on provider performance and improvements in equality of access. Staff and the wider system will benefit from performance-based incentives for senior executives and support for chief executives that take on the hardest challenges, mechanisms for clinician evaluations and rewards, opportunities for local innovation and greater autonomy and flexibilities to achieve high standards via foundation trusts.

A new transparency of quality of care

The NHS will become the most transparent healthcare system in the world by the introduction of a new, rigorous focus on high-quality care for all. This will improve transparency and patient involvement in care quality.

Policies to enable this include publishing league tables to rank providers against key quality indicators, allowing patients to choose providers based on quality data on the NHS App, a national independent investigation into maternity and neonatal services and the establishment of a national maternity and neonatal taskforce. The complaints process will be reformed, the CQC will be remodelled to be more data led and persistent poor-quality care will result in decommission or contract termination of services and providers.

Patients will benefit from more information for decision making, improved patient safety, better access to complaints pathways, stronger accountability to communities and their interests prioritised by regulators and inspectors. Staff voice will be brought in house with more freedom to speak up, clinicians will be empowered to continuously improve quality of care for patients, and a simpler regulatory landscape will help systems and services improve.

An NHS workforce, fit for the future

The plan and the 3 shifts will be delivered through the workforce. By 2035, staff will be better treated, more motivated and have better training and more scope to develop their careers.

Policies to enable a liberated, more confident workforce include delivering personalised career coaching and development plans to every NHS staff member, using AI as a supportive assistant for nurses and doctors, overhauling education and training curricula, introducing a new set of staff standards, creating more jobs with new postgraduate training posts for residence doctors and more apprenticeships and reorientating NHS recruitment towards local communities.

Staff will benefit from more flexible working arrangements, more confidence using digital tools, greater job satisfaction and retention, appropriate support and consistent access to basic amenities such as nutritious food and drink. Patients will see improved experience provided by a happy workforce, quicker triage times as clinical time is liberated by AI and digital tools and a healthcare workforce that reflects the diversity and needs of their community.

Powering transformation: innovation to drive healthcare reform

The life sciences are central to this plan, and a new approach to innovation strategy will drive healthcare reform. The NHS will be an active and collaborative partner in making innovation happen.

Policies for this innovation transformation include creating a new health data research service, seamlessly integrating AI into clinical pathways, expanding genomic sequencing to explore personalised prevention of obesity, making wearables standard in preventative and chronic treatment, expanding surgical robot adoption and transforming the research environment through new global institutes, streamlined regulatory approval processes and mainstreaming clinical trials.

Patients will benefit from wider and faster access to new medical innovations and treatments, improved health outcomes through the use of wearables and surgical robots and greater opportunities to participate in clinical trials in the community. Staff will have greater access to new digital products for productivity, greater adoption of AI to streamline services and reduced bureaucracy and duplication of functions to deliver research.

Productivity and a new financial foundation

The NHS approach to finance will be replaced with a new value-based approach focused on getting better outcomes for the money spent. New financial flows will incentivise

innovation, support the flow of money from hospital to community and reward best practice across the NHS.

The proposed reforms aim to enable this by redesigning funding flows, strengthening local accountability and ensuring that resources are better aligned with population health needs and patient experience. Policies include removing deficit support funding, moving from national tariffs based on average costs to tariffs based on best clinical practice, testing the development of ‘year of care’ payments and distributing funding more equally locally, so it is better aligned with health need.

Patients will benefit from fairer distribution of resources based on need, supporting the reduction of health inequalities, access to modern, fit-for-purpose care environments enabled by a reformed capital regime, stronger patient voice in how care is commissioned and paid for and improved experience and value of care through greater productivity transparency. Staff will see a more predictable and rules-based financial environment that supports long-term planning, financial autonomy to design and invest in services that reflect local priorities and better use of NHS land and assets to improve infrastructure and support workforce needs.

Summary of equalities analysis

Equality aim 1: giving due regard to eliminating discrimination, harassment and victimisation and other conduct prohibited by the act

Our overall assessment at this policy formulation stage is that the proposals can positively contribute to addressing this equality aim in relation to the protected characteristics. There is more evidence in relation to some protected characteristics, such as age, disability, race and sex and less evidence in relation to others, such as gender reassignment, sexual orientation, religion or belief and marriage and civil partnership.

With regards to improving healthcare experience, there is evidence that this will have a positive impact on protected characteristic groups that can have worse experience by way of more frequent use (age, disability and pregnancy and maternity), and those who have often faced institutional discrimination or disadvantage (disability, sex, gender reassignment, sexual orientation and race).

Chapter 6 of the 10 Year Health Plan details proposals which directly aim to improve the workplace for all staff, particularly in regard to this aim. There is more evidence for negative experiences at work for those under the protected characteristic of gender reassignment, sexual orientation and race.

Policies to amplify patient voice and offer patients more agency for their own healthcare, such as feedback and accountability mechanisms which are discussed in chapter 3 and chapter 5, will positively impact those who face worse healthcare experiences by amplifying patient voice and providing more opportunity to raise complaints, particularly in regard to experiences of conduct prohibited by the act.

In the policy design and implementation phases, a range of issues will need to be considered to ensure that any existing discriminatory barriers are identified and addressed rather than reinforced.

Equality aim 2: giving due regard to the advancement of equality of opportunity

Our overall assessment at this policy formulation stage is that the proposals can positively contribute to addressing this equality aim in relation to the protected characteristics. There is more evidence in relation to some protected characteristics, such as age, disability, race and sex and less evidence in relation to others, such as gender reassignment, sexual orientation, religion or belief and marriage and civil partnership.

With regards to advancing equality of opportunity by increasing access to health services there is substantial evidence for the protected characteristic of age, particularly for older patients, and for disability. These groups often use primary care services more and so will be disproportionately impacted by these measures. We have less evidence for how those under the protected characteristic of gender reassignment and sexual orientation engage with primary care. The shift to digital tools will advance equality of opportunity by providing more reliable routes for accessing health services. There is evidence that this will have a particular impact in relation to the protected characteristic of disability, where dependent on need, online access could be beneficial. There is also evidence that for some individuals under the protected characteristic of disability and age, digital tools may negatively impact this aim of the PSED. Alternative communication routes such as telephony are detailed in the plan to account for this.

The shift towards community-centred care will empower local health systems to tailor services towards specific needs of the populations they care for. This is likely to have a positive impact on this aim across all protected characteristics by providing more care closer to home and making healthcare services more accessible. There is substantial evidence for the impacts on older populations, patients with disabilities and women.

In the policy design and implementation phases, a range of issues will need to be considered to ensure that any existing discriminatory barriers are identified and addressed rather than reinforced.

Equality aim 3: fostering good relations

The good relations duty, which has its origins in good community relations also recognises the importance of taking steps when developing and implementing policies that reduce the potential for community conflict. In health settings, this duty most commonly can be engaged in relation to community engagement, consultation and outreach activities.

Addressing the impact on the 3 equality aims

Our assessment is that is that the proposals at this the policy formulation stage have the potential across the protected characteristics to contribute to identify and tackle discriminatory barriers that may exist and advance equality of opportunity. We also are mindful of the intersection with the health inequalities duties provided by section 1C and section 13G of the NHS Act 2006 and note that a number of the policy proposals could positively contribute to reducing health inequalities facing different groups at the same time as advancing equality of opportunity for these different groups. In terms of fostering good relations, the third equality aim is not directly engaged at this policy formulation stage. However, as the policies are rolled out it will be important to be sensitive to the views and opinions expressed on behalf of different groups to ensure that no one is left behind and that the needs of different protected characteristic groups are properly considered.

From hospital to community: a neighbourhood health service, designed around patients

Age

The number of older adults (65 and over) are projected to grow by 20.4% over the next 10 years and by nearly 60% over 25 years in England, compared to just 3.6% growth in the working-age population[32]. This ageing trend is significant given that individuals aged 75 to 79 had the highest number of hospital admissions (1.9 million; 9.5% of the total), and those aged 50 and over made up 64% of all hospital admissions[33]. Children and young people are also frequent users of NHS services at crucial developmental stages (the 0 to 4

[32] ONS (2016). How the population of England is projected to age https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/compendium/subnationalpopulationprojectionssupplementaryanalysis/2014basedprojections/howthepopulationofenglandisprojectedtoage Accessed 8 July 2025

[33] NHS England Digital (2023). Hospital Admitted Patient Care Activity, 2022-23 https://digital.nhs.uk/data-and-information/publications/statistical/hospital-admitted-patient-care-activity/2022-23/summary-reports-copy# Accessed 8 July 2025

age group had 1,284,504 hospital admissions (FCEs) in 2023 to 2024, making them the highest users among all age groups under 45[34]**)**. The policy proposals in this chapter therefore have significant relevance for different age groups, with both opportunities and risks identified across the life course. The available evidence has informed the policy proposals.

Older adults and ageing populations

This chapter proposes a major shift toward proactive, community-based care for people with long-term conditions and people living in care homes or who have frailty. This proposed shift is likely to benefit older people, who are more likely to live with multiple long-term conditions, more likely to be frail and more likely to live in a care home, and therefore require regular, coordinated support (35% of over 65s live with mild frailty[35] and 82% of all care home residents are over the age of 65[36]). The offer of a personalised care plan, supported by multidisciplinary teams, aims to advance equality of opportunity by improving continuity, supporting ageing in place and avoiding unnecessary hospital admissions.

A new approach to falls prevention includes updated guidance alongside AI-supported tools designed to detect hazards in the home. This technology aims to enable earlier home modifications or targeted support, particularly benefiting older adults living alone or with reduced mobility. The effectiveness of this approach will depend on the usability of the tools and the ability to act on identified risk.

Locating rehabilitation services in neighbourhood health centres may benefit older adults by reducing travel requirements and supporting faster recovery, closer to home (depending on the location of their home relative to current services). The proposed model of shorter and more intensive rehabilitation periods has the potentially to deliver better outcomes and faster independence, though care will be needed to ensure it does not inadvertently exclude those with more complex recovery needs or limited informal support.

Continuity of care has often been identified as an important consideration in supporting older adults with complex needs. The neighbourhood health model supports both relational continuity (seeing the same clinician when needed) and “team-based continuity”, in which

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[34] NHS England Digital (2024). Hospital Admitted Patient Care Activity, 2023-24 https://digital.nhs.uk/data-and-information/publications/statistical/hospital-admitted-patient-care-activity/2023-24

[35] Age UK (2019). Later Life in the United Kingdom 2019 https://www.ageuk.org.uk/siteassets/documents/reports-and-publications/later_life_uk_factsheet.pdf Accessed 8 July 2025

[36] ONS (2023). Older people living in care homes in 2021 and changes since 2011 https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/ageing/articles/olderpeoplelivingincarehomesin2021andchangessince2011/2023-10-09 Accessed 8 July 2025

care is provided by a consistent multidisciplinary group. Evidence suggests this improves outcomes and the patient's experience of care and may be especially important for people with multiple health issues who would otherwise need to repeat their history in each interaction[37].

Including unpaid carers in this model (and capturing information about unpaid carers) also addresses a long-standing gap in recognition and support. Carers UK, in response to the Change NHS engagement exercise, said that a challenge in moving to care in the community is unpaid carers picking up more caring responsibilities because of the shortfall of NHS and social care. Therefore, for this shift to become successful, the plan, the NHS and the government must recognise the importance of unpaid carers.

Neighbourhood teams will include staff from the voluntary sector, reflecting their established role in supporting people with specific conditions or needs. Voluntary sector organisations often hold expertise in managing long-term conditions, dementia, or end-of-life care, and may be particularly trusted by certain groups. Integration of these services may improve personalisation and extend the reach of care models, especially for people later in life.

New digital tools, such as ambient technology are expected to reduce GP admin time, enabling more clinical time with patients. This should have positive impacts for older patients, who are more likely to require longer appointments to better manage multiple conditions and improve continuity of care.

The chapter also develops the Patient-Initiated Follow Up (PIFU) as part of its wider shift towards more personalised and responsive care. For older adults with stable conditions and strong informal support, PIFU may provide welcome flexibility. As with other digital or self-directed tools, the benefits will likely depend on confidence, clarity and support mechanisms.

The planned investment in neighbourhood health centres, open at least 12 hours a day, 6 days a week, could improve physical access for older adults, particularly those with mobility limitations or restricted transport options. Co-location of services may also reduce the number of separate trips required to receive care.

The proposed redesign of hospital care includes a shift toward delivering outpatient and elective services in the community, supported by digital tools and enhanced rehabilitation. For older adults, this may improve access to care by reducing the need to travel to hospital settings and helping them recover more effectively at home after planned care. 1.45 million

[37] Otto R. Maarsingh. 'The Wall of Evidence for Continuity of Care: How Many More Bricks Do We Need?' (2024) https://doi.org/10.1370/afm.3116 Accessed 8 July 2025

older people in England find it difficult to get to hospital appointments[38]. The development of local day case surgery, digital follow-up, and neighbourhood rehabilitation has the potential to mitigate barriers to accessing care. However, the success of these models will depend on integration with community support and availability of wraparound services such as physiotherapy.

The proposed use of remote monitoring may allow more specialist care to be delivered at home. For some older people, this could reduce the need for hospital stays and associated risks such as deconditioning or loss of independence.

The proposal to develop mental health emergency departments for easier, walk-in access to psychological support may also support older adults, particularly those living alone or managing long-term mental and physical health needs. Older people are less likely to seek formal mental health support and may benefit from the normalisation and accessibility these centres offer (in 2020 to 2021, just 5% of referrals to NHS talking therapies was people over the age of 65)[39]. However, real-world uptake will depend on accessibility, stigma reduction and integration with physical health services.

The proposal for a new diagnosis service in partnership with a range of charities has the potential to support for older adults who are diagnosed with long-term conditions. Many in this age group manage multiple health conditions and may benefit from earlier, structured assistance to build self-care skills.

In emergency care, older people face high rates of avoidable hospital admissions, long stay and delayed discharges. The reforms to emergency and urgent care - including improved triage (through NHS App and 111) - have the potential to reduce these pressures. If successfully implemented, they could improve the experience of and outcomes for older people.

Improved day-case surgical pathways are intended to reduce unnecessary overnight stays. For older adults, this could minimise risk associated with hospitalisation, such as loss of independence. However, the success of these models will depend on timely access to community rehabilitation and monitoring services.

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[38] Age UK (2017). Painful Journeys in-depth policy report https://www.ageuk.org.uk/our-impact/policy-research/publications/reports-and-briefings/ Accessed 8 July 2025

[39] NHS England Digital (2021). Psychological Therapies, Annual report on the use of IAPT services, 2020-21 https://digital.nhs.uk/data-and-information/publications/statistical/psychological-therapies-annual-reports-on-the-use-of-iapt-services/annual-report-2020-21 Accessed 8 July 2025

The inclusion of genomics in care aims to improve anticipatory support - enabling earlier intervention and more tailored care. However, the benefit of this approach for older adults will depend on both equitable access to testing and patient confidence and understanding.

The shift to digital tools will consider the risks of digital exclusion. According to Age UK, 1 in 3 adults over the age of 65 lack the basic skills to use the internet effectively[40]. While the shift towards app-based booking, triage, and care plans offers benefits for many, it also necessitates strong offline alternatives. To address this, the plan includes policy to ensure that digital telephony services are more efficient and reliable. At the same time, improving and promoting online booking will help to ease demand on phone lines, ensuring that telephone access remains responsive and accessible. These risks and mitigations are explored further in the assessment of Chapter 2. From analogue to digital: power in your hands

As hospital care evolves to focus more on complex, high-acuity treatment and integrated advanced technologies such as robotics, personalised medicine, and remote monitoring, the implications for older adults will require effective coordination with community services. Many older people face longer recovery times and rely on support from carers or social care systems after hospital discharge. Delayed discharge and poor post-hospital coordination remain significant challenges for older adults, increasing the risk of readmission or unmet need[41]. To ensure these hospital reforms advance equality of opportunity, discharge pathways and follow-up care must be designed inclusively, with particular attention to transport, home support, and timely access to rehabilitation. Parents, babies and young children

This chapter identifies parents and their children as a priority group for early rollout of neighbourhood-based care. The early years represent a critical development stage, where gaps in prevention, access and coordination can have long lasting impacts on health and equity. neighbourhood health services will work in partnership with family hubs, schools, nurseries and colleges to offer timely support to babies, children and young people, including those with special educational needs.

Health visitors will lead a new approach to childhood vaccination uptake, using home visits to deliver tailored information. This responds directly to recent evidence of widening inequalities in vaccination rates, particularly among children in low-income households or

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[40] Age UK (2024). Briefing: Facts and figures about digital inclusion and older people https://www.ageuk.org.uk/our-impact/policy-research/publications/reports-and-briefings/ Accessed 8 July 2025

[41] British Red Cross. Getting hospital discharge right https://www.redcross.org.uk/about-us/what-we-do/we-speak-up-for-change/getting-hospital-discharge-right Accessed 8 July 2025

from ethnic minority backgrounds[42]. Improving vaccine access at the point of contact, rather than relying on appointments in primary care, has the potential to advance equality of opportunity and reduce preventable illness.

Access to general practice will be universally expanded and made more flexible, with enhanced hours (including evenings) and digital routes for accessing advice. These changes may particularly benefit single-parent households and those with limited social support, who currently face barriers to timely access.

A strengthened digital telephony offer will ensure that parents without digital access can still receive timely support. According to the Good Things Foundation, 4 in 10 households with children do not meet the Minimum Digital Living Standard[43].

The proposed partnership with the charitable sector to create a new diagnosis service is aimed at supporting individuals with new diagnoses and may apply to children and young people with new diagnoses of chronic conditions such as asthma, epilepsy, diabetes, or mental health diagnoses. Co-developing the service with input from paediatric specialists, youth organisations, and families would help to ensure that any support offered is developmentally appropriate, engaging, and safe. This includes recognising the need for parent/carer involvement and safeguarding considerations.

Mental health emergency departments will also serve children and young people, offering walk-in access to psychological support in local settings. For young people - who face rising mental health need but often struggle to access support - these centres may reduce stigma and improve early access. However, take-up will depend on service visibility, safeguarding approaches and integration with other youth services.

If implemented effectively, these proposals could significantly improve outcomes in the early years, support parental wellbeing as well as reducing access disparities linked to income and geography.

Working age adults

For working-age adults, the main impacts relate to access, flexibility and prevention. The use of the NHS App for triage and appointment booking is likely to appeal to digitally confident users - especially those balancing work or caring responsibilities. High street

[42] Claire X. Zhang and others. 'Ethnic inequities in routine childhood vaccinations in England 2006–2021: an observational cohort study using electronic health records' (2023). https://doi.org/10.1016/j.eclinm.2023.102281 Accessed 8 July 2025

[43] Good Things Foundation (2024). The Minimum Digital Living Standard for Households with Children https://www.goodthingsfoundation.org/policy-and-research/research-and-evidence/research-2024/minimum-digital-living-standard Accessed 8 July 2025

locations for services may also improve convenience for this group. These features could advance equality of opportunity for some, particularly younger working-age adults.

However, some adults already face barriers to access, for example, adults in insecure jobs, rural areas, or on low incomes may struggle with digital-first services or non-local care models[44] [45] [46]. The inclusion of digital telephony is an important mitigation, particularly where quick response times are achieved. These barriers will be considered throughout service design.

The expansion of day-case surgery may benefit working age adults by reducing disruption to employment or caring responsibilities. Virtual planned care services could enhance convenience but may disadvantage those with limited digital access or in need of workplace reductions during recovery.

Working-age adults are likely to be a frequent user group for the proposed diagnosis support service, which will be delivered in partnership with charities to assist people following a new diagnosis, particularly those diagnosed with conditions that require lifestyle changes, medication management, or psychosocial support. The service has the potential to reduce variation in early support and enable people to take a more active role in managing their health. However, the service must be responsive to varied needs. Engagement with organisations representing people in employment, caring roles, and lower-income groups would help to ensure the service is inclusive and practical for this diverse population.

In terms of emergency care, this group includes frequent users of A&E due to difficulties accessing same day GP care (in 2023, 12.2% of patients who could not secure a GP appointment went to an emergency department instead[47]). The expansion of same day access and home-based alternatives (for example, diagnostics, virtual wards) could reduce pressure and improve outcomes if delivered equitably. Delays or inconsistency in roll-out could disproportionately affect lower-income working adults, who often have fewer care options.

The chapter references Patient Initiated Follow-Up (PIFU) as part of its hospital-to-community shift. This model may offer greater flexibility to some adults, allowing them to

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[44] Response from the Head of Service Step2Skills. Tackling Digital Exclusion and Literacy in the District https://democracy.eastherts.gov.uk/documents/s65349/
[45] Local Government Association (2017). 'Health and wellbeing in rural areas' https://www.local.gov.uk/publications/health-and-wellbeing-rural-areas Accessed 11 July 2025
[46] Ofcom (2022). 'Digital exclusion research' https://www.ofcom.org.uk/phones-and-broadband/accessibility/exclusion Accessed 11 July 2025
[47] Adrian O'Dowd, 'GP Patient Survey: Getting an Appointment Is Harder but Decline in Satisfaction Slows' (2023) 382 BMJ

arrange reviews based on symptom changes rather than fixed schedules. For others, particularly those with fluctuating confidence, low health literacy or complex conditions, self-initiated contact may be less effective unless supported.

The new role for community pharmacy in prevention - particularly risk screening for cardiovascular disease and diabetes will primarily benefit middle-aged adults - conditions that are highly prevalent, preventable and strongly patterned by age and deprivation[48] [49] [50].

Dentistry

Dental health is a major issue for young children. Tooth decay remains the most common reason for hospital admission in children under 10, with significant variation by deprivation[51]. The chapter details the plans for children to be an urgent priority. The commitment to stabilise NHS dental services by requiring newly qualified dentists to practice in the NHS for an intended minimum of at least 3 years may help address this. Measures to expand the supervised toothbrushing programme and expand the use of fluoride varnish and fissure sealants will have positive impacts on children. Locating dentistry in community settings and schools may improve uptake, but without robust delivery, access gaps could persist. Expanding community water fluoridation is effective for improving dental health equality across the UK and can benefit both adults and children who are less likely to engage with other methods. The 2022 Water fluoridation report concluded that 5 year olds in areas with a fluoridation scheme in place were less likely to experience dental caries or be admitted to hospital to have teeth removed due to decay than in areas without a scheme.[52]

Among older adults, oral health is a growing concern that is often neglected in care planning. Over half of older adults who live in care homes live with untreated tooth decay

[48] GOV.UK (2018). 'Health matters: preventing Type 2 Diabetes' https://www.gov.uk/government/publications/health-matters-preventing-type-2-diabetes/ Accessed 11 July 2025
[49] NHS England (2023). 'National Diabetes Audit 2021-22, young people with type 2 diabetes' https://digital.nhs.uk/data-and-information/publications/statistical/national-diabetes-audit-yt2/ Accessed 11 July 2025
[50] NICE (2025). 'What is the impact of CVD?' https://cks.nice.org.uk/topics/cvd-risk-assessment-management/background-information/burden-of-cvd/#:~:text=It%20is%20estimated%20that%20CVD,CVD%20and%20all%2Dcause%20mortality Accessed 11 July 2025
[51] NHS England (2023) Hospital admitted patient care activity https://digital.nhs.uk/data-and-information/publications/statistical/hospital-admitted-patient-care-activity/2022-23/ Accessed 8 July 2025
[52] GOV.UK (2022). 'Water fluoridation: health monitoring report for England 2022' https://www.gov.uk/government/publications/water-fluoridation-health-monitoring-report-for-england-2022 Accessed 11 July 2025

while 40% of over 75s who do not live in care homes live with untreated tooth decay[53]. Reintegration of NHS dentistry has the potential to reduce longstanding inequalities in oral health outcomes.

Many working-age adults have gone without routine dental care due to limited access and cost. ONS data shows that 96.9% of those who do not have a dentist and who tried to access NHS dental care were unsuccessful[54]. The British Dental Association submitted a response to the Change NHS online portal and referenced that "there is a profound problem with patient access to NHS dentistry" - a quarter of adults in England have unmet need - creating a backlog of worsening treatment need. As a result of this, patients' oral health deteriorates to the extent where they require treatment only available in hospital." Re-establishing dentistry as a universal public service (beginning with targeted groups) could have a significant positive impact.

Community pharmacy

Community pharmacy is set to play a vital and expanded role within the neighbourhood health service. This is especially relevant for older adults and people managing long-term conditions - groups who are more likely to rely on regular medication and benefit from easy, local access to clinical advice and services.

Under the proposals, community pharmacists will increasingly:

- prescribe independently for conditions such as high blood pressure and high cholesterol
- provide chronic disease management, supporting adherence and reducing risk of harm
- take on a greater role in prevention, including through vaccine delivery and risk screening for cardiovascular disease and diabetes

These developments are particularly important for older adults with polypharmacy or frailty-related risks, as well as for working-age adults managing long-term conditions. Bringing pharmacy more clearly into the NHS' core clinical workforce also increases options for those who may struggle to access or engage with traditional GP services - including adults in low-income or rural areas.

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[53] NICE (2018). 'Improving oral health for adults in care homes' https://www.nice.org.uk/about/nice-communities/social-care/quick-guides/improving-oral-health-for-adults-in-care-homes#download-this-guide Accessed 11 July 2025

[54] ONS (2025). 'Experiences of NHS healthcare services in England' https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/datasets/experiencesofnhshealthcareservicesinengland Accessed 11 July 2025

Community pharmacies are well placed to support working age adults, particularly for advice, urgent medicines, and contraception. If pharmacy services are expanded, they could serve as an access point for adults who struggle to engage with traditional NHS services. The equality implications will depend on the specific services commissioned and these will be assessed during the policy development.

The chapter also sets out plans to modernise medicines dispensing through technologies such as robotic hubs, hub-and-spoke systems, and home delivery. This could significantly improve convenience and safety for people with reduced mobility, transport challenges, or social isolation. If implemented with attention to inclusion and access, these reforms could advance equality of opportunity by ensuring timely access to essential medicines without over-reliance on hospital or GP-based services.

Disability

Disabled people make up around 17% of the UK population[55]. Disability intersects significantly with long-term conditions, mental health, and social exclusion. Disabled people are more likely to require frequent, coordinated health and care support, and to experience barriers to access, continuity, and communication. This makes disability an important consideration in any reconfiguration of NHS services, particularly when linked to age, long-term conditions, and multimorbidity.

Improved continuity and co-ordination of care

This chapter proposes a major redesign of care around personalised support, with neighbourhood teams becoming the default model for most non-emergency care.

For many disabled people - particularly those with long-term conditions, complex needs or reliance on multiple services - improvements in continuity and coordination of care have the potential to significantly reduce the number of separate appointments, assessments and handovers and improve the effectiveness of the systems for both patients and the system. Currently, disabled people are more likely to experience (by virtue of using health services more) fragmented care and report poor communication between services[56]. The introduction of co-created care plans, embedded into the NHS App (or available through offline options), allows for more personalised care that reflects the realities of a person's daily life and will reduce the burden of having to repeatedly explain one's condition. The aim is to make care less fragmented, more joined up and more responsive to a person's

[55] House of Commons Library (2024) 'UK disability statistics: Prevalence and life experiences' https://commonslibrary.parliament.uk/research-briefings/cbp-9602/ Accessed 10 July 2025
[56] GOV.UK (2021). 'National disability Strategy' https://www.gov.uk/government/publications/national-disability-strategy Accessed 11 July 2025

needs. This could advance equality of opportunity by enabling more consistent support and reducing the cognitive and logistical burden of navigating care.

Continuity is reinforced not only through familiar clinicians but through team-based working. The chapter sets out evidence that continuity of care improves outcomes and satisfaction and reduces emergency hospital use - a priority for many disabled patients.

The expectation that unpaid carers will be involved in care planning is also relevant. Many disabled people rely on informal care, and formal recognition of carers could improve coordination and reduce crisis care.

The introduction of contracts for neighbourhood providers and multi-neighbourhood providers, may support more seamless care for people whose needs cross service boundaries. For disabled people who rely on both NHS and local authority services, a single accountable provider could improve coordination. Improved coordination of services and more local services will also have a positive impact on older carers[57]. Approximately 20% of people over 65 identify as a carer, and a quarter of these said caring duties had negatively affected their health and wellbeing.

Neighbourhood teams could include voluntary sector partners. These groups often have specific experience with disabilities (for example, mental health, neurodivergence, rare conditions) and may improve trust and relevance. Their inclusion could expand access and address gaps in traditional service models.

Staff in neighbourhood teams must be equipped to make reasonable adjustments, communicate accessibly, and recognise the rights and expertise of disabled people. Without this, the benefits of structural reform may not reach those who need them most.

Access to medication remains a core issue for many disabled people. The proposed expansion of community pharmacy services - including vaccine delivery, and more convenient dispensing - is likely to have a positive impact for people with mobility challenges or sensory impairments. If designed inclusively and promoted effectively, these services could improve safety and independence, thereby actively advancing equalities for some disabled people by enhancing both physical and digital access to care.

The redesign of outpatient services, with a focus on remote monitoring, patient-initiated follow-up (PIFU), and ‘advice and guidance’ models, may improve flexibility and reduce unnecessary travel for some disabled people, especially those with sensory impairments,

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[57] Carers Week (2023). ‘I care: report on unpaid care identification’ https://www.carersweek.org/about-carers-week/latest-news/posts-folder/2023/june/i-care-carers-week-report-on-unpaid-carer-identification/ Accessed 11 July 2025

energy-limiting conditions, or mobility barriers. Disabled people face well-documented transport barriers that can hinder access to hospital services. Motability Foundation data shows they make 38% fewer trips annually than non-disabled people, likely reducing opportunities to attend hospital outpatient, diagnostic and rehabilitation appointments[58]. Virtual outpatient and hospital care - when combined with the wider shift to delivering services closer to home - offers new opportunities to reduce access barriers for disabled people, particularly those with mobility impairments.

Dedicated services and access points

Neighbourhood health aims to address longstanding difficulties with disjointed services, diagnostic delays, and poor continuity. In England, people with SMI die on average 15 to 20 years earlier than the general population, and an estimated 2 in 3 deaths are from physical illnesses that can be prevented.[59] People with learning disabilities also experience disproportionate levels of inequality and have a higher number of avoidable deaths compared to the general population (42% compared to 22%)[60]. If effectively designed and resourced, this model may have significant positive impact on all 3 aims of the PSED, especially in reducing discrimination and fostering more equitable access. Design requirements include physical accessibility, inclusive communication, and staff training in disability awareness.

The proposed integration of community services including pharmacy and end-of-life care is also expected to benefit some disabled people who rely on regular support but face difficulties travelling or booking appointments.

While personal health budgets (PHBs) may offer greater flexibility and control over care, their success depends on the ability to understand options, navigate processes, and advocate for support. This assumes a level of health literacy and system confidence that cannot be presumed. People with long experience of managing their own care may be well equipped, but others - particularly those with learning disabilities, cognitive impairments, or limited formal support - may face significant barriers. According to NHS England, 43% of working-age adults lack adequate health literacy to understand and use everyday health information, and this rate is likely to be higher among people with learning difficulties or

[58] Motability Foundation (2022). 'The transport accessibility gap' https://www.motabilityfoundation.org.uk/impact-and-innovation/research/our-reports/ Accessed 11 July 2025
[59] GOV.UK (2023) 'Premature mortality in adults with severe mental illness (SMI)' https://www.gov.uk/government/publications/premature-mortality-in-adults-with-severe-mental-illness/premature-mortality-in-adults-with-severe-mental-illness-smi Accessed 11 July 2025
[60] Women and Equalities Committee (2024). 'Inequalities in healthcare and employment for people with a learning disability and autistic people' https://publications.parliament.uk/pa/cm5804/cmselect/cmwomeq/134/report.html#heading-1 Accessed 11 July 2025

neurodivergence.[61]. Reasonable adjustments, advocacy, and accessible materials will be essential to ensure PHBs advance rather than undermine equality of opportunity.

Locally delivered rehabilitation has the potential to significantly reduce access barriers for disabled people, particularly those with physical disabilities or reliance on assistive transport. Providing rehabilitation services with neighbourhood health centres or at home offers more equitable access and may enable earlier recovery following illness, injury or surgery. In addition, the model proposes shorter, more intensive rehabilitation periods, which may improve functional outcomes where appropriate, provided delivery is flexible enough to accommodate individual needs, fluctuating conditions or the need for pacing.

Other patients prioritised by the rollout of the neighbourhood health service are those with long-term conditions or complex needs. People with complex disabilities are significantly more likely to be unemployed (82%) compared with those with another type of disability (53%) and non-disabled people (23%). Those with multiple conditions are at risk of receiving fragmented care across the health system. A neighbourhood health service model which offers more joined-up care, recognises needs and can offer specialist care may lead to improved outcomes and healthcare experiences for patients.

The introduction of high street, home-based and community centred services may improve access for people with physical impairments who face transportation barriers, particularly where services are delivered in or nearer to the home. The use of wearable devices and remote monitoring may benefit some disabled patients by enabling earlier intervention. The chapter proposes to repurpose local building into health centres, which offers speed and cost advantages. However, many older or previously non-clinical buildings may present accessibility barriers, including limited step-free access or poor acoustics. It is essential that these buildings meet accessibility standards (Equality Act 2010).

The 2023 LeDeR review continues to highlight systemic failings in both physical and mental healthcare for people with learning disabilities. Cardiovascular disease remains a leading cause of premature and avoidable death in this population. The 2023 report found that cardiovascular conditions accounted for around one in 5 deaths among adults with learning disabilities, with ischaemic heart disease alone responsible for 9.5% of all deaths - making it one of the 3 most common avoidable causes of death. Similarly, the 2022 report found that of the 853 adults whose deaths were deemed potentially avoidable, 42% had a recorded history of cardiovascular disease, underlining the scale of unmet physical health needs in this population.[62]. The inclusion of secondary prevention in community

[61] NIHR (2022). 'Health information: are you getting your message across?' https://evidence.nihr.ac.uk/collection/health-information-are-you-getting-your-message-across/ Accessed 11 July 2025

[62] King's College London (2022). 'Learning from lives and deaths – people with a learning disability and autistic people (LeDeR)' https://www.kcl.ac.uk/research/leder Accessed 11 July 2025

pharmacy for cardiovascular disease and diabetes in the neighbourhood health model presents an important opportunity to reduce these inequalities. If this work proactively includes people with learning disabilities - through tailored risk assessment, reasonable adjustments, and accessible communication - they may help address one of the most common contributors to early and avoidable death in this group.

The redesign of urgent and emergency care services and the development of more personalised support in the community is particularly relevant for disabled people, who are more likely to rely on these services due to unmet needs elsewhere in the system. In England, people with learning disabilities are more likely to experience avoidable emergency admissions compared to the general population. Around 182 out of every 1000 emergency admissions for people with learning disabilities are avoidable, compared to 68 out of every 1000 for those without a learning disability[63]. The expansion of same day emergency care, co-located urgent treatment centres and virtual triage tools (via NHS 111 or the NHS App) could help reduce unnecessary admissions and improve experience - but only if designed accessibly.

Mental health

People with long-term physical disabilities and learning disabilities are more likely to experience mental health difficulties[64]. The introduction of mental health emergency departments, offering walk-in access to psychological support is a proposal in Chapter 2 with potential to reduce distress, prevent escalation and offer more appropriate support in times of need. This may particularly benefit people with sensory sensitivities or those reluctant to engage with traditional services. Integration with primary care, housing and social support will be essential.

Dental care and access

Evidence shows that people with learning disabilities have poorer oral health and more problems in accessing dental services than people in the general population[65]. Furthermore, barriers to access for people with physical disabilities can include transport, communication, and a lack of adapted services[66]. Reintegration of NHS dentistry into community models must be designed inclusively to avoid indirect discrimination.

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[63] Fay J Hosking and others, 'Preventable Emergency Hospital Admissions among Adults with Intellectual Disability in England' (2017) 15 The Annals of Family Medicine 462
[64] Norman Sartorious, 'Comorbidity of Mental and Physical Diseases: A Main Challenge for Medicine of the 21st Century' (2013) 25 Shanghai archives of psychiatry 68
[65] GOV.UK (2025). 'Oral care and people with learning disabilities' https://www.gov.uk/government/publications/oral-care-and-people-with-learning-disabilities/oral-care-and-people-with-learning-disabilities Accessed 11 July 2025
[66] The King's Fund (2022). 'Towards a new partnership between disabled people and health and care services: getting our voices heard' https://www.kingsfund.org.uk/insight-and-analysis/long-reads/new-partnership-disabled-people-health-care Accessed 11 July 2025

Expansion of community water fluoridation in the north-east of England will be beneficial to those who are less likely to participate in other oral health interventions, such as those with a disability.

Digital tools and accessibility

The shift to a digitally enabled, community-first model presents both opportunities and risks of exclusion for people with disabilities. Although some disabled people are more likely to use online health services than non-disabled people (for example, 23% compared to 13% used online consultations), others face substantial barriers, including affordability of tech, lack of digital skills, and inaccessible user interfaces[67]. The expanded use of the NHS App for triage, care plans, and digital tools may unintentionally exclude disabled users without clear accessibility standards and offline alternatives.

The chapter also proposes strengthening digital telephony, ensuring all phone are answered quickly. This will support some disabled people who prefer or rely on telephone contact. Detailed risks and mitigations regarding digital accessibility are addressed in full in the assessment for Chapter 2.

Gender reassignment

Evidence shows that there is a higher prevalence of mental health need within transgender communities - when adjusting for age, ethnicity and deprivation, transgender and non-binary adults are around twice as likely to be experiencing mental health difficulties compared to other groups[68].

The chapter introduces several proposals that are likely to be of benefit to transgender and non-binary people, some of whom may have undergone gender reassignment.

The establishment of mental health emergency departments may reduce barriers to psychological support by offering local, walk-in access without long waits or referral hurdles. The 2021 GP survey by the University of Cambridge found that trans and non-binary adults were around 3 times as likely to be living with dementia or to have a learning disability, and twice as likely to be experiencing mental health difficulties.[69] They were

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[67] Nuffield Trust (2020). 'Chart of the week: disabled people more likely to use the internet for health-related activities than non-disabled people' https://www.nuffieldtrust.org.uk/resource/chart-of-the-week-disabled-people-more-likely-to-use-the-internet-for-health-related-activities-than-non-disabled-people Accessed 11 July 2025

[68] Catherine L Saunders and others, 'Demographic Characteristics, Long-Term Health Conditions and Healthcare Experiences of 6333 Trans and Non-Binary Adults in England: Nationally Representative Evidence from the 2021 GP Patient Survey' (2023) BMJ Open

[69] Catherine L Saunders and others, 'Demographic Characteristics, Long-Term Health Conditions and Healthcare Experiences of 6333 Trans and Non-Binary Adults in England: Nationally Representative Evidence from the 2021 GP Patient Survey' (2023) BMJ Open

almost 6 times as likely to be autistic. Reform and integration of mental health and community services could reduce barriers to access and improve equality of experience for these individuals and improve integration by creating supportive environments in the community.

The overall emphasis on holistic, person-centred care - grounded in what matters to the individual - aligns strongly with the need for respectful, inclusive treatment that recognises and supports gender-diverse experiences.

The inclusion of voluntary partners in neighbourhood health teams may help ensure that services are delivered in a way that is trusted and relevant, particularly for groups who have historically experienced stigma or exclusion in healthcare settings.

Pregnancy and maternity

Provisions in the 10 Year Health Plan that affect women and children are considered under the protected characteristic of sex, as the parameters of the pregnancy and maternity characteristic within the Equality Act are narrowly defined. Therefore, inequalities relating to pregnancy and maternity are predominantly addressed through the broader lens of sex.

Race

Ethnic minority groups make up approximately 18% of the population in England, with higher concentrations in urban and economically disadvantaged areas[70]. However, it is recognised that it is important not to regard people from different ethnic minority groups as having the same experiences of discrimination or other inequalities in access.[71] However often the fact that ethnicity data is insufficiently disaggregated makes it difficult to understand these differences[72]. Research has shown that certain white ethnic minorities, such as Gypsy, Roma and Traveller communities[73], face significant disadvantages in areas like education, employment, and health and sone disparities are also evident in relation to newer migrant communities including those from Eastern Europe. Persistent

[70] GOV.UK (2025). Ethnicity facts and figures
[71] EHRC (2020). 'Race report statistics' https://www.equalityhumanrights.com/our-work/our-research/race-report-statistics?form=MG0AV3&form=MG0AV3 Accessed 10 July 2025
[72] NHS Race and Health Observatory (2021). 'Survey finds 'BAME', 'BME' and 'Ethnic Minority' not representative' https://nhsrho.org/news/survey-finds-bame-bme-and-ethnic-minority-not-representative/?form=MG0AV3&form=MG0AV3 Accessed 11 July 2025
[73] The Centre for Social Justice (2020). Facing the facts: ethnicity and disadvantage in Britain https://www.centreforsocialjustice.org.uk/library/facing-the-facts-ethnicity-and-disadvantage-in-britain Accessed 8 July 2025

inequalities in access, experience and outcomes are well documented and remain central to public health challenges. These include:

- experience of discrimination - 47% of Black and 34% of Asian patients report feeling they were treated differently in healthcare because of their ethnicity.[74]

- late diagnosis - some ethnic groups are more likely to experience delayed diagnosis, particularly for cancer, diabetes and mental health.[75] [76]

- language barriers and poor communication - these contribute significantly to dissatisfaction, lower engagement, and reduced adherence to treatment.[77] [78]

The benefits of the neighbourhood health model will only be realised if proposals are implemented with explicit attention to these structural and interpersonal barriers experienced by Black, Asian and minority ethnic communities. Disaggregated ethnic monitoring data will assist in the identification of inequalities faced by different ethnic groups.

Community led care

The proposed redesign of services around neighbourhood health centres and multidisciplinary teams (MDTs) has potential to improve coordination and responsiveness for people who currently face multiple, disconnected touchpoints across the system. If specialists (for example, diabetologists, respiratory physicians, psychiatrists) and social care professionals are effectively embedded within MDTs, and if these teams are supported to understand the cultural contexts in which health and care needs arise, this model could contribute to narrowing outcome gaps. The increased inclusion of social care is particularly relevant for communities who may have different informal caring structures and who have historically faced poorer experiences in in institutional care.

Evidence suggests that experience of care differs by ethnicity. 38% of Asian and 49% of Black respondents reported feeling they were treated differently in primary care due to

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[74] Marta Pineda-Moncusí and others, 'Ethnicity Data Resource in Population-Wide Health Records: Completeness, Coverage and Granularity of Diversity' (2024) 11 Scientific Data 221
[75] Yize I Wan and others, 'Ethnicity and Acute Hospital Admissions: Multi-Center Analysis of Routine Hospital Data' (2021) 39 eClinicalMedicine
[76] CM Toal and others, 'Health Resource Utilisation and Disparities: An Ecological Study of Admission Patterns across Ethnicity in England between 2017 and 2020' [2022] Journal of Racial and Ethnic Health Disparities.
[77] NHS England (2022). 'Ethnicity' https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/mental-health-services-data-set/submit-data/data-quality-of-protected-characteristics-and-other-vulnerable-groups/ethnicity Accessed 11 July 2025
[78] Hilal Al Shamsi and others, 'Implications of Language Barriers for Healthcare: A Systematic Review' (2020) 35 Oman Medical Journal 1

their ethnicity[79]. These disparities are relevant in the context of multidisciplinary and digital-first models, which rely on trust, continuity and equitable access.

On that basis, MDTs may contribute positively to equality of opportunity for individuals within the initial 6 priority groups. However, there is a risk that differences in experience and trust may limit how effectively changes reduce disparities.

The inclusion of voluntary organisations may also support culturally tailored outreach and improve trust, particularly for ethnic minority groups who have historically faced barriers in mainstream care. These organisations often play a critical role in delivering accessible services and addressing stigma.

This chapter also proposes that care is delivered closer to where people live - in neighbourhoods, on high streets and in the home - alongside integrated multidisciplinary teams. These changes have the potential to improve access in underserved areas with high ethnic diversity, increase continuity of care, especially where patients have previously experienced fragmented services and build trust through consistent relationships and more responsive, person-centred care[80]. Organisations such as the Race Equality Foundation highlighted the importance of services being offered and explained in accessible terminology and community languages so that people know what help is on offer and understand how the healthcare system works.

Ethnic minority groups are more likely to live in areas of high deprivation. Investment in hospitals as 'anchor' institutions - through local employment, apprenticeships and procurement - could help address place-based economic disparities that disproportionately affect these communities. This may support equality of opportunity by improving both healthcare roles and the broader social determinants of health. This is discussed in further detail in the assessment for Chapter 6: An NHS workforce fit for the future.

Prevention and chronic conditions

People from minority ethnic backgrounds continue to experience some of the most pronounced and persistent health inequalities. This includes significantly higher rates of type 2 diabetes and cardiovascular disease, earlier onset of chronic illness, and worse outcomes in areas such as maternity, cancer, and oral health. For example, people from Black African, Caribbean African and South Asian backgrounds are a higher risk of

[79] NHS Race and Health Observatory (2025). 'Patients report alarming lack of trust in NHS primary care providers' https://nhsrho.org/news/patients-report-alarming-lack-of-trust-in-nhs-primary-care-providers/ Accessed 11 July 2025

[80] The King's Fund (2024). 'Making care closer to home a reality' https://www.kingsfund.org.uk/insight-and-analysis/reports/making-care-closer-home-reality Accessed 11 July 2025

developing type 2 diabetes from a younger age[81]. The introduction of risk identification for cardiovascular disease and diabetes integrated into pharmacies is particularly relevant to minority ethnic communities, who experience higher prevalence and often later diagnosis. Furthermore, as hospital care becomes more technologically advanced, including the use of AI-enabled diagnostics - there is potential to support earlier detection and more personalised treatment. However, these tools must be carefully designed to avoid amplifying racial bias.

The chapter also references genomics as a future tool to support anticipatory care. Its implications for racial and ethnic groups - including fair access, consent, and the reliability of underlying datasets - will be addressed in further detail in the assessment for Chapter 4. A devolved and diverse NHS: a new operating model.

Mental health

People from Black and Asian backgrounds are more likely to experience poor mental health but less likely to access early intervention[82]. Black people are also more likely to be detained under the Mental Health Act[83]. These disparities are partly driven by poor access and fear or mistrust of services.

The proposed mental health emergency departments offer walk-in, non-hospital access to psychological support and could address known barriers to help-seeking among minority communities, particularly if co-designed with affected groups and embedded in community settings. Local, neighbourhood walk-in centres operating into the evening and led by diverse MDTs could offer a more acceptable and trusted form of support - particularly if staff are trained in cultural humility and systems of racial bias are actively addressed. Reducing health inequalities is a theme of the plan and improvements will be judged not just in terms of access, but also in experience and outcomes for Black and minority ethnic communities.

Digital health and algorithmic fairness

The proposed model relies heavily on digital platforms for triage and diagnostics, messaging and care planning. These innovations offer opportunities for early intervention

[81] Diabetes UK 'Ethnicity and type 2 diabetes' https://www.diabetes.org.uk/about-diabetes/type-2-diabetes/diabetes-ethnicity Accessed 11 July 2025
[82] NHS England (2014). 'Adult Psychiatric Morbidity Survey: survey of mental health and wellbeing, England' https://webarchive.nationalarchives.gov.uk/ukgwa/20180328140249/http:/digital.nhs.uk/catalogue/PUB21748 Accessed 11 July 2025
[83] GOV.UK (2024). 'Detentions under the Mental Health Act' https://www.ethnicity-facts-figures.service.gov.uk/health/mental-health/detentions-under-the-mental-health-act/latest/ Accessed 11 July 2025

and efficiency, however, should ensure that systems are inclusively designed, and take into account populations that are underrepresented in datasets.

The availability of digital telephony may help address some barriers where phone remains the preferred or only channel. Digital inclusion efforts will remain core to delivery, not supplemental. These risks are addressed in further detail in the assessment for Chapter 2.

Oral health and access to dentistry

This chapter's proposal to stabilise NHS dentistry by requiring all dentists to practice in the NHS for an intended minimum of at least 3 years could have an impact on racial health inequalities. Oral health disparities are marked: children from some ethnic minority groups have significantly higher rates of tooth decay, yet lower access to NHS dental care. According to a 2025 report by the Office of Health Improvement and Disparities, children in the Other ethnic group (45.4%) and the Asian or Asian British ethnic group (37.7%) have the highest experience in dental decay[84]. Higher proportions of adults from ethnic minority backgrounds experience issues accessing dental care compared to other groups[85]. Reintegration of community-based NHS dentistry and population health measures such as expansion to community water fluoridation offers a major opportunity to reduce these inequalities.

Outpatient and hospital care

The redesign of hospital outpatient services - including digital-first models, patient-initiated follow-up (PIFU), and NHS App enabled triage - may improve flexibility, but could exacerbate inequalities if not implemented inclusively. Studies show that many ethnic minority groups continue to experience digital exclusion. Between 2019 and 2021, NHS App registration rates were 36% higher in practices with the highest proportion of registered White patients and 25% lower registrations in the most deprived practices[86]. A more flexible and digitally led approach to outpatient care could help support people living in communities more remote from locations where face-to-face appointments take place, or where transport links are less reliable.

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[84] GOV.UK (2024). 'National Dental Epidemiology Programme (NDEP) for England: oral health survey of 5 year old schoolchildren 2024' https://www.gov.uk/government/statistics/oral-health-survey-of-5-year-old-schoolchildren-2024/national-dental-epidemiology-programme-ndep-for-england-oral-health-survey-of-5-year-old-schoolchildren-2024#method Accessed 11 July 2025

[85] General Dental Council (2024). 'Views and experiences of dentistry 2024' https://www.gdc-uk.org/about-us/what-we-do/research/our-research-library/detail/report/views-and-experiences-of-dentistry-2024 Accessed 11 July 2025

[86] Sukriti KC and others, 'Uptake and Adoption of the NHS App in England: An Observational Study' (2023) 73 British Journal of General Practice https://doi.org/10.3399/BJGP.2022.0150

Religion or belief

No adverse impacts of this policy have been identified in relation to people of no faith or religious beliefs. No impacts of this policy have been identified for people with or without philosophical beliefs protected by the Equality Act 2010.

Sex

Neighbourhood services

The plan identifies parents, and their children aged 0 to 5 as a priority group for early rollout of the neighbourhood health service. This includes improved access to general practice, same day consultations, and enhanced opening hours - changes which are likely to benefit pregnant women and new mothers needing timely advice, postnatal care, or support with infant health concerns.

The expanded use of the NHS App for triage and reassurance - including information on whether a child should attend school or when to seek clinical advice - may reduce anxiety and help mothers avoid unnecessary travel or appointment delays. Considerations will be made to ensure that digital tools are inclusive and alternative communications are in place for those that need it.

The integration of services through neighbourhood health centres and family hubs also has the potential to reduce fragmentation of support, enabling women to access maternal health, infant care, mental health support, and social services in one place. This is especially important for women who may find traditional service models difficult to navigate - such as single mothers, younger mothers, or those with insecure housing.

Vaccination and early intervention

Health visitors will play a greater role in raising vaccination uptake through direct engagement with families during home visits - an important route to reaching women and babies in deprived or marginalised communities. Increasing uptake of maternal and early years vaccines may have both short and long-term health benefits for mothers and children, particularly in communities where routine coverage is low.

The expansion of preventive oral health programmes (for example, supervised toothbrushing, fluoride varnish) will also benefit mothers indirectly, as these programmes are often delivered in nurseries, early years settings, and family hubs. Improvements in the availability of advice and access to care may reduce stress during a period of high vulnerability and demand.

Equality of access and experience

Women from minority ethnic backgrounds, particularly Black and South Asian women, face significantly worse maternal health outcomes. There was a nearly 3-fold difference in maternal mortality rates among women from Black ethnic backgrounds and an almost 2-fold difference among women from Asian ethnic backgrounds compared to White women[87]. Improving access to timely, continuous and culturally sensitive care is therefore essential for addressing inequalities in pregnancy and maternity outcomes.

The wider shift to personalised care plans, multidisciplinary working, and community-based services has the potential to narrow these gaps, particularly if neighbourhood teams are equipped to support pregnant women with complex social or clinical risk factors. The proposed social risk assessment discussed in Chapter 2 may help to mitigate this.

Uptake of free NHS dental care during pregnancy and for 12 months post-birth is currently low, despite eligibility[88]. Proposals to widen access to dentistry could improve access and awareness to offer, reducing maternal oral health issues and associated risks for infant health.

Personalised and co-ordinated care

The policy's focus on neighbourhood-based multidisciplinary care has potential to address some of these disparities if designed and delivered with gendered health patterns in mind. While access to multidisciplinary teams (MDTs) will initially be focused on 6 priority population groups, this model may still improve earlier identification and support for both women's and men's health issues, particularly where they relate to long-term conditions and health-seeking behaviour.

This is especially relevant in the context of the chapter's proposal regarding embedding risk detection for cardiovascular disease and diabetes into community pharmacy. These conditions show clear disparities between sexes: men are more likely to experience CVD at a younger age and are more likely to die from it prematurely, often due to delayed help-seeking or poor engagement with routine care[89]. Women face under-recognition of cardio-vascular risk (particularly post-menopause) and are more likely to have diabetes as a co-

[87] MBRRACE-UK (2024). Saving lives, improving mothers' care 2024 – Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2020-22 https://www.npeu.ox.ac.uk/mbrrace-uk/reports/maternal-reports/maternal-report-2020-2022 Accessed 8 July 2025

[88] 'Over a Million New Mothers Miss out on Free Access to NHS Dentistry' (2024) 236 British Dental Journal 672.

[89] NHS England (2022). 'Cardiovascular disease' https://www.nhs.uk/conditions/cardiovascular-disease/ Accessed 11 July 2025

morbidity[90]. If community pharmacists are equipped to proactively identify and engage both men and women using targeted outreach and inclusive care planning, this proposal could help close a significant gap in preventable illness and early death. The chapter references genomics as part of its anticipatory care model. This may enable earlier identification of sex-specific or sex-influenced conditions, such as breast and ovarian cancer, prostate cancer, or rare genetic conditions with sex-related expression. The implications for equity - including the quality of underlying data and consent to testing - will be explored further in the assessment for Chapter 4.

Chapter 1 also introduces remote monitoring to support long-term condition management at home. For conditions such as hypertension in men or postnatal complications in women, remote monitoring may reduce travel burden, enable earlier intervention, and support continuity.

The inclusion of voluntary and community sector partners in neighbourhood teams may also support sex-sensitive services - for example, organisations specialising in women's health, trauma recovery, or male suicide prevention. These providers often have expertise in culturally appropriate, community-led support.

Women are also disproportionately represented among unpaid carers (in England 10.3% of females provided unpaid care compared with 7.6% of males[91]), which can affect their ability to access healthcare for themselves. Proposals to formally recognise carers and to involve them in care planning could indirectly benefit women by improving flexibility, visibility, and coordinated support.

Mental health and crisis support

Pregnant and post-natal women are at elevated risk of experiencing mental health difficulties, such as perinatal depression and anxiety. As many as 1 in 5 people have mental health problems in pregnancy or after birth[92]. Women are more likely to experience common mental health conditions and seek support[93]. The introduction of mental health emergency departments as walk-in services for people experiencing mental health distress

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[90] Upasana Tayal and others, 'Advancing the Access to Cardiovascular Diagnosis and Treatment among Women with Cardiovascular Disease: A Joint British Cardiovascular Societies' Consensus Document' (2024) 110 Heart

[91] ONS (2021). 'Unpaid care by age, sex and deprivation, England and Wales: Census 2021' https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/socialcare/articles/unpaidcarebyagesexanddeprivationenglandandwales/census2021 Accessed 10 July 2025

[92] Royal College of Psychiatrists (2018). 'Mental health in pregnancy' https://www.rcpsych.ac.uk/mental-health/treatments-and-wellbeing/mental-health-in-pregnancy Accessed 11 July 2025

[93] ONS (2022) 'Cost of living and depression in adults, Great Britain' https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/mentalhealth/articles/costoflivinganddepressioninadultsgreatbritain/29septemberto23october2022 Accessed 11 July 2025

could offer a valuable alternative to GP or A&E routes, particularly for women who need immediate support but may be reluctant to disclose concerns in traditional settings.

Boys and men often experience undiagnosed mental health issues, with behavioural problems in boys leading to poor lifetime outcomes. Evidence suggests that boys and men are less likely to seek mental health care, yet suicide rates among young men and men generally remain high. Tailored community-based mental health programmes could encourage early engagement and reduce stigma. According to the statistics, around three quarters of suicides registered in England and Wales in 2023 were male (75.3%), with a rate of 17.4 deaths per 100,000 compared to 5.7 deaths per 100,000 for females[94]. Men, including young men, are also more likely to be sectioned under the Mental Health Act in England than women. Black men were 3.5 times more likely to be sectioned than white men.[95]

Access to community services

There are well-documented sex differences in the uptake and use of community-based health services. Uptake of NHS Health Checks has also been shown to be higher among women than men, despite similar eligibility rates, suggesting differences in engagement with preventative services[96]. Men have been found to use primary care services less frequently than women, with consultation rates around 32% lower between the ages of 16 and 60[97].

For men, who are statistically more likely to avoid preventative services and delay contact with healthcare providers, the shift to flexible, localised access through neighbourhood health centres, high street access and the NHS App may support earlier engagement - particularly if coupled with targeted outreach.

Community pharmacy could play a valuable role for men and women. For women, it offers more accessible support for contraception, menopause, and reproductive health. For men, particularly those who may avoid GP contact, pharmacy consultations may provide a less formal, lower threshold point of care. Proposals in the plan provide particular support to women from community pharmacies by offering free emergency contraception,

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[94] ONS (2024). 'Suicides in England and Wales: 2023 registrations' https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2023 Accessed 11 July 2025

[95] NHS England (2024). 'Mental Health Act Statistics, annual figures 2023-24' https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2023-24-annual-figures?form=MG0AV3&form=MG0AV3 Accessed 11 July 2025

[96] Riyaz Patel and others, 'Evaluation of the Uptake and Delivery of the NHS Health Check Programme in England, Using Primary Care Data from 9.5 Million People: A Cross-Sectional Study' (2020) 10 BMJ Open.

[97] Yingying Wang and others, 'Do Men Consult Less than Women? An Analysis of Routinely Collected UK General Practice Data' (2013) 3 BMJ Open

administering catch-up HPV vaccinations and offering self-sampling kits for cervical cancer screenings to test at home.

Sexual orientation

Hospitals are experienced in how to reduce the stigma associated with some services (for example, HIV services). More neighbourhood-based services may raise concerns and issues from groups that face increased discrimination, which could impact on some groups if appropriate consideration is not given to the issues in the policy design and implementation stages.

Measures to improve access to mental health and sexual health services for young people may positively impact LGBT individuals, who are known to face higher rates of mental health needs and may experience barriers in accessing inclusive care[98] [99] [100].

The inclusion of voluntary and community sector organisations in neighbourhood teams may be especially relevant to LGB communities. Trusted, identity affirming support from these organisations can improve confidence in services and can support earlier help seeking, particularly for those who feel marginalised by mainstream provision.

Marriage and civil partnership

These proposals are assessed to have no impact on people with the protected characteristic of marriage and civil partnership, in line with the public sector equality duty, which applies to this characteristic only in relation to the elimination of unlawful discrimination (aim 1).

[98] Francesca Robinson, 'Caring for LGBT Patients in the NHS' [2019] BMJ
[99] NHS (2024). Sexual orientation https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/mental-health-services-data-set/submit-data/data-quality-of-protected-characteristics-and-other-vulnerable-groups/sexual-orientation#:~:text=Research%20shows%20that%20that%20lesbian,out%20on%20routine%20health%20screening. Accessed 8 July 2025.
[100] The term LGB is used throughout this document when referring to sexual orientation. Where cited sources use broader terms such as LGBT, LGBT+, or LGBTQ+, those terms are retained to reflect the original language of the source.

From analogue to digital: power in your hands

Age

Working age adults

Generally, healthy working age adults aged 16 to 64 will benefit from increased convenience and flexibility in service access in the shift from analogue to digital. NHS App triage, access to health information, AI tools and digital consultations offer care options that better fit modern lifestyles and may improve uptake among those balancing work and family commitments. This is a cohort where long-term conditions begin to emerge or already be prevalent and improved access to booking services such as screening services and personalised information could reduce future disease burden if accessible equally.

Digital-first care offers many advantages but ensuring it is accessible to all remains essential. Certain groups, such as low-income adults, those in rural areas, or people in insecure employment, may face challenges in accessing online services, especially if they rely on shared or public devices. Connectivity across England is uneven: Superfast broadband is now available for 89% of all premises in rural areas, compared with near total coverage in urban areas (98%).[101] In response to the Change NHS organisation portal, the Royal College of Emergency Medicine echoed this concern; unequal access to reliable internet, devices, or digital literacy among certain populations - especially those in rural areas or from economically disadvantaged backgrounds - limits the equitable use of digital health solutions. This may be mitigated by plans to expand current partnerships with libraries and community spaces to help people set up and access the NHS App, which could provide those with limited connectivity an equal user experience.

Babies, children and young people

This chapter introduces the use of digital records through the ‘My Children’ tool in the NHS App. This will allow for better measurement of child development milestones and empower parents in the management of the health and care of their child that goes further than the current red book by supporting parents throughout childhood. The digital tools will also provide a means of improving prevention and health awareness for parents. This may have a positive impact on children and their parents and caregivers.

Young people are likely to see a positive impact from the policies in this chapter. The move to digital services provides more access to healthcare services and information and providing a platform for patients to manage their own health. The healthcare system can

[101] Ofcom (2024). ‘Connected nations’ https://www.ofcom.org.uk/phones-and-broadband/coverage-and-speeds/connected-nations-2024 Accessed 11 July 2025

be intimidating to young people, which can lead to anxiety in engaging with the system later in life and leading to poorer outcomes[102]. Young people also often turn to online sources to access health information. In a recent study, nearly a fifth (18%) of 16 to 24 year olds reported having self-diagnosed at least 4 times in the last 12 months[103]. Just under a third (30%) of respondents, particularly younger individuals, reported that they turn to social media platforms like TikTok and Instagram for health information, raising concerns about the accuracy of the information they encounter, due to the amount of user generated content on these platforms. Providing more information via the NHS App is likely to have a positive impact on young people by ensuring that they have access to reliable and accurate information and tailored advice.

There are approximately 120,000 young unpaid carers in England aged between 5 and 17.[104] The social risk assessment will be a component of the single patient record to provide clinicians with social context that is relevant to a patients' health. This may include information such as caring responsibilities. Recognition of caring status could allow for more support in the carer's ability to manage their own care and could direct young carers to mental health support if needed.

In 2023, about 1 in 5 children and young people aged 8 to 25 years had a probable mental disorder, such as anxiety, bipolar or depression.[105] Proposals to introduce a HealthStore app marketplace may have a positive impact on children and young people by increasing access to digital tools for mental health, such as those that provide cognitive behavioural therapy, that are tailored to this age group.

Older adults and ageing populations

England has an ageing population. 65 and over is the fastest growing age group and the number of people aged 65 to 79 is predicted to increase by nearly a third (30%) to over 10 million in the next 40 years.[106] Overall life expectancy has risen further and faster than disability-free expectancy, meaning more people are living into older age with multiple

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[102] NICE (2021). 'Babies, children and young people's experience of healthcare' https://www.nice.org.uk/news/articles/children-and-young-people-need-accurate-accessible-information-about-their-healthcare Accessed 11 July 2025
[103] AXA Health (2024). 'From search to solution: the prognosis for self-diagnosis in the UK' https://www.axahealth.co.uk/footer/news/2024/new-axa-health-research-shows-nearly-half-of-brits-have-self-diagnosed-at-least-once-in-the-last-year/ Accessed 11 July 2025
[104] ONS (2021). 'Unpaid care by age, sex and deprivation, England and Wales: Census 2021' https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/socialcare/articles/unpaidcarebyagesexanddeprivationenglandandwales/census2021 Accessed 10 July 2025
[105] NHS England (2023). 'Mental health of children and young people in England, 2023 – wave 4' https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2023-wave-4-follow-up/ Accessed 11 July 2023
[106] Centre for Ageing Better (2025) State of ageing report https://ageing-better.org.uk/state-ageing-2025 Accessed 8 July 2025

long-term conditions, frailty, dementia and social care needs. The measures in this chapter are likely to have disproportionate effects on the older population as this age group tends to use healthcare services more due to general worse health and a greater prevalence of multimorbidity at an older age.

According to the Census 2021, older age groups provide the highest hours of unpaid care per week. For women, those aged between 75 and 79 were most likely to provide 50 hours or more of care and for men, it is those aged 85 to 89 who provide most unpaid care.[107] These age groups are often more likely to experience poor health themselves due to the prevalence of multimorbidity rising with age. Potentially recognising carer status through the social risk assessment would help provide support to carers and the people they care for, for example by signposting to additional support, and allowing for contingency planning if the carer's ability to provide care is inhibited. This will have a positive impact on carers' and those that they care for, leading to improved health outcomes.

The digitalisation of health services presents clear benefits, but it must be implemented in a way that supports older patients, particularly those who do not use smartphones or have limited digital literacy. Only 15% of patients aged 85 and older have used online services for booking appointments, ordering repeat prescriptions or accessing medical information online.[108] These individuals may be more likely to rely on traditional face-to-face appointments with health professionals rather than engaging through the NHS App.

As the NHS moves towards digital booking systems, remote consultations, and a single patient record, it is essential that these changes do not unintentionally reduce access or increase social isolation for older people. Analogue options should be retained to ensure that all patients can engage with their care in a way that suits their needs. This is especially important for those living in care homes, who may require additional support to use digital tools. In response to the Change NHS online portal, Age UK discussed mitigations through voluntary and community sector (VCSE) organisations, such as local Age UK branches, who excel at providing the personalised, patient support necessary to help older people get online. However, Age UK highlighted that this requires time, effort, and increased funding for digital inclusion programmes.

Some older people may be more hesitant or find it more difficult to use new technology in comparison to younger people. In order to increase older people's ability to engage with the proposed changes, we will ensure that digital services and tools are developed in line with the government's Digital Inclusion Action Plan. The Department of Health and Social

[107] ONS (2021). 'Unpaid care by age, sex and deprivation, England and Wales: Census 2021' https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/socialcare/articles/unpaidcarebyagesexanddeprivationenglandandwales/census2021 Accessed 10 July 2025
[108] The Health Foundation (2020). 'Who gets in?' https://www.health.org.uk/reports-and-analysis/analysis/who-gets-in Accessed 11 July 2025

Care will work with the Department of Science, Innovation and Technology to ensure the benefits of digital inclusion reach patients, care recipients and staff.[109] The development and testing process will involve patient groups and organisations to improve user experience. The partnership with libraries and community organisations will also be expanded, helping those who need support to access the NHS App, such as older patients.

The future digital experience will be designed to address the needs of all groups with mitigations put in place to avoid exacerbating the digital divide. Health information will be tailored so that it meets the needs of people from different backgrounds, and those who may have low digital literacy could be identified, for example through the social risk assessment, so that their support needs can be addressed. This is not a digital only approach, and building the digital channels will not result in the closure of traditional face-to-face appointments or phone calls**.** The introduction and expansion of digital tools can also have a positive impact on those who are vulnerable to digital exclusion. By increasing access through the NHS App for those that can use it, telephone, face-to-face and other analogue channels will become more accessible to those that need more support.

The NHS App will include the addition of a My Carer tool. This will allow those that are providing care to securely gain access to the app on their patient's behalf. This will have a particular positive impact on older patients that face barriers accessing the app who receive care, by ensuring they can still utilise new digital tools the app provides and also making things more efficient for their carer. However, those who are providing unpaid care tend to be in older age brackets, and so may face barriers with digital tools themselves. For women, those aged between 75 and 79 were most likely to provide 50 hours or more of care and for men, it is those aged 85 to 89 who provide most unpaid care.[110] Consideration should be made to ensure that unpaid carers are also provided with support to access the app.

Disability

Disabled people are not a homogenous group - different people may have different circumstances, wishes and needs. The use of digital tools may greatly improve accessibility for patients with some disabilities, however this also holds the risk of exacerbating the digital divide and excluding those that may struggle with digital tools. For example, Parkinson's UK response to the Change NHS online portal highlighted the

[109] GOV.UK (2025). 'Digital Inclusion Action Plan: first steps' https://www.gov.uk/government/publications/digital-inclusion-action-plan-first-steps/digital-inclusion-action-plan-first-steps#chapter-4---our-approach-and-guiding-principles Accessed 11 July 2025
[110] ONS (2021). 'Unpaid care by age, sex and deprivation, England and Wales: Census 2021' https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/socialcare/articles/unpaidcarebyagesexanddeprivationenglandandwales/census2021 Accessed 10 July 2025

impact of a disability or health condition on the ability to use devices - dexterity, tremor and cognitive decline making it particularly problematic for people with Parkinson's.

Approximately 17% of the total population in England are disabled[111]. Proposals to remodel and improve the NHS App align strongly with the needs of this group and could have a positive impact across all 3 aims of the PSED on patients with disabilities who find it difficult to attend in-person services. A study showed that people with a disability were often more likely to use the internet for health-related activities than people without disabilities, whereas for non-health related activities they were less likely. For example, across the UK, 23% of people with a disability used an online health service such as getting a consultation or prescription online, compared to 13% of people without a disability.[112] An online booking platform for accessing primary care, virtual consultations and tools for managing long-term conditions may be beneficial for some patients.

The introduction of a HealthStore marketplace may also have a positive impact on patients with disabilities. The marketplace will increase access to a range of tools that could aid in long-term condition management or provide assistive technology that could have a positive impact on people with disabilities, dependent on their needs by increasing independence and reducing the need for frequent in-person GP or hospital visits. There is a disability pay gap in England[113]. The gap in 2023 was 12.7%, meaning disabled employees' median pay was 12.7% less than that of non-disabled employees. The subsidisation of apps by the NHS will have a positive impact on those who face financial barriers to accessing digital tools. It is important that these digital tools are built with accessibility in mind.

Digital exclusion remains a challenge for some disabled people, with15% of UK adults with a disability have never used the internet, compared to 6.3% of the wider population[114]. Even among users, confidence and skills can vary. As the NHS App expands to include more services and communication tools, it's important to ensure accessibility for all. Not all disabilities affect digital access in the same way, so tailored health information, adherence to accessibility standards and analogue alternatives should be part of the solution. Tools

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[111] UK disability statistics: Prevalence and life experiences - House of Commons Library
[112] Nuffield Trust (2020). 'Chart of the week: disabled people more likely to use the internet for health-related activities than non-disabled people' https://www.nuffieldtrust.org.uk/resource/chart-of-the-week-disabled-people-more-likely-to-use-the-internet-for-health-related-activities-than-non-disabled-people Accessed 11 July 2025
[113] ONS (2024). 'Disability pay gaps in the UK: 2014 to 2023' https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/disability/articles/disabilitypaygapsintheuk/2014to2023 Accessed 11 July 2023
[114] ONS (2021). 'Internet users' https://www.ons.gov.uk/businessindustryandtrade/itandinternetindustry/datasets/internetusers Accessed 11 July 2025

like the social risk assessment can help identify individuals with low digital literacy so their support needs can be addressed effectively.

The NHS App will include the addition of a My Carer tool. This will allow those that are providing care to securely gain access to the app on their patient's behalf. This will have a particular positive impact on those with disabilities that face barriers accessing the app who receive care, by ensuring they can still utilise new digital tools the app provides and also making things more efficient for their carer.

Policy development will align with the government's Digital Inclusion Action Plan, and the Department of Health and Social Care will work with the Department of Science, Innovation and Technology to ensure the benefits of digital inclusion reach patients, care recipients and staff[115]. The partnership with libraries and community organisations will also be continued, helping those with disabilities who need support to access the NHS App. The development and testing process will involve patient groups and organisations to improve user experience and will consider barriers to access for disabled people such adjustments for sensory impairments. The introduction of digital tools for those that can use them will also create more time and availability for those who cannot access these tools to interact with the healthcare system through non-digital channels that may be more appropriate for their needs. Phone calls and physical appointments will remain for those who need them.

Autistica's response to the Change NHS portal highlighted that some autistic people, particularly those with learning disabilities, are digitally excluded and would find these facilities very difficult to use. No single contact option is perfectly accessible; different neurodivergent people need different forms of communication, so it is important to offer genuine choice in how to communicate with healthcare services and professionals. Not everyone affected by these barriers will necessarily have a formal diagnosis; universal changes to contact options are likely to have a greater impact than expecting individual patients to come forward to request adjustments.

The introduction of a single care record and streamlined clinical administrative processes will reduce the need for patients to repeat their health history at every appointment, which can be stressful for patients, particularly those with long-term and complex conditions. This will positively impact their experience in healthcare settings and make consultations more efficient. A social risk assessment incorporated into the single care record could offer more context on barriers that patients are facing, such as transport challenges or caring responsibilities and enable services to be more responsive to those barriers. More unpaid

[115] GOV.UK (2025). 'Digital Inclusion Action Plan: first steps' https://www.gov.uk/government/publications/digital-inclusion-action-plan-first-steps/digital-inclusion-action-plan-first-steps#chapter-4---our-approach-and-guiding-principles Accessed 11 July 2025

carers in England are disabled (28%) compared to non-carers (18%), and recognition of caring status could allow for more support in the carer's ability to manage their own care, improving their own health outcomes and the outcomes of the care recipient[116].

Gender reassignment

A 2024 to 2025 Healthwatch survey found that just over half (53%) of trans respondents rated their GP as good or very good regarding general care services they had received. While the survey's question is not directly comparable to the GP Patient Survey (GPPS), the findings indicate that trans and non-binary patients may, overall, report lower satisfaction with GP care than the general population[117]. Providing a tool to provide feedback on healthcare experiences through the app will make this more accessible and provide patients with an opportunity for their voice to be heard - and allow providers to make improvements to services.

Pregnancy and maternity

Pregnant women in England engage with healthcare services at multiple points throughout their pregnancy journey. This includes over 600,000 booking appointments annually, multiple antenatal visits, ultrasound scans, blood tests, labour and delivery care, and postnatal follow-up appointments[118]. This amount of structured and frequent contact with healthcare services is significantly higher than that of non-pregnant women or men of similar age, who typically engage with services on a less frequent, ad-hoc basis unless managing a chronic condition. Improved booking systems and communication tools with GPs will have a disproportionately positive impact on pregnant patients who need to book appointments and access healthcare services regularly, increasing efficiency and allowing more flexibility when engaging with the healthcare system.

The single patient record will initially be rolled out in maternity care. This will streamline processes and allow maternity teams to have information about previous consultation, medical history and care preferences. This could provide a more efficient and better patient experience and have a positive impact with regards to the protected characteristic of pregnancy and maternity.

Digitalising the 'red book' will also significantly improve maternal and child health services. It would provide parents, carers and healthcare professionals with ready access to an

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[116] ONS (2021). 'Unpaid care by age, sex and deprivation, England and Wales: Census 2021' https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/socialcare/articles/unpaidcarebyagesexanddeprivationenglandandwales/census2021 Accessed 10 July 2025
[117] What trans and non-binary people told us about GP care | Healthwatch
[118] NHS - Maternity Services Monthly Statistics - NHS England Digital Accessed 29 June 2025

accurate record of the child's health (aim 2) and enable parents to manage their child's appointments from birth with greater flexibility. Improved data collection will also transform child health services to meet families' needs, allowing improved service planning, public health surveillance and enhanced research and innovation.

To ensure digital tools are inclusive, it's important to recognise that engagement may be lower among people with protected characteristics or from inclusion health groups - particularly those with mental health conditions or who are socially isolated[119]. Continuing partnerships with libraries and community services, along with recruiting more App Ambassadors, will help provide targeted support and improve access for those who may face additional barriers. The continuation of partnerships with libraries and community services, along with recruiting more App Ambassadors will help to ensure that support to access digital tools is available for those that need it.

Race

Patients whose race is other than White British are more likely to live in the most overall deprived 10% of neighbourhoods in England, showing correlations between ethnicity and deprivation[120].

People in more deprived areas are currently less likely to use the NHS App, with lower registration rates linked to factors such as affordability and digital access. A study found 25% lower registrations in the most deprived practices in England[121]. It also found registration rates were 36% higher in practices with the highest proportion of registered white patients. These challenges can also affect minority ethnic communities and inclusion health groups, where poverty and social exclusion are more common. Tools like the social risk assessment can help identify those facing barriers, allowing services to respond more effectively. Continuing partnerships with libraries, community spaces, and App Ambassadors will support uptake and help ensure more people benefit from digital health services.

Disparities in vaccine uptake persist within different ethnic groups. Some minority communities, such as Pakistani, Bangladeshi, Black Caribbean and Black African populations tend to have higher levels of vaccine hesitancy, which could be due to factors such as access barriers and the spread of misinformation. A study found that coverage for

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[119] Aljawharah Almuqrin and others, 'Smartphone Apps for Mental Health: Systematic Review of the Literature and Five Recommendations for Clinical Translation' (2025) 15 BMJ Open.
[120] GOV.UK (2020). 'People living in deprived neighbourhoods' https://www.ethnicity-facts-figures.service.gov.uk/uk-population-by-ethnicity/demographics/people-living-in-deprived-neighbourhoods/latest/ Accessed 10 July 2025
[121] Sukriti Kc and others, 'Uptake and Adoption of the NHS App in England: An Observational Study' (2023) 73 British Journal of General Practice https://doi.org/10.3399/BJGP.2022.0150

most vaccines in most years was above 90% for children who are White British, yet coverage for the infant vaccine plus preschool booster in 2020 to 2021 was 61% for the Caribbean group, and coverage for the first dose of MMR was 68% for any other Black, African and Caribbean background[122]. The NHS App will include My Vaccines - a tool which will display vaccination information and allow for vaccine appointments to be booked. This could have a positive impact on those who are more hesitant to take up vaccination programs by making accessing information and booking appointments easier.

These measures utilise wearable devices and biotechnology to allow individuals to monitor their health and for data to be collected. There is a risk of widening the digital divide, as access to wearables and digital literacy vary across socioeconomic groups. If not carefully managed, the system could favour those already engaged in proactive health management, leaving vulnerable populations behind. If components of the app or other digital tools utilise data from devices, there would inherently be a bias in the populations that this service would support. It will be important that consideration is given to potential biases and the importance of ensuring the needs of seldom heard groups are incorporated into service design.

Lived experience of encountering racism and unequal power dynamics can create mistrust between minority ethnic communities and the NHS. This could lead to wariness around sharing personal data and a lack of engagement with certain tools. This can contribute to poor quality data of certain demographics and misrepresentation in research and the development of services. The single patient record and data collection through the app and digital tools should be voluntary and benefit the individual directly, with clear informed consent. Patients will have access to their single patient record by default, putting them in control of their data and healthcare.

Language can be a barrier to digital inclusion, especially for the 12% of the population in England whose first language is not English[123]. Those with low proficiency in English may not understand information produced by the service. In their response to the Change NHS engagement exercise, Carers UK highlighted the cross-cutting issues - “the risks are that digital may exacerbate existing inequalities. Those who are likely to need services most, who are more likely to be digitally excluded, may find themselves prevented from accessing them.” To mitigate this, the app will continue to support translation. This may have a positive impact on experience for patients with limited English and improve

[122] Zhang CX and others. Ethnic inequities in routine childhood vaccinations in England 2006-2021: an observational cohort study using electronic health records EClinicalMedicine 2023.
[123] ONS (2021). ‘Language, England and Wales’ https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/language/bulletins/languageenglandandwales/census2021 Accessed 11 July 2025

efficiency by reducing the need for interpretive services in in-person healthcare settings that could be online.

It is well documented that there is significant need to address poor quality NHS datasets, particularly patient-level data for ethnic minorities[124]. The introduction of a single patient record will enable patients to directly provide this data via the NHS App where it can apply to all health settings. This will help the NHS identify communities most at risk from healthcare inequalities and social determinants of health through social risk assessments, driving actions at a local level.

Religion or belief

There is a possibility some people of faith might prefer more anonymised services for certain conditions so consideration should be given to the collection of health data and single patient record. No adverse impacts of this policy have been identified in relation to people of no faith or religious beliefs. No impacts of this policy have been identified for people with or without philosophical beliefs protected by the Equality Act 2010.

Sex

Women are generally more likely to use healthcare services, particularly women between the ages of 20 to 39 due to the use of maternity services[125]. Proposals in this chapter such as the digitisation of the red book will have a direct impact on women who access maternity services. This is further detailed in the 'Pregnancy and maternity' section.

Women can face unique challenges in healthcare, with many reporting that they feel unheard or dismissed. The Women's Health Strategy call for evidence in 2022 found that 84% of women who responded to the survey had felt that their healthcare professionals were not listening to them, and this could be due to feeling judged by staff, feeling symptoms are dismissed and lack of cultural awareness. The NHS App will include tools for providing feedback on care, helping ensure women's voices are better captured and used to improve services. This could enhance experiences and outcomes, especially for those who feel overlooked.

In the UK, women aged 16 to 44 are twice as likely as men of the same age to have visited their GP in the previous 12 months according to research[126]. This 'female excess' in

[124] ONS (2023). 'How ethnicity recording differs across health data sources and the impact on analysis' https://blog.ons.gov.uk/2023/01/16/how-ethnicity-recording-differs-across-health-data-sources-and-the-impact-on-analysis/ Accessed 11 July 2025
[125] NHS - Maternity Services Monthly Statistics - NHS England Digital Accessed 29 June 2025
[126] Yingying Wang and others, 'Do Men Consult Less than Women? An Analysis of Routinely Collected UK General Practice Data' (2013) 3 BMJ Open

consulting has led to the assumption that women are more likely than men to utilise health services at all ages. Men are often less likely to participate in regular health check-ups or follow through with preventive measures. Digital health tools could address this by increasing patient engagement and making healthcare more accessible and personalised. This may have a positive impact on male patients.

Women are also more likely to be unpaid carers - making up 59% of this group[127]. Recognising carer status through the social risk assessment could help identify support needs and connect carers to relevant services, improving outcomes for both carers and those they care for.

Sexual orientation

Research shows that that lesbian, gay, bisexual and trans (LGBT) people experience greater health inequalities compared to heterosexual people, such as being at higher risk of poor mental health or missing out on routine health screening[128] [129]. People who are gay, lesbian or bisexual were 2 to 3 times more likely to report having a longstanding psychological or emotional problem than heterosexual counterparts (age-adjusted for 5.2% heterosexual, 10.9% gay, 15% bisexual for men; 6% heterosexual, 12.3% lesbian and 18.8% bisexual for women). It was also found that poor mental health is more prevalent among LGBT people than the general population. Proposals to introduce access to apps that provide cognitive behavioural therapy would positively impact these groups.

Digital tools can play a key role in improving healthcare experiences for LGB patients, who are more likely to report challenges in primary care[130]. A platform for sharing feedback through the NHS App will make it easier for all patients to have their voices heard, helping services become more inclusive and responsive to diverse needs.

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[127] ONS (2021). 'Unpaid care by age, sex and deprivation, England and Wales: Census 2021' https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/socialcare/articles/unpaidcarebyagesexanddeprivationenglandandwales/census2021 Accessed 10 July 2025

[128] NHS (2024). Sexual orientation https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/mental-health-services-data-set/submit-data/data-quality-of-protected-characteristics-and-other-vulnerable-groups/sexual-orientation#:~:text=Research%20shows%20that%20that%20lesbian,out%20on%20routine%20health%20screening. Accessed 8 July 2025.

[129] The term LGB is used throughout this document in the sexual orientation sections. Where cited sources use broader terms such as LGBT, LGBT+, or LGBTQ+, those terms are retained to reflect the original language of the source.

[130] Marc N Elliott and others, 'Sexual Minorities in England Have Poorer Health and Worse Health Care Experiences: A National Survey' (2014) 30 Journal of General Internal Medicine Sexual Minorities in England Have Poorer Health and Worse Health Care Experiences: A National Survey - PMC

Marriage and civil partnership (in relation to aim 1 only)

These proposals are assessed to have no impact on people with the protected characteristic of marriage and civil partnership, in line with the public sector equality duty, which applies to this characteristic only in relation to the elimination of unlawful discrimination (aim 1).

From sickness to prevention: power to make the healthy choice

Age

Smoking

Chapter 3 of the plan details measures to tackle smoking through the tobacco and vapes bill and new stop smoking tools. While vapes can be effective tools for smoking cessation in adults, vaping in children is significantly increasing. The April 2023 youth vaping call for evidence showed that vaping among children is increasing, and that vapes are appealing to children and being marketed to them. A quarter of 11 to 15 year olds have tried vaping and 9% do so frequently, and in 2022, 16 to 24 year olds were more likely to report daily or occasional vaping than all other age groups.[131] [132] The Tobacco and Vapes Bill will target youth vaping, particularly through prohibition of sale to under 18s and preventing provision of free samples.

There are also digital measures to support people in quitting smoking through the NHS App and AI-powered tools. According to Age UK, 1 in 3 adults over the age of 65 lack the basic skills to use the internet effectively[133]. These may have a lesser impact on older people who may struggle accessing digital technologies. Older people are the least likely age group to smoke - however in 2023, 8.2% of those aged 65 and over were current

[131] NHS England (2023). 'Smoking, drinking and drug use among young people in England' https://digital.nhs.uk/data-and-information/publications/statistical/smoking-drinking-and-drug-use-among-young-people-in-england/2023 Accessed 11 July 2025
[132] ONS (2024). 'E-cigarette use in Great Britain' https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/drugusealcoholandsmoking/datasets/ecigaretteuseingreatbritain Accessed 11 July 2025
[133] Lloyds (2024). 'UK Consumer Digital Index and Essential Digital Skills report' https://www.lloydsbank.com/consumer-digital-index.html Accessed 11 July 2025

smokers[134]. The impacts of digital exclusion, and mitigations for this are discussed in more detail in the assessment for Chapter 2.

Obesity

This chapter details numerous measures to target and reduce obesity, in areas such as nutrition, physical activity, weight management and medications. Obesity affects all ages, and so the measures are likely to have a positive impact across all age groups, however some policies will have greater impact on certain cohorts.

Among children aged 2 to 15, the prevalence of obesity was 15% in 2022[135]. Measures to ensure all schools provide healthy and nutritious food will target, and have a positive impact on, all school-aged children by encouraging and providing more opportunity for them to eat balanced meals and build healthy eating habits. In the UK in 2023, 17% of children experienced food insecurity[136]. These measures will have a particular positive impact on children from low-income households. We will work closely with schools and run pilot schemes to ensure the adequate support is provided. Free school meals will also be expanded to all children in households in receipt of Universal Credit, providing opportunity for more families to be lifted out of food poverty. Increasing payments for the Healthy Start scheme will directly impact children aged 0 to 4 who are in lower income households and may struggle to have a healthy, nutritious diet. Measures to outline sugar and salt reduction targets and labelling guidelines for baby food will have positive impact on babies by encouraging industry to reformulate products to be healthier.

Children may be more vulnerable to marketing and promotional techniques, such as buy one get one free deals, and therefore more susceptible to its impact. Policies that set targets to increase average health of sales potentially through loyalty schemes and promotions may lead to lower consumption and this may have a greater positive impact on this group. Banning the sale of high-caffeine energy drinks for under 16s and uplifting the soft drinks industry levy will also have a positive impact on children and young people by encouraging industry to reformulate their products with less sugar and promote lower sugar alternatives.

Studies have shown that young adults aged 18 to 24 are at the highest risk of becoming overweight or developing obesity in the next decade of their life compared to any other age

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[134] ONS (2023). 'Adult smoking habits in the UK' https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/adultsmokinghabitsingreatbritain/2023 Accessed 11 July 2025

[135] NHS England (2024). 'Health survey for England, 2022 Part 2 – Adult overweight and obesity' https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/2022-part-2/adult-overweight-and-obesity Accessed 9 July 2025

[136] House of Commons Library (2024). 'Who is experiencing food insecurity in the UK?' https://commonslibrary.parliament.uk/who-is-experiencing-food-insecurity-in-the-uk/ Accessed 11 July 2025

group, and that being a young adult is a more important risk factor than sex, ethnicity or social deprivation[137]. The obesity prevention methods in this chapter will affect and have a positive impact on individuals in this age bracket.

In response to the Change NHS online portal, The Academy of Medical Sciences cited research from Our Future Health that found over half of UK adults have cholesterol levels above recommended, and over 25% have high blood pressure[138]. Their response also referenced a recent review by the National Audit Office found that just under half of the annual eligible population attended a Health Check in 2023 to 2024. The Academy said beyond early childhood intervention, rising risk factors like high blood pressure, cholesterol, and obesity, which are often underdiagnosed and undertreated, need to be addressed.

Obesity prevalence is highest among older adults, with the peak rate in the 55 to 64 age bracket[139]. The measures in this chapter that aim to reduce obesity, such as scaling up and subsidising weight management programmes, will improve health outcomes and have a positive impact on this cohort, particularly from deprived areas or on lower incomes.

Adults between the age of 18 to 75 may be prescribed GLP-1 agonists for managing overweight and obesity. These have shown to be significantly effective as a tool for weight management, leading to an average weight loss of around 15 to 20% of body weight - comparable with bariatric surgery[140]. Increasing access to these medications through the NHS will ensure patients who use them can do so in a safe, regulated way and will have a positive impact on patients within this age bracket. Those who are on lower incomes and more deprived communities who are excluded from these by not being financially able to access them through private healthcare services may see particularly positive impacts.

Proposals for digital tools, such as the expansion of the NHS Digital Weight Management Service and new innovations to encourage active communities run the risk of exacerbating digital exclusion for some people, particularly older patients who are less confident using

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[137] Michail Katsoulis and others, 'Identifying Adults at High-Risk for Change in Weight and BMI in England: A Longitudinal, Large-Scale, Population-Based Cohort Study Using Electronic Health Records' (2021) 9 The Lancet Diabetes & Endocrinology 681.
[138] Our Future Health (2023). 'Revealed: over half of people have high cholesterol and over 1 in 4 have high blood pressure' https://ourfuturehealth.org.uk/news/over-half-of-people-found-to-have-high-cholesterol-and-over-1-in-4-found-to-have-high-blood-pressure-in-transformative-health-research-programme/ Accessed 11 July 2025
[139] NHS England (2024). 'Health survey for England, 2022 Part 2 – Adult overweight and obesity' https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/2022-part-2/adult-overweight-and-obesity Accessed 9 July 2025
[140] Nesta (2023). 'Can weight loss drugs "solve" obesity?' https://www.nesta.org.uk/blog/can-weight-loss-drugs-solve-obesity/ Accessed 11 July 2025

digital technology. The impact of digital exclusion and mitigations to address it is discussed in more detail in the assessment for Chapter 2.

Reducing alcohol intake

The measures in this chapter will provide consumers with more information about the health risks of alcohol consumption to help them make more informed choices. These policies do not target certain age groups but are likely to have positive impacts across all ages.

Children and young people can be directly or indirectly affected by alcohol. Alcohol dependencies can make it harder for parents or carers to provide safe and loving environments for children, which can lead to abuse or neglect. It is estimated that between 189,000 and 208,000 children in England live with an alcohol-dependent adult[141]. Reducing alcohol intake will have a positive impact on children and young people who experience indirect impacts of alcohol.

The government will explore options to ensure access to NoLo products are restricted and treated in the same ways as all alcohol products, including banning sales to under-18s. The changing of the upper strength threshold for NoLo drinks to 0.5% ABV however, could have a positive impact on adults by offering more options for alcohol substitutes and facilitating a shift in the alcohol market for the development of more NoLo drinks.

Excessive alcohol consumption leads to serious health complications later in life, such as liver failure, obesity and various cancers. Alcohol consumption tends to increase with age, from 62% of 16 to 24 year olds to 85% of 55 to 74 year olds reporting having drank alcohol in 2022[142]. The age group that are most likely to drink more than 14 units a week, which is associated with increasing and higher risk, was 55 to 64 (30%). and alcohol linked conditions are also commonly associated with this age group. The measures in this chapter to address alcohol misuse are likely to have a disproportionate positive impact on this cohort.

Air pollution and housing standards

Air pollution affects all age groups but poses greater risks to children and older adults. In children, it's linked to asthma, slower lung development, and wheezing. In adults, it

[141] UK Parliament (2018). 'Parental alcohol misuse and children' https://post.parliament.uk/research-briefings/post-pn-0570/ Accessed 11 July 2025
[142] NHS England (2024). 'Health Survey for England, 2022 Part 1 – Adult drinking' https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/2022-part-1/adult-drinking Accessed 11 July 2025

increases the risk of asthma attacks, heart disease, stroke, COPD, lung cancer, and dementia[143] [144].

Young adults are most likely to live in polluted areas: 16% of 25 to 34 year olds live in the most polluted neighbourhoods, compared to 6% of those over 64[145]. Policies like decarbonising transport, promoting active travel, and improving public transport can significantly benefit young people in these areas. The impact of reducing emissions from domestic burning is being explored through consultation.

The proposals for the new Department for Energy Security and Net Zero (DESNZ) Warm Homes Plan and Fuel Poverty Strategy are likely to have a positive impact on people across different age groups, but particularly older people and children. Older adults are disproportionately affected by cold homes and are more likely to experience excess winter deaths linked to poor housing conditions[146]. In 2022 to 2023, 14% in England lived in a home that failed to meet the decent home standard, and 4% lived in a home with damp[147]. In England, 4.5 million people aged over 50 and over with a health condition aggravated by sub-standard housing are living in a home with one or more serious problems[148]. Children are also at increased risk: exposure to mould in the home is associated with respiratory infections and the development of asthma[149]. These proposals are therefore expected to reduce age-related health inequalities linked to sub-standard housing and fuel poverty.

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[143] GOV.UK (2018). 'Health matters: air pollution' https://www.gov.uk/government/publications/health-matters-air-pollution/health-matters-air-pollution#:~:text=2.5.,-Cancer&text=There%20is%20strong%20evidence%20that,of%20cancers%20in%20later%20life. Accessed 11 July 2025

[144] GOV.UK (2024). 'Chief Medical Officer's 2024 report: health in cities' https://www.gov.uk/government/publications/chief-medical-officers-annual-report-2024-health-in-cities Accessed 11 July 2025

[145] The Health Foundation (2024). 'Inequalities in likelihood of living in polluted neighbourhoods' https://www.gov.uk/government/publications/improving-outdoor-air-quality-and-health-review-of-interventions Accessed 11 July 2025

[146] Age UK (2024). 'Cold at home: How winter cost of living pressures continue to impact older people' https://www.ageuk.org.uk/our-impact/policy-research/publications/reports-and-briefings/ Accessed 11 July 2025

[147] GOV.UK (2024) 'English Housing Survey 2022 to 2023: housing quality and condition' https://www.gov.uk/government/statistics/english-housing-survey-2022-to-2023-housing-quality-and-condition/english-housing-survey-2022-to-2023-housing-quality-and-condition Accessed 11 July 2025

[148] Centre for Ageing Better (2024). 'Homes: the state of ageing report' https://ageing-better.org.uk/homes-state-ageing-2025#homes-key-points Accessed 11 July 2025

[149] GOV.UK (2024). 'Understanding and addressing the health risks of damp and mould in the home' https://www.gov.uk/government/publications/damp-and-mould-understanding-and-addressing-the-health-risks-for-rented-housing-providers/understanding-and-addressing-the-health-risks-of-damp-and-mould-in-the-home--2 Accessed 11 July 2025

Vaccination and screening

The risk of preventable diseases like cardiovascular conditions and lung cancer increases with age, making secondary prevention especially beneficial for older adults. However, such conditions can occur at any age. Plans to expand lung cancer screening for those with a smoking history could reach more people currently ineligible.

This chapter outlines plans to continue to work with local government and VCSEs to support public trust in vaccines. This will aim to help raise childhood immunisation rates, having a particular positive impact on children and young people.

The plan also outlines measures to reduce the transmission of HIV through the new HIV action plan. In 2023, over 100,000 people received HIV care in the UK, which is the highest number recorded[150]. The age group that has the highest amount of people receiving care is the 50 to 64 age group. This group is likely to be most benefitted by these interventions, although all ages in scope of the plan will see positive impacts.

Reforms to research funding and increased private sector investment in prevention may have mixed short-term effects, potentially widening inequalities for those with late-stage long-term conditions. However, long-term benefits include earlier access to preventative treatments, especially for the 1.7 million children in England with chronic conditions like asthma, diabetes, and epilepsy. With major illness projected to rise 37% by 2040, these measures aim to improve outcomes across all age groups.

Children and young people's mental health

The prevalence of mental health problems in children and young people is significantly rising. In 2023, around 1 in 5 children and young people aged 8 to 16 had a probable mental disorder, compared to around 1 in 9 in 2017[151]. This chapter outlines ambitions to increase the national coverage of mental health support teams. This will have a positive impact on school-age children and means consistent support for children no matter where they live or are educated. New Young Futures hubs will also deliver support within local communities, ensuring children and young people have open access to support.

Emphasis on ensuring that educations and health providers work together with other local services to plan and deliver flexible, evidence-based interventions for children with special

[150] National Aids Trust (2024). 'UK HIV statistics' https://nat.org.uk/about-hiv/hiv-statistics/ Accessed 11 July 2024

[151] NHS England (2023). 'Mental health of children and young people in England, 2023 – wave 4' https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2023-wave-4-follow-up/ Accessed 11 July 2023

educational needs and disabilities will have a positive impact on school-aged children to help with earlier diagnosis and more support.

Genomics

Genomics and predictive analysis can be hugely beneficial to the population, supporting early detection of disease and enabling personalised prevention and treatment. Proposals to expand the use of genomics in healthcare are likely to have a positive impact on people with regard to the protected characteristic of age. Genomics can identify age-related risks genetic risks, such as dementia, allowing for earlier intervention and diagnosis. Genetic testing for pharmacogenomic profiles will eventually be a universal offer but first will be integrated into the NHS over-40s Health Check, therefore having a particular impact on those who are over 40.

Disability

Smoking

There is limited evidence on smoking or vaping rates among disabled people. Smoking is a major cause of several diseases and, therefore, could increase the number of disabled people. For example, it is estimated that smokers are 1.6 times more at risk of dementia, including Alzheimer's and vascular dementia[152]. The measures in this chapter aim to reduce smoking rates for both people with disabilities and those without so are expected to have a positive or neutral impact on disability. There are also measures to encourage innovation to support smoking cessation through the new Health Coach programme and third-party tools via the HealthStore. The equalities impacts of these are outlined in the assessment for Chapter 2.

Obesity

There are links between obesity and disability. People with a learning disability, physical disability or severe mental health problem are more at risk of obesity[153]. Those who are obese are also at risk of developing complications leading to disability due to their weight. Measures in this chapter that aim to tackle or prevent obesity are likely to have a positive impact on people with a disability by promoting healthy eating habits and reducing sugar intake. It is important however to note that disabled people are not a homogenous group -

[152] Gill Livingston and others, 'Dementia Prevention, Intervention, and Care: 2020 Report of the Lancet Commission' (2020) 396 The Lancet 413
[153] GOV.UK (2020). 'Obesity and weight management for people with learning disabilities: guidance' https://www.gov.uk/government/publications/obesity-weight-management-and-people-with-learning-disabilities/obesity-and-weight-management-for-people-with-learning-disabilities-guidance

different people may have different wishes and needs and interventions should be considered based on the individuals' circumstance.

The policy to uplift the Soft Drinks Industry Levy (SDIL), and proposals to review sugar content thresholds and remove the current exclusion for some milk-based and milk substitute drinks, may have a negative impact on those who are Type 1 diabetic who use soft drinks to manage their condition. This is due to some products having a lower sugar content than they do currently; and because any cost increases incurred by businesses may be passed on to consumers.

Mitigations outlined in the equality impact assessment for the levy should be maintained to ensure those with Type 1 diabetes are still able to manage their condition and are not financially impacted by these measures.[154]. These mitigations are legislative exclusions from the scope of the SDIL for certain soft drinks to ensure that those consumers that need them will continue to have access to a range of soft drinks which can be used to manage their health conditions. Fruit juice is one such exclusion and is a product that the NHS website recommends for the emergency treatment of hypoglycaemia (hypos). Some milk-based and milk substitute drinks are not currently included within the scope of the SDIL and will continue to be out of scope if the current exclusion for these products is removed. The government also continues to take a number of actions to support those with type 1 diabetes to manage their condition.

Proposals for digital tools, such as the expansion of the NHS Digital Weight Management Service and new innovations to encourage active communities run the risk of exacerbating digital exclusion for some people, particularly patients with learning difficulties or sensory impairments who may find digital technology inaccessible. The impact of digital exclusion and mitigations to address it is discussed in more detail in the assessment for Chapter 2.

Physical activity

People living with long-term conditions, including disabled people, experience barriers to participation in physical activity opportunities, such as pain and perceptions that movement will make their condition worse.[155]. However, evidence suggests that for most people living with long-term conditions it is safer for them to be physically active than not.[156]. Policies to run national campaigns and the introduction of a new NHS points scheme should be

[154] GOV.UK (2020). 'Soft Drinks Industry Levy: initial equality impact assessment' https://www.gov.uk/government/publications/soft-drinks-industry-levy--2/soft-drinks-industry-levy-initial-equality-impact-assessment Accessed 11 July 2025
[155] Richmond Group of Charities: People with long-term conditions and attitudes towards physical activity. PowerPoint Presentation
[156] Benefits outweigh the risks: a consensus statement on the risks of physical activity for people living with long-term conditions | British Journal of Sports Medicine

designed to enable everyone, particularly people who are less active, to move a bit more - the latter is where the greatest health benefits are accrued[157]. Such policies should consider, throughout the course of design and development, how to break down the barriers that people living with long-term conditions face when it comes to movement - this will help to manage the risk of some people with long-term conditions being excluded or discouraged from getting involved compared to people without a long-term condition.

Air pollution and housing standards

Some people with disabilities may be disproportionately impacted by air pollution. This may be due to pre-existing long-term conditions such as asthma or chronic obstructive pulmonary disease (COPD), or potentially the increased dependence on public transport or other forms of transportation that contribute to pollution. Measures to reduce air pollution such as decarbonisation of public transport may have a positive impact on people with disabilities who are more affected by air pollution.

The development of a DESNZ-led Warm Homes Plan and Fuel Poverty Strategy is expected to benefit disabled people, who are more likely to experience poor housing conditions and are disproportionately affected by fuel poverty. The Health Evidence Equity Centre stated that "27% of households that include someone who is disabled are on a low income when measured before housing costs, compared to with 15% of households with no disability; and their cost of living is higher.[158]"

Screening

People with disabilities, particularly learning disabilities or autism, or those with severe mental illness tend to have lower screening uptakes than those without[159]. This, along with poor healthcare experiences and health outcomes results in a significant disparity for people with disabilities. Proposals to increase uptake and access to screening services will allow targeted interventions and improve access to those who face barriers engaging with screening services.

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[157] Physical activity guidelines: UK Chief Medical Officers' report - GOV.UK

[158] Institute of Health Equity (2022). 'Fuel poverty, cold homes and health inequalities in the UK' https://www.instituteofhealthequity.org/resources-reports/fuel-poverty-cold-homes-and-health-inequalities-in-the-uk

[159] GOV.UK (2021). 'Population screening: reducing inequalities for people with a learning disability, autism or both' https://www.gov.uk/government/publications/population-screening-supporting-people-with-learning-disabilities/population-screening-reducing-inequalities-for-people-with-a-learning-disability-autism-or-both Accessed 11 July 2025

Supporting employment

There is a disability employment gap in the UK. From the beginning of April to the end of June 2024, the disability employment rate was 53%, compared to 82% for non-disabled people[160]. The chapter details policy proposals to improve access to employment related support, along with support to those at risk of leaving work.

Expanding Individual Placement and Support schemes will help people with severe mental illness find meaningful employment. A new support guarantee and pilot access to employment advice via the neighbourhood health service aim to create more inclusive workplaces. While these measures will benefit many, although the extent of the benefit, and whether there is a benefit, will vary between individuals depending on their circumstances.

Reforms will also protect the income of those with the most severe disabilities by removing the need for benefit reassessments. This is crucial, as disabled people face higher unmet needs - those with severe disabilities are 4.5 times more likely to struggle with mental healthcare costs, and those with mild disabilities are 3.6 times more likely to face barriers to accessing prescribed medicine[161]. These changes will especially support those unable to work.

Children and young people's mental health

This chapter proposes increased roll out of mental health support teams in schools alongside the creation of new young future hubs. This may lead to more young people having access to support through a number of different avenues.

Emphasis on ensuring that educations and health providers work together with other local services to plan and deliver flexible, evidence-based interventions for children with special educational needs and disabilities will have a positive impact on children to help with earlier diagnosis and more support.

Genomics

Genomics and predictive analysis could have a mixed impact on those with disabilities. Genomics can allow for early identification of risks of genetic disorders, and pharmacogenetic profiles will allow patients and clinicians to understand drug interactions on an individual basis. This will particularly be beneficial to those with disabilities who take medication to ensure that treatments are as effective as possible and reduce harmful side

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[160] ONS (2025) Labour market status of disabled people Accessed 24 June 2025

[161] Dikaios Sakellariou and Elena S Rotarou, 'Access to Healthcare for Men and Women with Disabilities in the UK: Secondary Analysis of Cross-Sectional Data' (2017) 7 BMJ Open

effects. It is important to carefully consider the ethical aspects of genetic testing. Prenatal screening can offer valuable information to help prospective parents make informed choices. At the same time, it is recognised that care should be taken to avoid any unintended consequences, such as feelings of pressure or reinforcing negative societal attitudes towards disability.

Gender reassignment

These proposals are assessed to have no specific or disproportionate impact for people with the protected characteristic of gender reassignment.

Pregnancy and maternity

Obesity

Women who are obese when they become pregnant have increased risks to their own and their babies' health. The proportion of women recorded as living with obesity in early pregnancy was 26.2% in 2023 to 2024.[162]. Obesity during pregnancy is associated with low birth weight, which is a major factor in infant mortality and has serious consequences for health in later life. Some of the proposals in this chapter that aim to reduce obesity will have a positive impact on those who are pregnant, for example advertising and financial support through the Healthy Start scheme, and those that promote healthier habits. Policies that directly aim to encourage weight loss will not benefit pregnant women due to ineligibility, such as wider access to weight management services and GLP-1 medications.

Research has found that some pregnant women's diets are missing essential nutrients needed for them and their babies, such as vitamins B12, B6, D, folic acid and riboflavin.[163]. Socioeconomic factors can be a contributor to this, and those on lower incomes may face financial barriers in accessing more nutritious food. Increasing weekly payments for the Healthy Start scheme will support those who qualify and increase the opportunity to afford more nutritious and vitamin supplements. This will policy aims to directly support pregnant women and so will have a disproportionate impact on this group.

[162] GOV.UK. 'Child and maternal health profiles, December 2024 update: statistical commentary' https://www.gov.uk/government/statistics/child-and-maternal-health-profiles-december-2024-update/child-and-maternal-health-profiles-december-2024-update-statistical-commentary. Accessed 11 July 2025

[163] Keith M Godfrey and others, 'Maternal B-Vitamin and Vitamin D Status Before, During, and after Pregnancy and the Influence of Supplementation Preconception and during Pregnancy: Prespecified Secondary Analysis of the NiPPeR Double-Blind Randomized Controlled Trial' (2023) 20 PLOS Medicine.

Alcohol intake

Alcohol intake during pregnancy can have detrimental effects and lead to poor health outcomes for babies. Approximately 41% of women have drunk alcohol at some point in pregnancy - either before or after they knew they had conceived[164]. Impacts of excessive alcohol intake include foetal alcohol spectrum disorder, reduced height and weight, cardiac abnormalities, sight and hearing problems and intellectual and behavioural disabilities. Researchers have found that women who said they had more than 4 alcoholic drinks per week were almost 3 times more likely to miscarry than women who didn't drink at all[165]. The measures in this chapter will provide consumers with more information about the health risks of alcohol consumption to help them make more informed choices. Tackling alcohol consumption will have a positive impact on pregnant women, and their babies who could have significant long-term implications from alcohol.

Air pollution

Exposure to high levels of air pollution can harm pregnant women and their babies. There are links between pre-natal exposure to particulate matter from road traffic and reductions in lung function during childhood[166]. There is also a correlation between risk of term low birth weight with maternal exposure to particulate matter. Measures to reduce air pollution will have a positive impact on pregnant women and their babies who live in areas of high air pollution.

Supporting employment

In a survey of 6000 women and employers, 77% of mothers reported negative of discriminatory practices during pregnancy, maternity and/or on their return to work[167]. Improved work and health services, provided by supporting SMEs to offer their employees more access to occupational health services, along with defined work standards and providing holistic support, could include maternity health checks and more protections for pregnant workers and their baby. This will positively impact women who are pregnant or returning from maternity leave.

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[164] Svetlana Popova and others, 'Estimation of National, Regional, and Global Prevalence of Alcohol Use during Pregnancy and Fetal Alcohol Syndrome: A Systematic Review and Meta-Analysis' (2017) 5 The Lancet Global Health.
[165] Loubaba Mamluk and others, 'Low Alcohol Consumption and Pregnancy and Childhood Outcomes: Time to Change Guidelines Indicating Apparently "Safe" Levels of Alcohol during Pregnancy? A Systematic Review and Meta-Analyses' (2017) 7 BMJ Open.
[166] Yutong Cai and others, 'Prenatal, Early-Life, and Childhood Exposure to Air Pollution and Lung Function: The ALSPAC Cohort' (2020) 202 American Journal of Respiratory and Critical Care Medicine 112.
[167] EHRC (2018). 'Pregnancy and maternity discrimination research findings' https://www.equalityhumanrights.com/guidance/business/pregnancy-and-maternity-discrimination-research-findings Accessed 11 July 2025

Race

Smoking

Smoking rates are generally higher among people from White and Mixed backgrounds but this is also affected by gender, where prevalence among men in several minority ethnic groups is higher than among White and Mixed ethnicity men, while smoking rates are often substantially lower among minority ethnic women.[168] Measures in this chapter aim to reduce the number of new smokers through the Tobacco and Vapes Bill. There are also measures to encourage innovation to support smoking cessation through the new Health Coach programme and third-party tools via HealthStore. The equalities impacts of this are outlined in the assessment for chapter 2.

Obesity

Obesity prevalence varies across ethnicity groups due to various factors such as environmental factors, health behaviours, socioeconomic status, social marginalisation, access to healthcare or discrimination. The measures in this chapter target individuals from all ethnicities and are likely to have a positive impact across all ethnic groups. In 2022, 70.8% of black adults were overweight or living with obesity - the highest percentage out of all ethnic groups.[169] However, the cause for difference in prevalence across ethnic groups are difficult to quantify and it is difficult to predict whether impacts would disproportionately impact particular groups over others.

Air pollution and housing standards

A higher proportion of people from a non-white ethnic background are more likely to be exposed to higher levels of air pollution. 36% of black, black British, Caribbean or African people, 33% of people of 'other' ethnic groups, 28% of Asian or Asian British people and 21% of people of mixed or multiple ethnic groups live in the 10% most polluted neighbourhoods.[170] This compares with just 7% of white people living in the most polluted neighbourhoods. Policies to reduce air pollution through decarbonising public transport and investing in active travel schemes and delivering more public transport choices and better services may have a disproportionate impact on those who are living in highly polluted areas.

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[168] ASH (2024). 'Tobacco and ethnic minorities' https://ash.org.uk/resources/view/tobacco-and-ethnic-minorities Accessed 11 July 2025
[169] GOV.UK (2024). 'Overweight adults' https://www.ethnicity-facts-figures.service.gov.uk/health/diet-and-exercise/overweight-adults/latest/ Accessed 11 July 2025
[170] The Health Foundation (2024). 'Inequalities in likelihood of living in polluted neighbourhoods' https://www.gov.uk/government/publications/improving-outdoor-air-quality-and-health-review-of-interventions Accessed 11 July 2025

Asthma and Lung UK's response to the Change NHS portal referenced that it is those least responsible for air pollution who are often the most exposed, with evidence showing that exposure to air pollution is disproportionately experienced by people living on lower incomes and from ethnic minority backgrounds.[171]

In the 2 years to March 2021, an average of 12.6% of white households were in fuel poverty, compared with 19.1% of households from all other ethnic groups combined.[172]. The disproportionate exposure of minority ethnic groups to damp and mould can also lead to worse health outcomes, including the development of asthma and respiratory illness.[173] [174]. Therefore, the proposals for a new Fuel Poverty Strategy and Warm Homes Plan are likely to contribute to addressing racial inequalities in housing conditions.

Screening uptake

People of Black African origin are disproportionally affected by HIV. They represent a third of the people in HIV care but only represent around 4% of the UK population.[175] This is associated with the prevalence of HIV in their countries of origin and complicated by late diagnosis, requiring culturally competent and targeted interventions. The plan lays out an ambition to end new transmissions of HIV through the HIV action plan, which will particularly impact these individuals, and efforts in the plan to improve testing will help identify the need for and initiation of HIV pre-exposure prophylaxis (PrEP) among communities that are at greater risk.

Some ethnic minority communities have lower participation rates in screening services, potentially due to access barriers and higher stigma.[176] Improving access and uptake of screening services through the national cancer plan will have a positive impact on individuals who may be facing these barriers.

Reforms to NIHR funding and introducing frameworks to encourage more private sector research and development investment into prevention will have a positive impact on people in ethnic groups that are more at risk of certain conditions, for example there is a

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[171] GOV.UK (2019). 'Improving outdoor air quality and health: review of intentions' https://www.gov.uk/government/publications/improving-outdoor-air-quality-and-health-review-of-interventions Accessed 11 July 2025

[172] GOV.UK (2022). 'Fuel poverty' https://www.ethnicity-facts-figures.service.gov.uk/housing/housing-conditions/fuel-poverty/latest/ Accessed 11 July 2025

[173] Understanding and addressing the health risks of damp and mould in the home - GOV.UK

[174] GOV.UK (2024). 'English Housing Survey data on dwelling condition, security and fire safety' https://www.gov.uk/government/statistical-data-sets/dwelling-condition-and-safety#full-publication-update-history Accessed 11 July 2025

[175] National Aids Trust (2024). 'UK HIV statistics' https://nat.org.uk/about-hiv/hiv-statistics/ Accessed 11 July 2024

[176] Charlotte Vrinten and others, 'Cancer Stigma and Cancer Screening Attendance: A Population Based Survey in England' (2019) 19 BMC Cancer.

higher risk of cardiovascular disease in South Asian people compared to white Europeans. Increased research focus into preventable conditions could address these inequalities and lead to more equitable outcomes.

Genomics

Proposals to utilise genomic innovations in healthcare, such as expanding the NHS Genomics Medicine Service to create a new genomics population health service will have a mixed impact on people with regards to the protected characteristic of race. Genomics can reveal population-specific risks, leading to earlier interventions or diagnosis which will have positive impacts on groups who are at higher risks of certain conditions. However, there is evidence of racial bias in genetic datasets for polygenic risk scores, which are heavily skewed towards people of European ancestry.[177] In the UK Biobank, a large-scale biomedical database and research resource, 94.6% of the 500,000 participants are classed as White (compared to 76% in the 2021 Census)[178], 1.6% are classed as Black or Black British and 1.6% British South Asian.[179] Genetic diversity is important for equitable research, as genetic variants that play a role in health and disease will differ by ancestral population. A lack of diversity can result in delayed or misdiagnosis for some ethnic minority groups. There have been other substantial government investments to address the lack of representation of ethnic minorities in datasets, including Our Future Health, which has an ambition to recruit up to 5 million participants, including one million from ethnic minority and more disadvantaged socioeconomic groups and is beginning to address the lack of diversity. Ensuring the genomics population health service is accessible to all by the end of the decade and carrying out studies in the community will provide the opportunity for people of all ethnicities to take part, however this should be supported by informed consent and building trust with historically underserved populations.

Religion or belief

People who are of certain religions or beliefs may have lower participation rates in screening services, potentially due to access barriers, cultural factors and higher

[177] NHS Race and Health Observatory (2024). 'Ethnic inequities in genomics and precision medicine review report' https://nhsrho.org/research/ethnic-inequities-in-genomics-and-precision-medicine-review-report/ Accessed 11 July 2025
[178] GOV.UK (2022) 'Population of England and Wales' https://www.ethnicity-facts-figures.service.gov.uk/uk-population-by-ethnicity/national-and-regional-populations/population-of-england-and-wales/ Accessed 10 July 2025
[179] GOV.UK (2024). 'Equity in medical devices: independent review' https://www.gov.uk/government/groups/equity-in-medical-devices-independent-review Accessed 11 July 2025

stigma.[180] Improving access and uptake of screening services through the national cancer plan will have a positive impact on individuals who may be facing these barriers.

For example, the British Islamic Medical Association response to the Change NHS engagement exercise stated that there is a need for further studies, particularly qualitative research, to better understand the barriers preventing Muslim and other minority communities from participating in screening programs.

Sex

Smoking

Smoking rates are higher among men than women, with 14.5% of men in England smoking and 10.9% of women.[181] The policies in this chapter may therefore have a more positive impact on men. Measures in this chapter aim to reduce the number of new smokers through the Tobacco and Vapes Bill. There are also measures to encourage innovation to support smoking cessation through the new Health Coach programme and third-party tools via HealthStore. The equalities impacts of this are outlined in the assessment for chapter 2.

Obesity

Obesity rates differ according to sex. In 2022 to 2023, the prevalence of overweight (including obesity) was higher among men (69.2%) than women (58.6%),[182] According to an NHS survey, 45% of respondents were trying to lose weight, and this was more common among women (52%) than men (38%). Measures to encourage weight loss through healthy eating habits, physical activity and weight loss management may have a disproportionate effect on women who are more likely to engage.

Reducing alcohol intake

Alcohol consumption rates differ by sex. A greater proportion of men exceed the recommended weekly limit for alcohol consumption. In 2022, 30% of men exceeded the weekly limit, double the proportion of women (15%)[183]. The measures in this chapter will

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[180] Charlotte Vrinten and others, 'Cancer Stigma and Cancer Screening Attendance: A Population Based Survey in England' (2019) 19 BMC Cancer.
[181] GOV.UK (2023). 'Local tobacco control profiles for England: statistical commentary' https://www.gov.uk/government/statistics/local-tobacco-control-profiles-september-2023-update/local-tobacco-control-profiles-for-england-statistical-commentary-september-2023-update Accessed 11 July 2025
[182] GOV.UK (2024). 'Obesity profile: short statistical commentary' https://www.gov.uk/government/statistics/update-to-the-obesity-profile-on-fingertips/obesity-profile-short-statistical-commentary-may-2024 Accessed 11 July 2025
[183] House of Commons Library (2024). 'Statistics on alcohol: England' https://commonslibrary.parliament.uk/research-briefings/cbp-7626/ Accessed 11 July 2025

provide consumers with more information about the health risks of alcohol consumption to help them make more informed choices, resulting in better health outcomes and reduced risk of alcohol-linked morbidities for both men and women. There is likely to be a slight greater positive impact on men, who have higher average consumption rates and are therefore suffer more from direct alcohol harms. Deaths caused by alcohol are more prevalent among men. Over the past 2 decades, around two thirds of alcohol-specific deaths each year have been of men.[184]

Screening and vaccination

Men are generally more likely to develop CVD at a young age than women.[185] Measures to develop CVD prevention interventions are therefore likely to have a particularly positive impact on men who are likely to develop the condition at a young age, although the measures will have a positive impact on all individuals regardless of sex. Lung cancer prevalence is similar between sexes, although smoking rates are higher in men. The expansion of lung cancer screening would be more likely to include male participants who would benefit from earlier diagnosis of lung cancer.

Men are disproportionately impacted by HIV, especially men of Black African origin and men who have sex with men. The impacts on these 2 cohorts are further detailed in their respective sections. Of those receiving HIV care, 72% are men.[186] They are therefore most likely to benefit from the HIV action plan and reduction in transmissions.

The HPV vaccine is highly effective in preventing cervical cancer, with studies showing it has reduced cases by 90% in those who were vaccinated aged 12 to 13.[187] This has significantly improved health outcomes for women, and improving uptake for young people who have left school will have a positive impact on women in particular. The HPV vaccine also reduces the chance of getting other types of cancer which men are also susceptible to, so these measures will have positive impacts regardless of sex.

Increasing funding for prevention research may enable preventative medicines for women's health conditions, which would have positive impacts on the lives on women.

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[184] ONS (2021). 'Alcohol-specific deaths in the UK' https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/alcoholspecificdeathsintheuk/2021registrations Accessed 11 July 2025

[185] NHS England (2022). 'Cardiovascular disease' https://www.nhs.uk/conditions/cardiovascular-disease/ Accessed 11 July 2025

[186] National Aids Trust (2024). 'UK HIV statistics' https://nat.org.uk/about-hiv/hiv-statistics/ Accessed 11 July 2024

[187] Milena Falcaro and others, 'The Effects of the National HPV Vaccination Programme in England, UK, on Cervical Cancer and Grade 3 Cervical Intraepithelial Neoplasia Incidence: A Register-Based Observational Study' (2021) 398 The Lancet

Supporting employment

Fawcett Society research highlighted the gender health gap, and the lack of support women receive during employment.[188] The UK is losing 150 million working days each year due to women's poor health and a lack of suitable support and 42% of women have heard derogatory comments about a female employee's health in the workplace. Policy proposals to provide greater support to SMEs to assist their employees will have a disproportionately positive impact on women who are not receiving sufficient support at work, for example by providing more opportunity to raise health concerns and influencing workplace policy to help manage symptoms related to menstruation and menopause. The impact on pregnant women is discussed in the Pregnancy and Maternity protected characteristic section.

Genomics

Genomics and predictive analysis can be hugely beneficial to the population, supporting early detection of disease and enabling personalised prevention and treatment. Proposals to expand the use of genomics in healthcare are likely to have a positive impact on people with regard to the protected characteristic of age. Genomics can identify sex-related risks genetic risks, such as the BCRP mutation in women, allowing for earlier intervention and diagnosis.

Sexual orientation

Reducing alcohol intake

Evidence suggests that those in the LGBT community are likely to have higher levels of alcohol consumption than those who are not[189] [190]. Measures to reduce alcohol intake in those with high rates of consumption are therefore likely to have a positive impact on this group.

Screening

Gay and bisexual men, especially young white men who have sex with men (MSM) and ethnic minority MSM of all ages, continue to bear a disproportionate burden of new HIV infections and require continued vigilance and enhanced focus, in light of changing

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[188] The Fawcett Society (2024). 'The gender health gap: our stories' https://www.fawcettsociety.org.uk/the-gender-health-gap-our-stories Accessed 11 July 2025

[189] NO-ONE BLOOMS IN ISOLATION: COMMUNITY SUPPORT FOR SUBSTANCE MISUSE – LGBT Foundation

[190] The term LGB is used throughout this document in the sexual orientation sections. Where cited sources use broader terms such as LGBT, LGBT+, or LGBTQ+, those terms are retained to reflect the original language of the source.

patterns of sexual risk behaviour and high rates of bacterial STIs. Efforts in the HIV action plan to improve testing will help identify the need for and initiation of HIV pre-exposure prophylaxis (PrEP) among communities that are at greater risk.

Marriage and civil partnership (in relation to aim 1 only)

These proposals are assessed to have no impact on people with the protected characteristic of marriage and civil partnership, in line with the public sector equality duty, which applies to this characteristic only in relation to the elimination of unlawful discrimination (aim 1).

A devolved and diverse NHS: a new operating model

Age

Older adults

The fastest-growing age group (65 and over) is projected to continue to grow, and the population share of this age group is predicted to get larger[191]. Older adults are likely to be most affected by proposals for the shift to community-based care. The number of hospital care episodes is highest in the 75 to 79 age group and the most hospital outpatient appointment attendances are made by patients aged between 60 to 79[192, 193]. Older people therefore stand to be disproportionately affected - either positively or negatively - by significant change to the way services are delivered.

The proposed expansion of neighbourhood health services, delivered via localised neighbourhood health plans, is likely to improve access for older adults, particularly those with complex needs requiring input from multiple services. These plans will integrate public health, social care, housing, and community services at upper-tier local authority level. For older people with reduced mobility, cognitive decline, or dependency, more care delivered closer to home, along with delivering more care within the home, could reduce hospital admissions and address barriers to access, advancing equality of opportunity.

[191] Centre for Ageing Better (2025) State of ageing report https://ageing-better.org.uk/state-ageing-2025 Accessed 8 July 2025
[192] NHS England (2023) Hospital admitted patient care activity https://digital.nhs.uk/data-and-information/publications/statistical/hospital-admitted-patient-care-activity/2022-23/ Accessed 8 July 2025
[193] NHS England (2020) 'Hospital outpatient activity 2019-20' https://digital.nhs.uk/data-and-information/publications/statistical/hospital-outpatient-activity/2019-20/ Accessed 11 July 2025

Reinvigorating and reinventing foundation trusts - with a stronger focus on partnership working to secure wider health outcomes and equity - has the potential to improve services in areas of high older adult populations. Additionally, the performance framework could incentivise a focus on inequalities. In order to ensure maximum positive impact on older individuals or on communities with a high concentration of older people, it will be important for the implementation of this policy to ensure that all provider organisations are able to deliver to the high standards expected of foundation trusts so that the benefits are seen everywhere.

When older adults do require hospital care, patients will be given a greater choice of providers and information will be published on aspects such as journey times and waiting times. Patients will have greater control over their health and care through the NHS App, with the ability to get advice via an AI-powered chat, rate experience, choose a provider based on ratings and manage and book appointments.

Working age adults

The introduction of a Choice Charter will provide greater transparency on quality, patient experience and outcomes. Patients will have more control of their care through the NHS App, with access to AI-powered chat, provider ratings and appointment management. This will empower patient choice on provider selection and equalise opportunity for the most disadvantaged. However, some working age adults, such as those in areas of deprivation, can face digital exclusion and this could affect access to information[194]. Risks and mitigations regarding digital accessibility are addressed in full in the assessment for Chapter 2.

The commissioning of neighbourhood health services from a broader range of providers (such as voluntary, private and social enterprises) has the potential to increase service diversity and innovation. If designed around varied working patterns, this may help address existing access issues for shift workers, single parents and people in precarious employment, who may otherwise struggle to engage with traditional 9-to-5 NHS provision.

[194] Ofcom (2022). 'Digital exclusion research' https://www.ofcom.org.uk/phones-and-broadband/accessibility/exclusion Accessed 11 July 2025

Disability

In England, approximately 17% of the population are disabled and people in this group report worse access to healthcare. Barriers include long waiting lists and people often report that their needs are not understood[195] [196].

The introduction of neighbourhood health plans could improve coordination between health, social care, and public health. ICBs will establish better partnerships with local government and will draw upon data from population health analysis, outcomes indicators and diagnostic reports to understand specific requirements of the population served. They will ensure that money for local care systems is put to the best use to advance population health and reduce health inequalities.

For disabled people, who often rely on multiple overlapping services, this may address long-standing fragmentation. If disabled people and representative groups are involved in shaping these plans, and if data on disability and unmet need is actively used, this could support more responsive services and advance equality of opportunity. However, the positive impact will depend on the extent to which inclusive design and reasonable adjustments are embedded from the outset.

36% of inpatients in hospital travel over 50km for care[197]. A barrier for people with disabilities is access to transportation and disabled people are more likely to have multiple health needs and need NHS care more often[198]. ICBs will work closely with local authorities and will oversee a shift of money from hospitals to the community. They will ensure that money is directed toward advancement of population health and improving access to high-quality services. Investment in capacity in the community, including offering care within patients' homes, could reduce barriers and positively impact quality of opportunity for this group and access to neighbourhood services could reduce travelling distances for some disabled people.

However, there is a risk of exclusion for this group if accessibility and reasonable adjustments are not factored into the design of community-based services and mitigations

[195] ONS (2021) Disability, England and Wales: Census 2021 https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandwellbeing/bulletins/disabilityenglandandwales/census2021 Accessed 10 July 2025
[196] Dikaios Sakellariou and Elena S Rotarou, 'Access to Healthcare for Men and Women with Disabilities in the UK: Secondary Analysis of Cross-Sectional Data' (2017) 7 BMJ Open
[197] NHS England (2022). 'Summary findings from the AT dataset' https://digital.nhs.uk/data-and-information/publications/statistical/learning-disability-services-statistics/at-january-2022-mhsds-november-2021-final/ Accessed 11 July 2025
[198] Dikaios Sakellariou and Elena S Rotarou, 'Access to Healthcare for Men and Women with Disabilities in the UK: Secondary Analysis of Cross-Sectional Data' (2017) 7 BMJ Open

should include assistance for patients who need help navigating the system or understanding their care options.

The introduction of a new Choice Charter will ensure that the patient voice is heard. Patients will have more control of their care through the NHS App, with access to AI-powered chat, provider ratings and appointment management. This will empower patient choice on provider selection and equalise opportunity for the most disadvantaged (aim 2).

Disabled people are not a homogenous group - different people may have different circumstances, wishes and needs. The use of digital tools may greatly improve accessibility for patients with some disabilities, however this also holds the risk of exacerbating the digital divide and excluding those that may struggle with digital tools.

A study found that people with a disability are often more likely to use the internet for health-related activities compared to people without a disability.[199] However, 15% of adults with a disability have never used the internet, compared to 3% of individuals without a disability.[200] Mitigations will need to ensure accessible information is available for those people with disabilities who require support. Risks and mitigations regarding digital accessibility are addressed in full in the assessment of Chapter 2.

High performing providers will become foundation trusts and will be given greater flexibilities to meet the health needs of local populations. In order to ensure maximum positive impact on disabled individuals, it will be important for the implementation of this policy to ensure that all provider organisations are able to deliver to the high standards expected of foundation trusts so that the benefits are seen everywhere. The reforms should be supported by a strong focus on equitable allocation of resources and effective commissioning of services.

All providers will be required to connect with communities and take account of patient insight and clinical outcomes and patient experiences will feed into mechanisms to evaluate provider performance. Poor performing providers will be given greater support to improve, especially in disadvantaged communities where health needs are greatest and the NHS will continue to make use of private providers to manage waiting times, with expansion of NHS provision in the most disadvantaged areas.

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[199] Nuffield Trust (2020). 'Chart of the week: disabled people more likely to use the internet for health-related activities than non-disabled people' https://www.nuffieldtrust.org.uk/resource/chart-of-the-week-disabled-people-more-likely-to-use-the-internet-for-health-related-activities-than-non-disabled-people Accessed 11 July 2025

[200] ONS (2021). 'Internet users' https://www.ons.gov.uk/businessindustryandtrade/itandinternetindustry/datasets/internetusers Accessed 11 July 2025

Personal health budgets will be expanded for those with long-term health conditions so that they can determine the care they want and that best meets their needs. However, successfully navigating a personal budget requires a high level of health literacy, organisational skill, and advocacy, though with the right support health literacy does not have to belong to the patient themselves. Personal health budgets are assessed in more detail in the 'productivity: a new financial foundation' chapter EQIA.

Gender reassignment

Trans and non-binary people experience relatively poorer access to health services compared to other groups within the population. In the national LGBT survey 2018[201], 40% of trans respondents reported at least one negative experience of accessing healthcare because of their gender identity. Inequitable access can result in sub-optimal care, poorer experiences and worse mental and physical health outcomes. Trans people experience more problems with their mental health and report higher use of mental health services, than those without this protected characteristic.[202]

The shift to both stronger strategic commissioning at ICB level and more effective planning for neighbourhood health in localities will require a stronger emphasis on the needs of the population in all their diversity. As part of the effective commissioning and collaborative design of services, user and community voices will play a much stronger part, supported by measures such as the Choice Charter.

Pregnancy and maternity

Pregnant women engage with healthcare services at multiple points throughout their pregnancy journey[203]. Frequent contact with healthcare services is significantly higher for this protected group than that of non-pregnant women or men of similar age.[204]

Proposals include giving patients greater choice of hospital providers and information will be published on aspects such as waiting times. ICBs will invest in capacity in neighbourhood health services and ensure that money is directed toward advancement of population health and improving access to high-quality services in communities. Care

[201] BMA (2024). 'Inclusive care of trans and non-binary patients' https://www.bma.org.uk/advice-and-support/equality-and-diversity-guidance/lgbtplus-equality-in-medicine/inclusive-care-of-trans-and-non-binary-patients Accessed 11 July 2025
[202] The King's Fund (2022). 'Acting on the evidence: ensuring the NHS meets the needs of trans people' https://www.kingsfund.org.uk/insight-and-analysis/blogs/ensuring-nhs-meets-needs-trans-people Accessed 11 July 2025
[203] NHS - Maternity Services Monthly Statistics - NHS England Digital Accessed 29 June 2025
[204] NHS England (2023) Hospital admitted patient care activity https://digital.nhs.uk/data-and-information/publications/statistical/hospital-admitted-patient-care-activity/2022-23/ Accessed 8 July 2025

closer to home could reduce access barriers for pregnant women and improve experience of healthcare while pregnant, potentially reducing inequalities for people with this protected characteristic. However, no direct impacts related to pregnancy and maternity have been identified.

Race

18% of people in England and Wales belong to a Black, Asian, mixed or other ethnic group.[205] Some ethnic minority groups are more likely to report poorer experiences of using health services than the White British group.[206] and the highest rate of hospital admissions is for the 'Any other ethnic' group.[207] The proposals in this chapter have the potential to improve equity - particularly through local commissioning and enhanced patient voice - but outcomes will depend heavily on inclusive implementation.

Choice, access and inclusion

Proposals include patients being given a greater choice of providers when they require elective hospital care and information will be published on aspects such as journey times, waiting times. Patients will have greater control over their health and care through the NHS App, with the ability to get advice via AI-powered chat, rate experience, access quality metrics, choose a provider based on ratings and manage and book appointments more easily. This will empower patient choice and could equalise opportunity for the most disadvantaged (aim 2).

However, not all patients are equally able to exercise choice. Some ethnic minority communities may feel less confident navigating multiple options due to language barriers, previous experiences of discrimination, or limited digital access. In order for these reforms to deliver maximum benefits for people and communities with this protected characteristic they will need to be reinforced by a combination of targeted support - such as advocacy, accessible formats, and culturally competent information, as part of commissioning and delivery models.

People from ethnic minority groups are more likely to experience socioeconomic deprivation.[208] People who experience deprivation are more likely to be at risk of digital

[205] GOV.UK (2022) 'Population of England and Wales' Ethnicity facts and figures Accessed 10 July 2025
[206] The King's Fund (2023). The health of people from ethnic minority groups in England https://nhsrho.org/research/patient-experience-and-trust-in-nhs-primary-care/ Accessed 8 July 2025
[207] NHS England (2023) Hospital admitted patient care activity https://digital.nhs.uk/data-and-information/publications/statistical/hospital-admitted-patient-care-activity/2022-23/ Accessed 8 July 2025
[208] NHS Race and Health Observatory (2025) Patient experience and trust in NHS primary care https://nhsrho.org/research/patient-experience-and-trust-in-nhs-primary-care/ Accessed 8 July 2025

exclusion[209] and less likely to use the NHS App.[210] Risks and mitigations regarding digital accessibility are addressed in full in the assessment for Chapter 2.

Local commissioning and public health

The devolution of power from the centre, and the development of neighbourhood health plans offers an opportunity to address race-related health inequalities at a local level. These structures allow ICBs to tailor services to population needs, but their success will depend on how effectively they use data disaggregated by ethnicity, how meaningfully they engage with local communities, and whether equity is embedded in commissioning criteria.

The real-terms increase to the public health grant and new requirement for 5-year public health peer reviews could particularly benefit areas with high ethnic minority populations, who are overrepresented in more deprived parts of England[211] [212]. If this investment is used to improve access to services such as smoking cessation, sexual health and substance misuse support - all of which see disproportionate unmet need in some ethnic groups (for example, people of Black Caribbean ethnicity have disproportionately high rates of certain STIs) - this could advance equality of opportunity[213] [214] [215]. However, the benefits will depend on how local authorities prioritise and implement this funding.

Geographic variation and provider performance

High performing trusts will become foundation trusts and will develop services that meet local need. Patient outcomes and experiences will feed into mechanisms to evaluate provider performance. Improvement will be supported for providers with poor performance, especially in disadvantaged communities where health needs are greatest. It will be important for the reforms in this chapter to retain a strong focus on equitable allocation of

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[209] Ofcom (2022). 'Digital exclusion research' https://www.ofcom.org.uk/phones-and-broadband/accessibility/exclusion Accessed 11 July 2025
[210] Sukriti Kc and others, 'Uptake and Adoption of the NHS App in England: An Observational Study' (2023) 73 British Journal of General Practice https://doi.org/10.3399/BJGP.2022.0150
[211] GOV.UK (2020). 'People living in deprived neighbourhoods' https://www.ethnicity-facts-figures.service.gov.uk/uk-population-by-ethnicity/demographics/people-living-in-deprived-neighbourhoods/latest/ Accessed 10 July 2025
[212] NHS Race and Health Observatory (2025) Patient experience and trust in NHS primary care https://nhsrho.org/research/patient-experience-and-trust-in-nhs-primary-care/ Accessed 8 July 2025
[213] GOV.UK (2021). 'Promoting the sexual health and wellbeing of people from a Black Caribbean background: an evidence-based resource' https://www.gov.uk/government/publications/promoting-the-sexual-health-and-wellbeing-of-people-from-a-black-caribbean-background-an-evidence-based-resource Accessed 11 July 2025
[214] Women and Equalities Committee (2024). 'The prevalence of sexually transmitted infections in young people and other high risk groups' https://publications.parliament.uk/pa/cm5804/cmselect/cmwomeq/463/ Accessed 11 July 2025
[215] GOV.UK (2017). 'Illicit drug use' https://www.ethnicity-facts-figures.service.gov.uk/health/alcohol-smoking-and-drug-use/illicit-drug-use-among-adults/latest/ Accessed 11 July 2025

resources and effective commissioning of services to support the reduction of health inequalities at both national and system level.

Religion or belief

These proposals are assessed to have no specific or disproportionate impact for people with the protected characteristic of religion or belief.

Sex

Women interact with the health system more frequently than men, particularly during childbearing years and as carers. They are more likely to use primary care, mental health, and community services, and continue to provide the majority of unpaid family care[216] [217]. System-wide changes to NHS structure and access will therefore have a disproportionate impact on women - both as patients and informal care coordinators.

The shift toward neighbourhood-based, integrated services has the potential to advance equality of opportunity for both men and women - but in different ways. Women, who are more likely to be unpaid carers and to use multiple public services (for example, health, social care, early years), may benefit from more locally accessible, joined-up care that reduces the logistical and time burden of travelling between fragmented services[218] [219]. At the same time, men are statistically less likely to engage with community or preventive services (men are less likely to use the NHS Health Check service) and are more likely to delay seeking help[220] [221] [222]. Without proactive outreach and inclusive design, men may continue to underuse neighbourhood services, particularly in relation to mental health, substance misuse and early diagnosis. To be effective, neighbourhood health plans must be informed by sex-disaggregated data and consider different patterns of access, trust, and help-seeking behaviour. When requiring hospital care, patients will be given a greater

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[216] NHS England (2023) Hospital admitted patient care activity https://digital.nhs.uk/data-and-information/publications/statistical/hospital-admitted-patient-care-activity/2022-23/ Accessed 8 July 2025
[217] Yingying Wang and others, 'Do Men Consult Less than Women? An Analysis of Routinely Collected UK General Practice Data' (2013) 3 BMJ Open
[218] ONS (2021). 'Unpaid care by age, sex and deprivation, England and Wales: Census 2021' https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/socialcare/articles/unpaidcarebyagesexanddeprivationenglandandwales/census2021 Accessed 10 July 2025
[219] Sarah M Temkin and others, 'Chronic Conditions in Women: The Development of a National Institutes of Health Framework' (2023) 23 BMC Women's Health
[220] Yingying Wang and others, 'Do Men Consult Less than Women? An Analysis of Routinely Collected UK General Practice Data' (2013) 3 BMJ Open
[221] ONS (2022) Socioeconomic inequalities in avoidable mortality in England' https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/socioeconomicinequalitiesinavoidablemortalityinengland/2020 Accessed 11 July 2025
[222] Riyaz Patel and others, 'Evaluation of the Uptake and Delivery of the NHS Health Check Programme in England, Using Primary Care Data from 9.5 Million People: A Cross-Sectional Study' (2020) 10 BMJ Open.

choice of providers and information will be published on aspects such as journey times and waiting times. Proposals to invest in care in the community, including within patient's homes, and to improve quality of care have some potential to support greater equality of opportunity for this group (aim 2). However, no direct impacts related to sex have been identified.

That said, the introduction of stronger strategic commissioning, more effective planning for neighbourhood health and an enhanced patient voice, could help ensure that service providers are held to account for sex-based aspects of experience - for example, listening to pain reports, respecting reproductive healthcare choices, or avoiding dismissal of symptoms. If provider performance incorporates patient-reported experience data that is disaggregated by sex, this could drive improvements in how services respond to concerns and needs specific to men and women.

Sexual orientation

LGBT people experience greater health inequalities compared to heterosexual people, such as being at higher risk of poor mental health[223] [224]. LGB people are around one and one-half times more likely than heterosexual people to report unfavourable experiences with each of 4 aspects of primary care.[225]

The shift to both stronger strategic commissioning at ICB level and more effective planning for neighbourhood health in localities will require a stronger emphasis on the needs of the population in all their diversity. There will be a new failure regime to bring poor performers up to standard, with support in place to solve problems. The NHS will also develop its own self-financing improvement capability, drawing on talent and innovation. As part of the effective commissioning and collaborative design of services, user and community voices will play a much stronger part, supported by measures such as the Choice Charter.

Marriage and civil partnership (in relation to aim 1 only)

These proposals are assessed to have no impact on people with the protected characteristic of marriage and civil partnership, in line with the public sector equality duty,

[223] NHS (2024). Sexual orientation https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/mental-health-services-data-set/submit-data/data-quality-of-protected-characteristics-and-other-vulnerable-groups/sexual-orientation#:~:text=Research%20shows%20that%20that%20lesbian,out%20on%20routine%20health%20screening. Accessed 8 July 2025.
[224] The term LGB is used throughout this document in the sexual orientation sections. Where cited sources use broader terms such as LGBT, LGBT+, or LGBTQ+, those terms are retained to reflect the original language of the source.
[225] Marc N Elliott and others, 'Sexual Minorities in England Have Poorer Health and Worse Health Care Experiences: A National Survey' (2014) 30 Journal of General Internal Medicine 9

which applies to this characteristic only in relation to the elimination of unlawful discrimination (aim 1).

A new transparency of quality of care

Age

Older adults

Proposals to publish quality performance data include patients being able to access quality measures on NHS.UK and via the NHS App. Patients will have the ability to search for dimensions that matter to them, such as waiting times, patient ratings and clinical outcome measures, informing patient choice and specific to their local area.

The fastest-growing age group over the next 10 years is those aged 65 and over[226]. Older people are less likely to have used online services and are at higher risk of digital exclusion. Those aged 75 and over are statistically less likely to have internet access at home and only 15% of people aged 85 and older use the online services available in primary care [227] [228]. Older people therefore may be less likely to access the quality measures available, which might result in a disproportionate impact (aim 2). Mitigations could include alternative offline channels, such as providing leaflets in accessible formats, which could be explored by the department on considering operational delivery. Risks and mitigations regarding digital accessibility are addressed in full in the assessment for Chapter 2.

Older adults are statistically more likely to report positive overall experiences with NHS services compared to younger age groups (people aged 65 and over were more likely to be satisfied (68%) with the quality of NHS care than those under 65 (47%)[229]. However, older adults are also higher users of the NHS - people aged 75 to 79 had the highest number of hospital admissions in 2022 to 2023 (1.9 million), and individuals aged 50 and over accounted for 64% of all admissions[230]. This increased contact means they are more

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[226] Centre for Ageing Better (2025) State of ageing report https://ageing-better.org.uk/state-ageing-2025 Accessed 8 July 2025
[227] Ofcom (2022). 'Digital exclusion research' https://www.ofcom.org.uk/phones-and-broadband/accessibility/exclusion Accessed 11 July 2025
[228] The Health Foundation (2020). 'Who gets in?' https://www.health.org.uk/reports-and-analysis/analysis/who-gets-in Accessed 11 July 2025
[229] The King's Fund (2025). 'Public satisfaction with the NHS and social care in 2024 (BSA)' https://www.kingsfund.org.uk/insight-and-analysis/reports/public-satisfaction-nhs-social-care-in-2024-bsa Accessed 11 July 2025
[230] NHS England (2023) Hospital admitted patient care activity https://digital.nhs.uk/data-and-information/publications/statistical/hospital-admitted-patient-care-activity/2022-23/ Accessed 8 July 2025

likely, in absolute terms, to experience safety concerns, neglect or failures in care. Efforts to improve transparency and feedback systems must therefore ensure that repeated users of services are not overlooked simply because they report satisfaction overall.

The forthcoming modern service frameworks, for example for frailty and dementia and CVD are designed to drive improvements in care standards and reduce unwarranted variation. An estimated 3% of the population aged 65 and over in England live with severe frailty, 12% with moderate frailty and 35% with mild frailty and 7.1% of older people have dementia[231] [232]. The risk of CVD increases with age. Almost 8% of people in their 60s are diagnosed with coronary heart disease, and over a third with hypertension which increases the risk of other CVD conditions.[233] By setting long-term outcome goals and best-practice intervention standards, the framework is intended to advance equality of opportunity for this group, who often experience fragmented or inconsistent care.

The proposal to remove the existing 3-year statutory time limit for the CQC to bring legal action is particularly relevant to older adults. The Francis Inquiry into Mid Staffordshire NHS Foundation Trust exposed appalling failures in basic care - including older patients left unwashed, unfed, or untreated for pain - and concluded that many concerns raised by families and staff were dismissed or ignored[234]. These failings disproportionately affected older adults, particularly those with multiple or complex needs. Allowing the CQC to act beyond the current time limits may improve accountability in similar cases and provide reassurance for patients and families who struggle to navigate complaints systems quickly.

Proposals for clinical teams to be eligible for financial incentives based on patient outcomes and feedback could support improvements in older people's care. However, older adults are less likely to leave online feedback or engage with app-based review systems due to low digital confidence[235]. There is therefore a risk that older adults' views may be underrepresented in the data used to determine these incentives. Mitigations may include carer-assisted feedback mechanisms and offline channels for feedback collection.

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[231] Age UK (2019). Later Life in the United Kingdom 2019 https://www.ageuk.org.uk/siteassets/documents/reports-and-publications/later_life_uk_factsheet.pdf Accessed 8 July 2025

[232] Raphael Wittenberg and others, 'Projections of Care for Older People with Dementia in England: 2015 to 2040' (2019) 49 Age and Ageing 264.

[233] British Heart Foundation (2018) The CVD challenge in England' https://www.bhf.org.uk/for-professionals/healthcare-professionals/data-and-statistics/ Accessed 11 July 2025

[234] GOV.UK (2013). 'Report of the Mid Staffordshire NHS Foundation Trust Public Enquiry' https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry Accessed 11 July 2025

[235] Parliamentary and Health Service Ombudsman (2015). 'Breaking down the barriers: Older people and complaints about health care' https://www.ombudsman.org.uk/publications/breaking-down-barriers-older-people-and-complaints-about-health-care-0 Accessed 11 July 2025

Working age adults

Greater transparency of quality and outcomes data could empower patient choice and trust for working age adults who can access this data, allowing patients to make more informed choices on provider selection.

However, some working age adults, such as those in areas of deprivation, can face digital exclusion and those in deprived areas are less likely to be registered to use the NHS app[236] [237].This lack of access could widen inequalities and risks should be mitigated via steps to remove digital barriers to ensure that access to information is equitable.

Proposals to enable incentives for high-performing clinical teams may result in improvements in quality for services used by working-age adults. However, as with older adults, this depends on equitable feedback mechanisms and appropriate targeting to avoid inadvertently privileging better-resourced areas.

Disability

In England, approximately 17% of the population are disabled and people in this protected characteristic group report worse access to healthcare[238]. Barriers include long waiting lists and people often report that their needs are not understood, they do not feel listened to, and they are perceived as patients of low priority due to their pre-existing conditions[239]. Barriers in communication such as the absence of BSL interpreters or information in the format required can result in additional delays for disabled people in diagnosis, treatment and recovery[240].

Proposals include sharing quality metrics and patient feedback with clinicians, teams and service leaders, who will be held to account for the quality of care they deliver. A new complaints pathway will review patient experiences, enabling the patient voice to be heard.

However, while the purpose here is to place more power in the hands of patients, it is essential to consider whose voices are heard and who is positioned to benefit from these reforms. Without deliberate inclusion of people across all underserved communities and

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[236] Ofcom (2022). 'Digital exclusion research' https://www.ofcom.org.uk/phones-and-broadband/accessibility/exclusion Accessed 11 July 2025
[237] Sukriti Kc and others, 'Uptake and Adoption of the NHS App in England: An Observational Study' (2023) 73 British Journal of General Practice https://doi.org/10.3399/BJGP.2022.0150
[238] ONS (2021) Disability, England and Wales: Census 2021 https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandwellbeing/bulletins/disabilityenglandandwales/census2021 Accessed 11 July 2025
[239] Dikaios Sakellariou and Elena S Rotarou, 'Access to Healthcare for Men and Women with Disabilities in the UK: Secondary Analysis of Cross-Sectional Data' (2017) 7 BMJ Open
[240] SignHealth (2025). 'Still ignored: the fight for accessible healthcare' https://signhealth.org.uk/resources/still-ignored-the-fight-for-accessible-healthcare/ Accessed 11 July 2025

protected characteristics, such as disabled people, there is a risk that some communities may remain under-represented in both design and delivery.

The proposal for patients to be able to access quality measures on NHS.UK and the NHS App, including transparency on waiting list information, patient ratings, outcomes and quality, could have a positive impact across the aims of the PSED. This could lead to improved patient choice and better access to healthcare for disabled people. Improving patient experience could help to promote equality between those that share this characteristic and those that do not.

Disabled people are not a homogenous group - different people may have different circumstances, wishes and needs. The use of digital tools may greatly improve accessibility for patients with some disabilities; however this also holds the risk of exacerbating the digital divide and excluding those that may struggle with digital tools.

A study found that people with a disability are more likely to use the internet for health-related activities compared to people without a disability (23% compared to. 13%).[241]. However, 15% of adults with a disability have never used the internet, compared to 3% of individuals without a disability.[242]. Access to digital tools could benefit some disabled people but exclude others (aim 1), therefore it is essential that mitigations are put in place to ensure accessibility and support for this group. Risks and mitigations regarding digital accessibility are addressed in full in the assessment for Chapter 2.

The use of Patient-Reported Outcome Measures (PROMs) and Patient-Reported Experience Measures (PREMs) as part of the transparency agenda may benefit disabled people by offering a more systematic and person-centred means of capturing how care affects daily life. These tools shift focus from institutional or clinical views to patient perspectives - a shift that is likely to be particularly meaningful for disabled people, whose health outcomes often depend on experience and accessibility rather than clinical metrics alone.

The creation of a National Director of Patient Experience, and efforts to bring the patient voice ‘in house’, also hold potential for this group. Ensuring disabled people’s voices are directly incorporated into national systems may increase visibility of recurring access or quality issues. However, feedback systems must be co-designed to capture diverse experiences, for example, by offering easy read formats, BSL options and offline or supported submission routes.

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[241] Nuffield Trust (2020). ‘Chart of the week: disabled people more likely to use the internet for health-related activities than non-disabled people’ https://www.nuffieldtrust.org.uk/resource/chart-of-the-week-disabled-people-more-likely-to-use-the-internet-for-health-related-activities-than-non-disabled-people Accessed 11 July 2025

[242] ONS (2021). ‘Internet users’ https://www.ons.gov.uk/businessindustryandtrade/itandinternetindustry/datasets/internetusers Accessed 11 July 2025

The new complaints model, including AI triage tools and clearer standards for timeliness and tone of responses, may help address longstanding concerns around poor complaint handling for disabled people. A 2024 report by the Parliamentary and Health Services Ombudsman (PHSO) identified that around 44% of the complainants surveyed report that they have a disability. This is significantly above the population average of 17%. Improving responsiveness, transparency and feedback loops could help build trust and reduce complaints fatigue among disabled patients and carers.

Changes to the CQC's operating model - particularly the shift to an intelligence-led approach with rapid response inspections - may also be of significance. Disabled people and people with learning disabilities frequently experience accessibility issues in NHS services, including communication barriers, physical inaccessibility and lack of reasonable adjustments[243] [244]. The use of AI to trigger inspections and access more granular patient safety data may help services respond more swiftly to care failures affecting disabled people, especially those receiving community or long-term care.

The development of a new national quality strategy, and the introduction of modern service frameworks focused on conditions including CVD and mental health (including severe and enduring mental illness), also offer opportunities for equity-focused quality improvement. Disabled people - particularly those with mental health conditions, learning disabilities or neurodivergent profiles - often experience lower standards of care and outcomes[245]. These frameworks are expected to prioritise conditions where the best means to "drive up value and equity" exist. However, attention must be paid to intersectional factors (for example, disability and race, disability and deprivation) to avoid replicating inequalities within quality improvement initiatives.

Finally, the introduction of financial incentives for clinical teams based on outcomes and feedback must be implemented with caution. If patient feedback is used to determine performance-based rewards, then services for people with communication impairments, low literacy or low engagement may be disadvantaged unless feedback tools are designed inclusively. There is a risk of undercounting the experiences of people less likely or able to submit formal feedback. Incentive structures must avoid reinforcing existing bias or neglect.

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[243] Health Services Safety Investigations Body (2023). 'Caring for adults with a learning disability in acute hospitals' https://www.hssib.org.uk/patient-safety-investigations/caring-for-adults-with-learning-disabilities-in-acute-hospitals/investigation-report/ Accessed 11 July 2025
[244] Healthwatch (2024). 'NHS buildings – your stories' https://www.healthwatch.co.uk/blog/2024-07-29/nhs-buildings-your-stories Accessed 11 July 2025
[245] King's College London (2022). 'Learning from lives and deaths – people with a learning disability and autistic people (LeDeR)' https://www.kcl.ac.uk/research/leder Accessed 11 July 2025

Gender reassignment

Trans and non-binary people experience relatively poorer access to health services compared to other groups within the population. Inequitable access can result in people receiving less care or sub-optimal care, which can lead to poorer experiences and worse mental and physical health outcomes. 70% of respondents to TransActual's Trans Lives Survey in 2021 reported being impacted by transphobia when accessing non-transition related healthcare.[246]

Patient reported outcome measures (PROMs) and patient-reported experience measures (PREMs) will measure the impact of care from a patient perspective. However, some people in this protected group who have poor care experiences may be reluctant to take part in voluntary data collection and data could therefore be lacking for this protected characteristic.

Improved patient choice and experience, alongside a louder patient voice, could reduce the risk of missing out on care when it is needed due to fear of a negative experience. This would help to promote equality between those that share the characteristic and those that do not (aim 2). However, while the vision is to place more power in the hands of patients, it is essential to consider whose voices are heard and who is positioned to benefit from these reforms. Without deliberate inclusion of people across all underserved communities and protected characteristics, such as trans people, there is a risk that some communities may remain under-represented in both design and delivery.

Pregnancy and maternity

For individuals aged between 20 and 39, females are significantly more likely to seek hospital treatment, predominantly due to maternity services.[247].

Data standardisation means that poor quality maternity care could be detected earlier. A new Maternity Outcomes Signal System (MOSS) system will be introduced, drawing information from existing NHS national data systems, this tool will utilise near-real time data to indicate deterioration in services so that swift action can be taken.

An independent investigation into maternity and neonatal services will conduct urgent reviews and systematically investigate care. A set of national actions will drive the improvements needed, ensuring high quality care and that women are listened to. A

[246] TransActual (2021). 'Trans lives survey 2021: Enduring the UK's hostile environment' https://transactual.org.uk/trans-lives-21/ Accessed 11 July 2025
[247] NHS England (2023). 'Hospital admitted patient care activity, 2022-23' https://digital.nhs.uk/data-and-information/publications/statistical/hospital-admitted-patient-care-activity/2022-23/summary-reports-copy Accessed 11 July 2025

National Maternity and Neonatal Taskforce will be established and an action plan, co-produced with bereaved families, will lead to improvement of maternity and neonatal quality and safety, ensuring that families who are harmed or bereaved get answers about what happened.

Access to quality metrics could benefit people who use maternity services due to greater transparency and patient choice, improving equality for this group (aim 2). However, there is a risk of digital exclusion for some women, including those in deprived areas, as people who experience deprivation are more likely to be at risk of digital exclusion[248] and less likely to be registered to use the NHS App[249]. Mitigation involves ensuring that digital services are inclusive for all, with offline alternatives available. Risks and mitigations regarding digital accessibility are addressed in full in the assessment for Chapter 2.

Race

Proposals are likely to have a mixed impact under aims of the PSED for people with this protected characteristic. Approximately 18% of people in England and Wales belong to a black, Asian, mixed or other ethnic group [250]. Some ethnic minority groups are more likely to report poorer experiences of using health services than the White British group [251].

However, it is recognised that it is important not to regard people from different ethnic minority groups as having the same experiences of discrimination or other inequalities in access[252]. However often the fact that ethnicity data is insufficiently disaggregated makes it difficult to understand these differences[253]. Research has shown that certain white ethnic minorities, such as Gypsy, Roma and Traveller communities, face significant disadvantages in areas like education, employment, and health and some disparities are also evident in relation to newer migrant communities including those from Eastern Europe[254].

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[248] Ofcom (2022). 'Digital exclusion research' https://www.ofcom.org.uk/phones-and-broadband/accessibility/exclusion Accessed 10 July 2025
[249] Sukriti Kc and others, 'Uptake and Adoption of the NHS App in England: An Observational Study' (2023) 73 British Journal of General Practice https://doi.org/10.3399/BJGP.2022.0150
[250] GOV.UK (2025). 'Population of England and Wales' Ethnicity facts and figures Accessed 10 July 2025
[251] The King's Fund (2023). 'The health of people from ethnic minority groups in England' https://www.kingsfund.org.uk/insight-and-analysis/long-reads/health-people-ethnic-minority-groups-england#:~:text=people%20from%20the%20White%20Gypsy,inequalities%20in%20health%20is%20difficult. Accessed 10 July 2025
[252] EHRC (2020). 'Race report statistics' https://www.equalityhumanrights.com/our-work/our-research/race-report-statistics?form=MG0AV3&form=MG0AV3 Accessed 10 July 2025
[253] Marta Pineda-Moncusí and others, 'Ethnicity Data Resource in Population-Wide Health Records: Completeness, Coverage and Granularity of Diversity' (2024) 11 Scientific Data 221
[254] EHRC (2020). 'Race report statistics' https://www.equalityhumanrights.com/our-work/our-research/race-report-statistics?form=MG0AV3&form=MG0AV3 Accessed 10 July 2025

Persistent inequalities in access, experience and outcomes are well documented. Language barriers and poor communication contribute significantly to dissatisfaction and lower engagement. 47% of Black and 34% of Asian patients report feeling they were treated differently in healthcare because of their ethnicity.[255]

The proposals in this chapter include published data metrics on quality and outcomes and new mechanisms to flow quality metrics and patient feedback to individual clinicians and service leaders, who will be held to account for quality of care. The new complaints pathway will compassionately review patient experiences. Greater transparency on outcomes by ethnicity and deprivation indices and greater clinical accountability, could help to identify inequalities, leading to direct action to reduce or remove these disparities.

The creation of a National Director of Patient Experience offers a national opportunity to bring attention to long-standing racial disparities in care experiences. This role is intended to provide stronger oversight of how patient voices are heard, including those from ethnic minority groups, who have historically faced worse experiences of NHS care.

Quality performance data will be published that patients can access on NHS.UK and the NHS App, with the ability to search for dimensions such as waiting times, patient experience and clinical outcomes measures, allowing for patient choice. However, there is a potential risk of digital exclusion for ethnic minorities if public platforms are not accessible to those in this protected group who lack digital literacy. Ethnic minorities are more likely to experience socioeconomic deprivation[256] . People who experience deprivation are more likely to be at risk of digital exclusion[257] and less likely to use the NHS app[258]. This risk should be mitigated via steps to remove digital barriers and enable offline alternatives and language options. Risks and mitigations regarding digital accessibility are addressed in full in the assessment for Chapter 2.

The revised NHS complaints system, with clearer standards for response quality and timeliness and the use of AI to triage complaints, may improve the responsiveness of services to ethnic minority patients who report concerns. The NHS Race and Health Observatory highlighted that Black and minority ethnic individuals often experience a lack

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[255] NHS Race and Health Observatory (2025) Patient experience and trust in NHS primary care https://nhsrho.org/research/patient-experience-and-trust-in-nhs-primary-care/ Accessed 8 July 2025
[256] The King's Fund (2023). 'The health of people from ethnic minority groups in England' https://www.kingsfund.org.uk/insight-and-analysis/long-reads/health-people-ethnic-minority-groups-england#:~:text=people%20from%20the%20White%20Gypsy,inequalities%20in%20health%20is%20difficult. Accessed 10 July 2025
[257] Ofcom (2022). 'Digital exclusion research' https://www.ofcom.org.uk/phones-and-broadband/accessibility/exclusion Accessed 10 July 2025
[258] Sukriti Kc and others, 'Uptake and Adoption of the NHS App in England: An Observational Study' (2023) 73 British Journal of General Practice https://doi.org/10.3399/BJGP.2022.0150

of cultural understanding or report being dismissed when raising safety issues - contributing to lower satisfaction and trust[259] [260].

The proposed modern service frameworks, with a specific focus “driving up value and equity”, could support improvements for conditions where disparities are most severe - such as diabetes, cardiovascular disease and maternal mortality. Black and Asian communities are disproportionately affected by these conditions (CVD is higher among Black and South Asian groups than white groups) and often receive lower-quality care[261] [262]. Embedding equity goals and outcome monitoring within the frameworks could help address these gaps, particularly if local commissioners are held to account for reducing disparities.

Patient reported outcome measures (PROMs) and patient-reported experience measures (PREMs) will measure the impact of care from a patient perspective. There is a risk that data collection may not be consistently gathered across all protected characteristic groups, therefore it is important that mitigations include ensuring consistency across all characteristics.

Benefits for these groups will only be realised if proposals are implemented with attention to the structural and intersectional barriers experienced by Black, Asian and minority ethnic communities.

Religion or belief

These proposals are assessed to have no specific or disproportionate impact for people with the protected characteristic of religion or belief.

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[259] NHS Race and Health Observatory (2022). ‘Ethnic equality in raising worries and concerns’ https://nhsrho.org/resources/ethnic-equality-in-raising-worries-and-concerns/ Accessed 10 July 2025
[260] NHS Race and Health Observatory (2022). ‘Ethnic inequalities in healthcare: a rapid evidence review’ https://nhsrho.org/research/ethnic-inequalities-in-healthcare-a-rapid-evidence-review-3/ Accessed 10 July 2025
[261] Martin B Whyte and others, ‘Disparities in Glycaemic Control, Monitoring, and Treatment of Type 2 Diabetes in England: A Retrospective Cohort Analysis’ (2019) 16 PLOS Medicine https://doi.org/10.1371/journal.pmed.1002942
[262] The King’s Fund (2023). ‘The health of people from ethnic minority groups in England’ https://www.kingsfund.org.uk/insight-and-analysis/long-reads/health-people-ethnic-minority-groups-england#:~:text=people%20from%20the%20White%20Gypsy,inequalities%20in%20health%20is%20difficult. Accessed 10 July 2025

Sex

Women report being less satisfied with NHS services than men[263]. Access to quality metrics and patient outcomes via the NHS App, offering transparency and patient choice, could improve experiences for this group and lead to improved equality (aim 2).

However, there is a risk of digital exclusion for women in deprived areas, as people who experience deprivation are more likely to be at risk of digital exclusion [264]. Mitigations include ensuring availability of accessible materials, including provision of alternative offline channels. Risks and mitigations regarding digital accessibility are addressed in full in the assessment for Chapter 2.

The introduction of a new national maternity PREM from 2026, alongside near real-time monitoring of outcomes via the Maternity Outcomes Signal System (MOSS), aims to improve the safety, personalisation and responsiveness of maternity care. These reforms take place against the backdrop of repeated maternity safety failures - most notably at Shrewsbury and Telford (Ockenden, 2022) and East Kent (Kirkup, 2022) - where women reported not being listened to and concerns being dismissed, often with tragic consequences[265] [266]. The system-wide recognition of these failings underscores the importance of embedding patient voice and outcome monitoring into maternity services.

An independent investigation into maternity and neonatal services will conduct urgent reviews and systematically investigate care. A set of national actions will aim to drive improvements in quality of care and to ensure that women are listened to. A National Maternity and Neonatal Taskforce will produce an action plan to improve maternity and neonatal quality and safety.

The Reproductive Health Survey further confirms that women often feel their health concerns - especially in areas such as gynaecology, pain, or contraception - are dismissed or minimised[267]. The explicit use of that survey's findings to inform new patient experience

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[263] The King's Fund (2023). 'Public satisfaction with the NHS and social care in 2022' https://www.kingsfund.org.uk/insight-and-analysis/reports/public-satisfaction-nhs-and-social-care-2022#:~:text=Satisfaction%20and%20dissatisfaction%20in%202022&text=Figure%202a%20shows%20that%20male,differences%20were%20not%20statistically%20significant. Accessed 10 July 2025

[264] Ofcom (2022). 'Digital exclusion research' https://www.ofcom.org.uk/phones-and-broadband/accessibility/exclusion Accessed 10 July 2025

[265] GOV.UK (2022) 'Ockenden review: summary of findings, conclusions and essential actions' https://www.gov.uk/government/publications/final-report-of-the-ockenden-review/ockenden-review-summary-of-findings-conclusions-and-essential-actions Accessed 10 July 2025

[266] GOV.UK (2022). 'Maternity and neonatal services in East Kent: "Reading the signals" report' https://www.gov.uk/government/publications/maternity-and-neonatal-services-in-east-kent-reading-the-signals-report Accessed 10 July 2025

[267] Melissa J Palmer, Ona L McCarthy and Rebecca S French, 'The Burden of Poor Reproductive Health in England: Results from a Cross-Sectional Survey' [2025] BJOG: An International Journal of Obstetrics & Gynaecology. https://doi.org/10.1111%2F1471-0528.18133

metrics for women's health represents a significant opportunity to make services more responsive to women's needs and supports PSED aim 2.

The updated complaints system, which includes AI triage, rapid response requirements and clear standards on tone and engagement, could also improve trust among women. 84% of women who responded to the Women's Health, Let's Talk About It Survey for the Women's Health Strategy call for evidence reported that there have been times when they were not listened to by health professionals[268].

However, care must be taken to ensure that new tools for patient feedback and engagement reflect the full diversity of women's experiences, including those of disabled women, migrant women, survivors of domestic abuse, and women from ethnic minority backgrounds. Without inclusive design and deliberate outreach, structural inequalities may be replicated rather than resolved.

Sexual orientation

LGBT people experience greater health inequalities compared to heterosexual people and are about one-and-a-half times more likely than heterosexual people to report unfavourable experiences with each of 4 aspects of primary care[269] [270] [271].

Mechanisms will be introduced to flow quality metrics and patient feedback to clinicians, teams and service leaders and they will be held to account for the quality of care they deliver. A new complaints pathway will review patient experiences and provide rapid answers.

Quality performance data on outcomes and patient experience will be published and will be available for patients to view on NHS.UK and the NHS App. These measures will lead to greater transparency, allow for the patient voice to be heard and help to promote equality.

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[268] GOV.UK (2022). 'Results of the "Women's Health – Let's talk about it" survey' https://www.gov.uk/government/calls-for-evidence/womens-health-strategy-call-for-evidence/outcome/results-of-the-womens-health-lets-talk-about-it-survey Accessed 10 July 2025

[269] NHS England (2024). 'Sexual orientation' https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/mental-health-services-data-set/submit-data/data-quality-of-protected-characteristics-and-other-vulnerable-groups/sexual-orientation. Accessed 10 July 2025

[270] Marc N Elliott and others, 'Sexual Minorities in England Have Poorer Health and Worse Health Care Experiences: A National Survey' (2014) 30 Journal of General Internal Medicine 9

[271] The term LGB is used throughout this document in the sexual orientation sections. Where cited sources use broader terms such as LGBT, LGBT+, or LGBTQ+, those terms are retained to reflect the original language of the source.

Patient reported outcome measures (PROMs) and patient-reported experience measures (PREMs) will measure the impact of care from a patient perspective. However, some people in this protected group who have poor care experiences may be reluctant to take part in voluntary data collection and data could therefore be lacking for this group.

While the vision is to place more power in the hands of patients, there is a risk that not all patient voices will be heard equitably. Without deliberate inclusion of people across all underserved communities and protected characteristics, there is a risk that some communities may remain under-represented in both design and delivery.

The appointment of a National Director of Patient Experience, and efforts to consolidate and standardise patient voice mechanisms, present an opportunity to strengthen visibility and accountability around the experiences of LGB patients. If data is collected and analysed with appropriate disaggregation and safeguarding, this role could help ensure that patterns of discrimination or poor care are more consistently addressed.

The revised NHS complaints system, including standards for tone, timeliness and use of AI-supported triage, may also help to address concerns from LGB patients about being dismissed or invalidated. A compassionate and transparent complaints process may support more equitable access to redress and learning.

Finally, the introduction of flexibilities for local employers to make performance-based incentives for clinical teams must be monitored for equity impacts. If patient experience data is used to inform rewards, it will be critical that collection methods are inclusive of LGB patients. Barriers such as fear of disclosure, poor prior experiences or lack of representation in surveys may otherwise lead to underreporting and inadvertently exclude the needs of this group from quality improvement frameworks.

Marriage and civil partnership

These proposals are assessed to have no impact on people with the protected characteristic of marriage and civil partnership, in line with the public sector equality duty, which applies to this characteristic only in relation to the elimination of unlawful discrimination (aim 1).

An NHS workforce fit for the future

Age

While some parts of the NHS workforce are ageing - for example, with over 44% of the NHS workforce aged 45 and over - other areas are seeing younger joiners[272]. The impact of workforce changes may therefore vary by profession and location, and policies must account for this diversity.

Flexible working

Proposals to improve flexible working, such as digitised HR services, app-based rostering, and the creation of a more agile workforce model, are expected to benefit staff across age groups but may be particularly positive for older staff. Greater flexibility around working hours and roles can support phased retirement and reduce the risk of early workforce exit, helping retain experienced staff.

The further development of flexible workforce models will increase opportunities for staff to contribute at different life stages, including older workers who may not be able or willing to work in traditional settings full-time. This could mitigate some age-related barriers to continued employment.

Health, wellbeing and digital inclusion

The roll-out of staff treatment hubs will improve access to high-quality occupational health and wellbeing services, including support for back conditions and mental health issues, 2 leading causes of long-term sickness absence[273] [274].These services will benefit older staff, who are more likely to have accumulated long-term health conditions over the course of their careers.

However, the shift toward digitisation, such as greater digital automation of HR, self-service onboarding, and AI integration in clinical care, must be designed to account for digital inclusion. Older staff are more likely to experience barriers to engaging with digital platforms and tools. The commitment that all NHS staff will have a personalised career

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[272] NHS England (2024) 'Equality & Diversity data by NHSE region, staff group and grade, December 2023' https://digital.nhs.uk/supplementary-information/2024/hchs-staff-by-protected-characteristics-nhse-region-sg-grade-dec23 Accessed 10 July 2025

[273] Nuffield Trust (2023). 'All is not well: Sickness absence in the NHS in England' https://www.nuffieldtrust.org.uk/resource/all-is-not-well-sickness-absence-in-the-nhs-in-england#:~:text=The%20reported%20reasons%20for%20absences,certain%20reasons%20for%20sickness%20absence. Accessed 10 July 2025

[274] NHS Employers (2025). 'Sickness absence toolkit' https://www.nhsemployers.org/toolkits/sickness-absence-toolkit Accessed 10 July 2025

coaching and development plan, based on ubiquitous digital literacy presents a significant opportunity - but also a potential risk - for older staff if appropriate support is not in place. At the same time, it is important to note that challenges with digital tools are not limited to older workers; staff of all ages may need tailored support. Ensuring adequate support, training, and user-friendly design will be essential to avoid unintentional disadvantage. More information on digital exclusion and mitigations is discussed in the assessment for Chapter 2.

Career development

Proposals for clinical apprenticeship models will also positively impact young people. However, nursing apprentices are more likely than undergraduate nurses to be aged 25 years and older[275]. The opportunity to earn while learning will reduce financial barriers faced by those who wish to join the healthcare profession and provide equity of opportunity.

The development of new advanced practice models for nurses, midwives and allied health professionals (AHPs) presents a significant opportunity for experienced staff to progress into more autonomous and specialised roles. These pathways are particularly relevant to older clinical staff, who are more likely to have the extensive experience required. As of 2023, the average age of NHS nurses was approximately 44 years, with 14.8 % aged 60 to 64[276]. Supporting progression into advanced practice may therefore help retain skilled staff later in their careers by providing fulfilling, senior-level roles without requiring transition into management or education tracks. This could mitigate early retirement driven by stagnation or a lack of meaningful progression options.

The expansion of 1,000 new postgraduate training places may benefit early-career staff most directly, but could also create opportunities for older, locally employed doctors seeking career progression, particularly those who may have taken non-traditional or interrupted training routes.

This chapter also includes a focus on lifelong learning and a shift to modular, skills-based training. This could support older staff looking to retrain, adapt their roles, or gain new competencies, particularly in digital and AI-enabled care. This reflects a more inclusive approach to professional development that recognises learning potential across all age groups.

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[275] The Health Foundation (2025). 'NHS nursing apprenticeships – breaking down barriers to nursing careers?' https://www.health.org.uk/features-and-opinion/blogs/nhs-nursing-apprenticeships-breaking-down-barriers-to-nursing-careers Accessed 10 July 2025

[276] Nursing and Midwifery Council (2025). 'March 2025 annual data report' https://www.nmc.org.uk/about-us/reports-and-accounts/registration-statistics/ Accessed 10 July 2025

The introduction of new NHS Staff Standards - which include system-wide commitments to flexible working, access to nutritious food and drink, support for occupational health, and action to tackle racism, sexual harassment, and violence against staff - will support both older and younger staff across the NHS. These standards may be particularly valuable for older workers, who are more likely to experience health conditions or be managing long-term workplace fatigue. However, they are also likely to benefit younger staff, who are often newer to the workforce and may face disproportionate risks of bullying, harassment or poor treatment due to lower seniority or insecure contracts. They are expected to provide important protections and promote equality of experience across age groups.

Disability

As of December 2024, 8% of staff who had disclosed their disability status identified as disabled, which is below the England average (17%), suggesting a disability employment gap and a reporting gap[277] [278]. However, the NHS staff survey data shows that nearly 1 in 4 members of the NHS workforce has lived experience of a disability or long-term condition[279]. The proportion of staff with a disability ranges from 10% of scientific and technical support staff to 4% of doctors. Between 2009 and 2023, the proportion of staff reporting a disability increased from 5% to 7%. This increase is likely to reflect improvements in disclosure and recording rather than a true rise in prevalence.

Declaration rates among senior staff are lower than average. In 2023, 2.2% of senior leaders had declared a disability. This is lower than both the overall NHS declaration rate and the estimated proportion of disabled people in the wider population. As of 2023, 4 NHS trusts had no senior staff with a declared disability[280].

This context highlights areas where disparities in declaration rates and representation remain and provides a basis for understanding how the policies set out in this chapter are expected to have a positive impact on staff with disabilities across several dimensions of employment and experience. Safeguards will be needed to ensure that individual needs and reasonable adjustment continue to be met where roles change both in type and location.

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[277] NHS England (2025). 'NHS workforce statistics' https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics Accessed 10 July 2025
[278] House of Commons Library (2024) 'UK disability statistics: Prevalence and life experiences' https://commonslibrary.parliament.uk/research-briefings/cbp-9602/ Accessed 10 July 2025
[279] NHS England (2024). 'Workforce Disability Equality Standard: 2023 data analysis report for NHS trusts' https://www.england.nhs.uk/long-read/workforce-disability-equality-standard-2023-data-analysis-report-for-nhs-trusts/ Accessed 10 July 2025
[280] NHS England (2024). 'Workforce Disability Equality Standard: 2023 data analysis report for NHS trusts' https://www.england.nhs.uk/long-read/workforce-disability-equality-standard-2023-data-analysis-report-for-nhs-trusts/ Accessed 10 July 2025

Workplace standards and inclusive leadership

The new Staff Standards, to be introduced from April 2026, will set clear expectations for all NHS employers on working conditions. These include core standards for healthy work - such as access to nutritious food and drink, flexible working, and occupational health - and will also require action on racism, sexual harassment and violence against staff. For disabled staff, these measures may help address both physical and cultural barriers to inclusion, such as fatigue, inaccessible environments, inadequate support, or stigma. The chapter also proposes linking organisational performance on staff outcomes to CQC scrutiny, which may strengthen accountability for reasonable adjustments and inclusive practices.

Reforms to management and leadership standards and the introduction of a new code of practice could increase expectations for inclusive, accountable leadership. This may help challenge poor practices and support better management of reasonable adjustments. These frameworks should include disability awareness and accessibility standards to ensure that inclusion is embedded in performance expectations for all NHS leaders.

Disabled staff may benefit from appraisal systems that account for varied progression trajectories, reasonable adjustments, and workplace context. Traditional performance reviews have often been perceived as insufficiently flexible. A modern appraisal system that integrates inclusive practices could enable more equitable recognition of contribution, particularly where health conditions may affect consistency or role scope.

Health, wellbeing and flexible working

The roll-out of staff treatment hubs is likely to have a positive impact. By expanding access to occupational health and wellbeing services, particularly for musculoskeletal (MSK) conditions (in 2021, 30.8% of NHS staff reported MSK issues[281]) and mental health (the results of a 2024 survey of more than 1,000 NHS staff show that 76% of NHS staff said they have experienced a mental health condition in the last year[282]), both prevalent among disabled staff, staff treatment hubs supports staff with existing conditions to remain in work and thrive. Staff will see more flexible working options through these policies and app-based flexible rostering. These may be of particular benefit for staff who have specific health needs, for example, those with a long-term disability.

Remote service models may benefit disabled staff who face physical or environmental barriers to traditional in-person work. Professionals with mobility issues, long-term health

[281] NHS Employers (2022). 'NHS Staff Survey 2021: health and wellbeing' https://www.nhsemployers.org/articles/nhs-staff-survey-2021-health-and-wellbeing Accessed 10 July 2025
[282] NHS Charities Together (2024). 'Three in four NHS staff struggled with their mental health in the past year' https://nhscharitiestogether.co.uk/news/research/three-in-four-nhs-staff-struggled-with-their-mental-health-in-the-past-year/ Accessed 10 July 2025

conditions or energy-limiting impairments may find virtual roles more sustainable. However, implementation must ensure remote workers are not excluded from training, promotion or team engagement. Ensuring accessible technology, inclusive management practices and equitable appraisal structures will be important to avoiding indirect discrimination.

Digital transformation

Plans to pursue greater automation of HR services, including through a new NHS staff app, will simplify access to HR records, onboarding, flexible working requests and leave. These improvements will be especially beneficial for disabled staff who may previously have faced barriers navigating fragmented or inaccessible systems. The move to a single sign-on for NHS systems will also reduce friction and stress for all staff, but especially for those with physical or cognitive impairments who may struggle with complex logins.

However, increased reliance on digital systems also introduces potential new barriers. Not all disabled staff will benefit equally from digitisation. For example:

- staff with visual impairments or dexterity limitations may find some app interfaces or automation tools difficult to use if not designed with accessibility in mind
- neurodivergent staff may find some systems either overwhelming or overly rigid, depending on how user interfaces are constructed
- staff with learning disabilities may require more tailored training or support to access and benefit from digitised systems and AI-enabled tools

The chapter's ambition for all NHS staff to have a personalised career coaching and development plan by 2035 (underpinned by universal digital literacy) presents a good opportunity, but also a risk if not implemented inclusively. Disabled staff may face additional barriers accessing digital training or engaging with automated coaching platforms. These policies should be supported by accessible design and individualised support to ensure disabled staff are not unintentionally excluded from career development pathways.

The substantial reduction in time spent on statutory and mandatory training may relieve pressure on disabled staff who experience fatigue, concentration challenges, or difficulty completing long-form training. However, any replacement models should be accessible in both format and pace and avoid assuming a default level of digital ability. More information on digital exclusion and mitigations is discussed in the assessment for chapter 2.

The chapter's ambition for all NHS staff to become AI-trained and for AI to be used as a 'companion' in delivering care could offer practical benefits to some disabled staff, such as reducing cognitive or administrative burdens. However, there is a risk that AI tools designed without inclusive input could exacerbate disparities, especially if assumptions

about ability, communication, or pace of work are built into system defaults. Implementation should be underpinned by inclusive design principles and user testing that includes staff with a wide range of disabilities.

Career progression

In the UK, people with a disability are less likely to go to the university than people without. 22% of disabled people had a degree in 2019 compared with 38% of non-disabled people. Individuals with severe or specific learning difficulties were the disabled group least likely to have a degree (7%)[283]. A shift in investment away from solely degree-based courses to entry level jobs and apprenticeships will allow more opportunity for those who wish to join the healthcare profession to take a career path more suitable for their needs. This will have a disproportionately positive impact on those with disabilities who face barriers attending university and gaining degree qualifications.

The proposal to implement a fair pay agreement for adult social care staff may positively affect disabled workers in the sector. Estimates by the King's Fund suggest that approximately 2% of the adult social care workforce report having a disability[284]. However, this figure is likely to be significantly underreported due to stigma, lack of disclosure, and inconsistent workforce data collection. Standardising pay and conditions across the sector may reduce financial stress and improve job security for disabled staff, many of whom work in lower-paid or insecure roles.

Finally, measures to increase diversity of the NHS workforce by recruiting locally and supporting self-sufficiency by providing more career opportunities to those who are underrepresented, such as people with chronic conditions, and shifting towards more apprenticeship career pathways will have a positive impact on patients with disabilities. In the 2022 NHS staff survey, 28% of staff experienced presenteeism, and 27% did not believe their employer had made reasonable adjustments to enable them to carry out their work.[285]

[283] ONS (2019). 'Disability and education' https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/disability/bulletins/disabilityandeducationuk/2019#disability-and-education-data Accessed 10 July 2025
[284] The King's Fund (2024). 'The adult social care workforce in a nutshell' https://www.kingsfund.org.uk/insight-and-analysis/data-and-charts/social-care-workforce-nutshell#:~:text=is%20just%207%25.-,Demographics,to%2044%25%20of%20registered%20nurses.
[285] NHS England (2024). 'Workforce Disability Equality Standard: 2023 data analysis report for NHS trusts' https://www.england.nhs.uk/long-read/workforce-disability-equality-standard-2023-data-analysis-report-for-nhs-trusts/ Accessed 10 July 2025

Gender reassignment

In 2023, 0.4% of NHS staff were reported to identify as transgender[286]. The 2024 NHS Staff Survey found that 32% of staff who's 'sex is not the same as the sex registered at birth' reported bullying and harassment at work (compared to around 25% who's sex is the same as the sex registered at birth)[287]. Several of the policies have the potential to support improvements in workplace culture, accountability and staff voice, which may help to address some of the issues reported by transgender members of staff.

The introduction of updated Staff Standards will set minimum expectations for respectful treatment, inclusion and workplace safety. These standards will be supported by regular data publication at employer level and will feed into performance assurance frameworks. This could drive earlier intervention where trans staff experience poor treatment or report exclusionary practices.

Wider reforms to leadership and accountability, including the rollout of a new Management and Leadership Framework, are designed to ensure that those in leadership roles have the skills and expectations needed to build inclusive, respectful teams. This includes a focus on relational leadership and a shift away from top-down bureaucratic cultures that can suppress staff voice. Establishing legal mechanisms to disbar senior leaders for misconduct, including bullying, harassment or suppressing whistleblowers, may also strengthen trust among transgender staff.

Pregnancy and maternity

Most NHS employees in England are women[288]. Of these, many will become pregnant or have children during their careers. Across a 6-year period up until 2020, more than 17% of female nurses/midwives and doctors/dentists under the age of 50 went on maternity leave and, at any point in time, 3.7% of female doctors and dentists under the age of 50 and 3.4% of female nurses and midwives under the age of 50 were on maternity leave[289].

Flexible working is a central feature of the chapter. The greater digital automation of HR processes through a new NHS staff app, including flexible rostering and easier access to employment support, will make it simpler for staff to request and manage flexible working arrangements, particularly important for staff returning from maternity leave or managing

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[286] NHS Confederation (2025). 'Exploring LGBTQ+ staff experience in the NHS' https://www.nhsconfed.org/articles/exploring-lgbtq-staff-experience-nhs Accessed 10 July 2025
[287] NHS (2024). 'NHS staff survey national results' https://www.nhsstaffsurveys.com/results/national-results/ Accessed 10 July 2025
[288] Equality & Diversity data by NHSE region, staff group and grade, December 2023 - NHS England Digital
[289] Institute for Fiscal Studies (2022). 'Maternity and the labour supply of NHS doctors and nurses' https://ifs.org.uk/publications/maternity-and-labour-supply-nhs-doctors-and-nurses Accessed 10 July 2025

childcare responsibilities. The app may also reduce the administrative burden currently associated with returning to work. The staff treatment hubs will expand the availability of occupational health and wellbeing support, which could benefit staff during and after pregnancy.

Race

31% of NHS England staff are from an ethnic minority background - higher than the population average in England.[290] The proportion of ethnic minority staff ranges from 54% of doctors to 5% of ambulance staff. The proportion of staff whose ethnicity is known that are from ethnic minority groups has increased from 17% in 2009 to 30% in 2023.

Despite this growing diversity, ethnic minority staff continue to report significantly worse experiences in the workplace[291]. NHS Staff Survey data and stakeholder responses to the Change NHS engagement exercise highlight that these staff are more likely to experience bullying, discrimination, lack of support, and barriers to progression.

Workplace culture and leadership

The introduction of new Staff Standards will set out minimum conditions for respectful treatment, workplace safety and staff wellbeing, with published performance data linked to assurance frameworks. This may provide earlier visibility where ethnic minority staff are experiencing exclusion, burnout or discrimination, and strengthen organisational accountability.

Reforms to leadership, such as the new Management and Leadership Framework and the establishment of a College of Executive and Clinical Leadership, aim to raise standards, improve line management capability, and create clearer, fairer progression routes. 31% of NHS workforce are from an ethnic minority background, yet only 11% of executive roles are done by people from an ethnic minority background[292] [293]. Given the evidence that

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[290] NHS England (2024) Equality & diversity data by NHSE region, staff group and grade, December 2023' https://digital.nhs.uk/supplementary-information/2024/hchs-staff-by-protected-characteristics-nhse-region-sg-grade-dec23 Accessed 10 July 2025
[291] NHS England (2024). 'NHS Workforce Race Equality Standard (WRES)' https://www.england.nhs.uk/long-read/workforce-race-equality-standard-2023-data-analysis-report-for-nhs-trusts/ Accessed 10 July 2025
[292] NHS England (2024) Equality & diversity data by NHSE region, staff group and grade, December 2023' https://digital.nhs.uk/supplementary-information/2024/hchs-staff-by-protected-characteristics-nhse-region-sg-grade-dec23 Accessed 10 July 2025
[293] NHS England (2024). 'NHS Workforce Race Equality Standard (WRES)' https://www.england.nhs.uk/long-read/workforce-race-equality-standard-2023-data-analysis-report-for-nhs-trusts/ Accessed 10 July 2025

ethnic minority staff face disproportionate barriers in reaching senior roles, these changes may help improve leadership diversity and challenge cultural gatekeeping.

The planned shift to modern appraisal arrangements, focused on continuous development and feedback, could help address longstanding inequities in progression faced by ethnic minority staff. NHS Workforce Race Equality Standard (WRES) data shows persistent disparities in promotion and access to career development (39.3% of staff from a black background believes their trust provides equal opportunities for career progression or promotion[294]). Inclusive and evidence-based appraisals, especially when supported by anti-bias training for line managers, could help reduce these disparities and improve retention.

Committing to publish workforce data by socioeconomic background, sex and ethnicity can help expose disparities. The Race Equality Foundation notes that poor-quality ethnicity data hinders progress[295]. Routine, transparent reporting will allow more targeted interventions to tackle disproportionate barriers, such as those seen in recruitment, training progression, and pay, especially for ethnic minority staff. By publishing workforce data across these 3 dimensions, the system will be able to identify and address intersectional disadvantage. This level of granularity is essential to designing workforce policy that works for everyone.

Access to careers and widening participation

Ethnic minority staff are over-represented in the NHS workforce compared to the proportion in the general UK population. As of 2023, 31% of NHS England staff are from an ethnic minority background, compared to 18% in England and Wales[296] [297]. This reflects the valuable and essential contribution of ethnic minority professionals across all parts of the NHS. However, this is a well-evidenced correlation between ethnicity and socioeconomic disadvantage. Individuals from Black, Pakistani, Bangladeshi and some other ethnic minority backgrounds are statistically more likely to grow up in lower income households, experience educational disadvantage and face barriers to career

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[294] NHS England (2024). 'NHS Workforce Race Equality Standard (WRES)' https://www.england.nhs.uk/long-read/workforce-race-equality-standard-2023-data-analysis-report-for-nhs-trusts/ Accessed 10 July 2025

[295] Race Equality Foundation (2022). 'Improving the recording of ethnicity in health datasets' https://raceequalityfoundation.org.uk/projects/recording-of-ethnicity-project/ Accessed 10 July 2025

[296] NHS England (2024) Equality & diversity data by NHSE region, staff group and grade, December 2023' https://digital.nhs.uk/supplementary-information/2024/hchs-staff-by-protected-characteristics-nhse-region-sg-grade-dec23 Accessed 10 July 2025

[297] GOV.UK (2022). 'Population of England and Wales' https://www.ethnicity-facts-figures.service.gov.uk/uk-population-by-ethnicity/demographics/people-living-in-deprived-neighbourhoods/latest/ Accessed 10 July 2025

progression[298] [299]. These inequalities can influence access to and success in medical training.

The plan proposes to explore options for improving financial support for medical students from the lowest socioeconomic backgrounds, recognising that the high cost of studying medicine is a significant barrier for many. This is likely to have positive, indirect impacts on racial equality, given the disproportionate number of ethnic minority individuals affected by socioeconomic disadvantage.

Measures to increase diversity through local recruitment, expansion of apprenticeships, and accessible entry routes are likely to benefit ethnic minority communities, particularly in urban areas and areas of deprivation, where ethnic diversity is higher. This includes targeted funding for Widening Access Demonstrators.

The expansion of medical school places will be directed towards institutions with a strong record on widening participation, and reforms to admissions, including greater use of contextual data, are intended to support fairer access. Given that ethnic minority applicants are disproportionately affected by barriers to entry and success in medical education, these reforms could significantly improve representation in the medical profession over time.

These measures also have clear implications for patient care. A more representative workforce can improve trust in clinical advice, communication and adherence to treatment, especially when patients see themselves in the professionals who care for them. Patients are more likely to engage with services when they feel culturally understood. This makes widening access and building a locally rooted, diverse NHS workforce not just a workforce priority, but a quality imperative.

The chapter commits to building a more self-sufficient NHS workforce, with a shift away from international recruitment and towards local recruitment and apprenticeships, especially in communities experiencing poverty or unemployment. These policies could significantly benefit ethnic minority communities, particularly in urban areas where ethnic diversity is higher. Increased access to NHS jobs through earn-while-you-learn models and community-based recruitment may help address long-standing underemployment and access gaps.

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[298] GOV.UK (2020). 'People living in deprived neighbourhoods' https://www.ethnicity-facts-figures.service.gov.uk/uk-population-by-ethnicity/demographics/people-living-in-deprived-neighbourhoods/latest/ Accessed 10 July 2025

[299] GOV.UK (2022) 'Outcomes by ethnicity in schools in England' https://www.gov.uk/government/publications/outcomes-by-ethnicity-in-schools-in-england Accessed 10 July 2025

Targeted reforms to nursing education and training, including efforts to reduce attrition and implement minimum placement standards, are particularly relevant to race equality given the high representation of ethnic minority staff in nursing (in 2022 it was reported that 37.8% of nurses and health visitors are from ethnic minorities[300]). Improvements in placement quality, support, and progression may help address the specific barriers faced by ethnic minority nursing students and early-career staff.

The prioritisation of UK medical graduates will likely mean we will see changes due to the differing demographic composition of international medical graduates (IMGs) compared to UK medical graduates (UKMGs). The proposal to do so is proportionate given the important benefits it would bring - for example, by ensuring sustainable workforce planning for the NHS and recruiting from our existing substantial pool of appointable domestically trained doctors. As the NHS reduces its reliance on international recruitment, the widening participation efforts also mentioned in this chapter play an important role in maintaining a diverse and representative workforce. While the NHS is already more ethnically diverse than the general population, international recruitment has been a driver of this. Ensuring that domestic recruitment pathways actively engage ethnic minority communities across the UK will be essential to sustaining and building on that diversity in the long term.

Pay and conditions

Fair pay agreements in adult social care are likely to benefit ethnic minority staff disproportionately. Around 32% of the adult social care workforce in England are from an ethnic minority background, rising to 75% in London, compared to 18% of the overall population[301] [302]. 7% of social care roles are zero-hours contracts, and women from an ethnic minority are nearly 3 times as likely to be on zero-hours contracts than white men[303] [304].

[300] NHS England (2024) 'Equality & Diversity data by NHSE region, staff group and grade' https://digital.nhs.uk/supplementary-information/2024/hchs-staff-by-protected-characteristics-nhse-region-sg-grade-dec23 Accessed 10 July 2025
[301] Skills for Care (2024). 'The state of the adult social care sector and workforce in England' https://www.skillsforcare.org.uk/Adult-Social-Care-Workforce-Data/Workforce-intelligence/publications/national-information/The-state-of-the-adult-social-care-sector-and-workforce-in-England.aspx Accessed 10 July 2025
[302] GOV.UK (2022) 'Population of England and Wales' https://www.ethnicity-facts-figures.service.gov.uk/uk-population-by-ethnicity/national-and-regional-populations/population-of-england-and-wales/ Accessed 10 July 2025
[303] Resolution Foundation (2024) 'Low pay Britain 2024' https://www.resolutionfoundation.org/publications/low-pay-britain-2024/ Accessed 10 July 2025
[304] TUC (2023). 'BME women far more likely to be on zero-hours contracts' https://www.tuc.org.uk/blogs/bme-women-far-more-likely-be-zero-hours-contracts. Accessed 10 July 2025

Development and career progression

The commitment to provide each NHS staff member with a personalised development plan by 2035, supported by digital literacy and ongoing training, may help tackle informal exclusion from development networks that can particularly affect ethnic minority staff. Transparency in coaching and career support may also contribute to better representation in senior and specialist roles.

Initiatives to increase research access for nurses, midwives, and AHPs - including targeted NIHR support and inclusion criteria - may help ethnic minority staff working in underrepresented professions and regions access funding and progression in research careers. This is important in addressing historical underrepresentation of minority ethnic staff in clinical research leadership roles.

Religion or belief

Approximately two thirds of the 1.3 million people working in the NHS declare a religion or belief[305]. Staff from all faiths experience discrimination based on their religion or belief, and this is highest against Muslim and Jewish colleagues[306].

While the chapter does not include policies specifically targeted at religious inclusion, several proposals are likely to have positive, indirect impacts. Most significantly, the introduction of the new Staff Standards - which include commitments to eliminate harassment, bullying and discrimination - may play a central role in addressing unequal treatment linked to religion or belief. These standards will set out clear expectations for respectful behaviour, workplace safety and inclusive organisational culture.

Improvements in leadership capability and accountability, through the new Management and Leadership Framework, may support a more inclusive working culture where religious diversity is respected and accommodated may also provide a route for raising and addressing issues linked to religious discrimination or inclusion, where they arise.

[305] NHS England (2023). 'NHS equality, diversity and inclusion improvement plan' https://www.england.nhs.uk/long-read/nhs-equality-diversity-and-inclusion-improvement-plan/ Accessed 10 July 2025
[306] NHS England (2023). 'NHS equality, diversity and inclusion improvement plan' https://www.england.nhs.uk/long-read/nhs-equality-diversity-and-inclusion-improvement-plan/ Accessed 10 July 2025

Sex

Over three quarters (77%) of NHS England staff are female[307]. The rates vary from role to role, for example the proportion of female staff ranges from nearly 100% of midwives to 46% of doctors. Therefore, the measures in this chapter are likely to have a disproportionate impact on women.

Workplace conditions, flexibility and wellbeing

A central theme of the chapter is improving staff experience, flexibility, and wellbeing - issues that disproportionately affect women, particularly those with caring responsibilities. The introduction of new Staff Standards, covering issues such as respectful treatment, healthy work, access to nutritious food and support for flexible working, is expected to benefit female staff significantly. These standards also aim to reduce bullying, harassment, and discrimination - common issues for women in the workforce - and promote a safer and more inclusive working environment.

More flexible working will increase staff autonomy in how, when and where they work. This is likely to benefit women, who statistically carry a greater share of unpaid domestic and caring labour (in England, 10.3% of women provide unpaid care compared to 7.5% of men; 1 in 10 women in their 30s is out of the labour market due to caring responsibilities compared to 1 in 100 men in their 30s[308] [309]). If implemented well, these models may support greater labour market participation and job satisfaction among women, particularly during life stages where balancing paid and unpaid work is challenging.

The rollout of a new NHS staff app and the greater digital automation of HR processes, including flexible rostering, annual leave, and onboarding, could improve access to basic employment support for all staff. This may benefit women in particular, who are more likely to work part-time or return to work after maternity leave (according to NHS England 41% of women are in part time roles in the NHS compared to 17.2% of men[310]). Simplified access to support services and clearer policies across organisations may also improve job retention for women with fluctuating needs across their working lives.

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[307] Equality & Diversity data by NHSE region, staff group and grade, December 2023 - NHS England Digital
[308] ONS (2021). 'Unpaid care by age, sex and deprivation, England and Wales: Census 2021' https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/socialcare/articles/unpaidcarebyagesexanddeprivationenglandandwales/census2021 Accessed 10 July 2025
[309] TUC (2023). 'Women 7 times more likely than men to be out of work due to caring commitments' https://www.tuc.org.uk/news/women-7-times-more-likely-men-be-out-work-due-caring-commitments. Accessed 10 July 2025
[310] NHS England (2025) 'NHS sickness absence rates' https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates Accessed 10 July 2025

The expansion of occupational health and wellbeing services under staff treatment hubs could help reduce sickness absence, which is consistently higher among female staff (according to NHS England, in March 2025, women took 5% more sick days than men[311]).

Musculoskeletal issues and mental health concerns are frequent drivers of sickness absence. In 2023, the prevalence of self-reported MSK conditions was 15.8% in males and 20.9% in females[312]. In addition, in 2017, women were three times more likely than men to report common mental health problems[313]. These conditions disproportionately affect women in clinical and frontline roles, often exacerbated by physically demanding work and caring responsibilities outside of employment[314] [315].

Pay and conditions

The fair pay agreement for adult social care staff is likely to advance equality by addressing conditions disproportionately experienced by women. Approximately 79% of the social care workforce is female[316]. Broader UK labour market trends indicate that women are significantly more likely than men to be on zero-hours contracts. For example, 53.6% of zero-hours workers are women, and part-time employment is similarly gendered - the majority (73%) of part-time workers are women[317]. A sector-wide agreement could primarily benefit female social care workers, many of whom currently face insecure employment and lower pay. At the same time, the agreement may also help men in care roles, who are underrepresented and often overlooked in workforce reform debates.

The plan also contains commitments to reduce reliance on agency staffing, which can impact pay equity, continuity of care, and the ability to deliver consistent workplace

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311 NHS England data
312 GOV.UK (2024) 'Musculoskeletal health local profiles: short commentary, January 2024' https://www.gov.uk/government/statistics/musculoskeletal-health-local-profiles-january-2024-update/ Accessed 9 July 2025
313 Buckinghamshire Council (2023). 'Director of Public Health annual report 2023: Mental health matters' https://www.buckinghamshire.gov.uk/health-wellbeing-and-sports/joint-strategic-needs-assessment/director-of-public-health-annual-reports/director-of-public-health-annual-report-2023-mental-health-matters/ Accessed 9 July 2025
314 NHS Employers (2022). 'NHS staff survey 2021: health and wellbeing' https://www.nhsemployers.org/articles/nhs-staff-survey-2021-health-and-wellbeing Accessed 9 July 2025
315 NHS Charities Together (2024). 'Three in four NHS staff struggled with their mental health in the past year' https://nhscharitiestogether.co.uk/news/research/three-in-four-nhs-staff-struggled-with-their-mental-health-in-the-past-year/ Accessed 9 July 2025
316 Skills for Care (2024). 'The state of the adult social care sector and workforce in England' https://www.skillsforcare.org.uk/Adult-Social-Care-Workforce-Data/Workforce-intelligence/publications/national-information/The-state-of-the-adult-social-care-sector-and-workforce-in-England.aspx Accessed 9 July 2025
317 Women's Budget Group (2018) 'Women, employment and earnings' https://www.wbg.org.uk/publication/2018-wbg-briefing-employment-and-earnings/ Accessed 9 July 2025

standards. Reducing the agency dependency may enhance contractual stability for all staff, particularly in roles disproportionately filled by women.

Education and training

Reforms to nursing education and retention are particularly relevant. 88% of nurses are women[318], therefore attrition from training programmes disproportionately affects women. Policies to reduce barriers to completing pre-registration training, reforming the travel expenses process and improve the transition from training to employment, such as faster confirmation of course completion and a reformed travel expense system, may disproportionately benefit female nursing students. These interventions may help reduce financial strain, which is a known factor in the dropout rate.

The planned expansion of 2,000 nursing apprenticeships and the creation of more accessible local training pathways will benefit women who may not be able to access full-time degree routes due to family or financial responsibilities. As 88% of the nursing workforce are women[319], these policies will disproportionately affect female staff and prospective students. Apprenticeships allow individuals to earn while they learn and may open opportunities to enter or progress within the NHS on more flexible terms, particularly for women balancing work with caregiving roles.

The NHS employs more men in senior pay bands than women and more women in pay band 3 to 5 than men[320]. Expanding the Graduate Management Training Scheme, with a specific focus on improving leadership diversity, is therefore a relevant development. These leadership reforms can help dismantle barriers to advancement for women and reduce gendered patterns of exclusion from informal networks and promotion pathways.

It should also be noted that proposals for increased use of automation, AI and digital tools within NHS operations could change the shape of the workforce. As these roles are disproportionately held by women, any changes in workforce composition linked to technology adoption should be carefully monitored to ensure that women are not adversely and disproportionately affected by workforce displacement[321]. Where efficiencies are

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[318] NHS England (2024) 'Equality & Diversity data by NHSE region, staff group and grade, December 2023' https://digital.nhs.uk/supplementary-information/2024/hchs-staff-by-protected-characteristics-nhse-region-sg-grade-dec23 Accessed 9 July 2025

[319] NHS England (2024) 'Equality & Diversity data by NHSE region, staff group and grade, December 2023' https://digital.nhs.uk/supplementary-information/2024/hchs-staff-by-protected-characteristics-nhse-region-sg-grade-dec23 Accessed 9 July 2025

[320] NHS England (2025) 'Diversity pay gap reporting 2023/24 for NHS England' https://www.england.nhs.uk/long-read/gender-pay-gap-report-2023-for-nhs-england/

[321] International Labour Organization (2025). 'Generative AI and jobs: a refined global index of occupational exposure' https://www.ilo.org/publications/generative-ai-and-jobs-refined-global-index-occupational-exposure Accessed 9 July 2025

achieved through technology, this should be accompanied by active support for staff redeployment, retraining and progression.

Progression, leadership and accountability

The development of new advanced practice roles for nurses, midwives and AHPs presents an opportunity to support progression into more autonomous and senior clinical roles without necessarily requiring formal medical training or managerial transition. This may offer new leadership opportunities for women in professions that have historically faced glass ceilings within the NHS.

Policies aimed at improving leadership and line management, including the new Management and Leadership Framework, may help address the underrepresentation of women in senior roles, particularly in executive and medical leadership. Clearer progression routes and a stronger emphasis on inclusive and relational leadership could also challenge gendered patterns of exclusion from informal networks and advancement.

Modern appraisal models may support more equitable assessment of women's contributions, particularly in roles where unpaid or informal leadership is undervalued. This includes nursing and administrative roles, which are disproportionately staffed by women. A focus on real-time feedback and professional development could challenge existing biases in line management that often hinder women's progression into senior roles.

The proposal to publish workforce data by socioeconomic status, sex, and ethnicity at employer level represents a significant step toward strengthening accountability for equality across the NHS. While high-level gender data is routinely reported, local-level patterns - including variation in progression, pay or contract type - are harder to identify and act on without disaggregated information. Publishing this data by employer will make it possible to spot inequalities between organisations, support targeted local interventions, and enable a clearer understanding of how gender outcomes vary across settings. It will also create the foundation for better analysis of how gender interacts with other characteristics, without assuming those patterns are uniform across the system.

Sexual orientation

In the 2023 NHS staff survey, 2.6% of respondents reported that they are lesbian or gay, 2.3% bisexual and 6% preferred not to say.[322] LGB staff are more likely to experience bullying, harassment, discrimination and unwanted sexual behaviour compared to

[322] NHS England (2024) 'Equality & Diversity data by NHSE region, staff group and grade, December 2023' https://digital.nhs.uk/supplementary-information/2024/hchs-staff-by-protected-characteristics-nhse-region-sg-grade-dec23 Accessed 9 July 2025

heterosexual colleagues, with 33% of bisexual staff and 31% of lesbian or gay staff reporting experiencing bullying or harassment at work compared to 24% of heterosexual staff.[323]

Policies in this chapter that aim to improve workplace culture, such as the introduction of Staff Standards and stronger line management and leadership frameworks may help create more inclusive and supportive environments for LGB staff. These reforms have the potential to reduce disproportionate experiences of poor treatment and improve retention and satisfaction.

Marriage and civil partnership (in relation to aim 1 only)

General measures to improve line management, leadership standards and performance appraisal may contribute to more consistent and fair treatment of all staff. These changes are expected to help reduce the risk of discriminatory practices, including for staff who are married or in civil partnerships.

Powering transformation: innovation to drive healthcare reform

Age

England has an ageing population. 65 and over is the fastest growing age group and the number of people aged 65 to 79 is predicted to increase by nearly a third (30%) to over 10 million in the next 40 years.[324] Overall life expectancy has risen further and faster than disability-free expectancy, meaning more people are living into older age with multiple long-term conditions, frailty, dementia and social care needs. As of 2023, 73.9% of 65 to 74 year olds have at least one long-term condition.[325] People aged 75 to 79 had the highest number of hospital admissions in 2022 to 2023 (1.9 million), and individuals aged 50 and over accounted for 64% of all admissions.[326] Due to this, the increase in investments into innovative medicines, particularly those that keep people out of hospital may have a particularly positive impact on older patients who tend to have higher hospital

[323] NHS Confederation (2025) 'Exploring LGBTQ+ staff experience in the NHS' https://www.nhsconfed.org/articles/exploring-lgbtq-staff-experience-nhs Accessed 9 July 2025
[324] Centre for Ageing Better (2025) State of ageing report https://ageing-better.org.uk/state-ageing-2025 Accessed 8 July 2025
[325] Age UK (2023). State of health and care of older people https://www.ageuk.org.uk/our-impact/policy-research/publications/reports-and-briefings/ Accessed 8 July 2025
[326] NHS England (2023) Hospital admitted patient care activity https://digital.nhs.uk/data-and-information/publications/statistical/hospital-admitted-patient-care-activity/2022-23/ Accessed 8 July 2025

admissions. This, along with streamlined medicine and innovation pathways will increase patient access to new medicines and improve patient outcomes.

The Chief Medical Officer highlighted in his 2023 report the substantive need for greater research effort for older people than we see currently.[327] This lack of research into the older age group is significant in areas such as social care and ageing in ethnic minority populations. Proposals to establish a Health Data Research Service will streamline access to NHS health and care data and accelerate the development of new treatments, having a positive impact on older patients. This includes age-related conditions such as Alzheimer's and heart disease that are more likely to affect older patients (Alzheimer's disease affects an estimated 1 in 14 people over the age of 65 and 1 in 6 people over the age of 80).[328] In response to the Change NHS engagement exercise, Alzheimer's UK echoed the lack of health data specifically with regards to dementia diagnosis rates and the significant challenge this brings. It will also improve data linkage for sectors outside the health system and allow evaluations on the wider determinants of health, providing insights for prevention interventions.

The shift to personalised healthcare and prevention will start from birth. Newborns will undergo whole genome sequencing to inform potential health risks and inform a lifelong personalised prevention plan. The NHS and Genomics England will continue to recruit 100,000 babies whose genomes will be sequenced from birth and where results will enable earlier NHS care and life saving interventions. While newborns are the subject of this policy, implications extend to their health throughout their whole life. This will have a positive impact on those who receive earlier diagnosis through the sequencing programme, and also could provide better disease monitoring which would lead to better research priorities and more innovations for treatment. However, there are some societal and ethical concerns as decisions will be made by parents on behalf of the child.

Obesity prevalence is highest among older adults, with the peak rate in the 55 to 64 age bracket[329]. The measures in the chapter to use genomics to explore personalised prevention of obesity and related conditions will allow those at highest risk of obesity to have proactive support, including early access to GLP-1s and digital behaviour support. This will have a positive impact on all patients at risk who are eligible for weight loss medications and treatment. The impacts of measures to tackle obesity are discussed in

[327] GOV.UK (2023) 'Chief Medical Officer's annual report 2023: health in an ageing society' https://www.gov.uk/government/publications/chief-medical-officers-annual-report-2023-health-in-an-ageing-society
[328] NHS (2024) 'Alzheimer's disease' https://www.nhs.uk/conditions/alzheimers-disease/
[329] NHS England (2024). 'Health survey for England, 2022 Part 2 – Adult overweight and obesity' https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/2022-part-2/adult-overweight-and-obesity Accessed 9 July 2025

more detail in the assessment for Chapter 3. From sickness to prevention: power to make the healthy choice.

The Be Part of Research initiative aims to increase participation in clinical trials by allowing patients to volunteer and integrating this into the NHS App. Initially this will allow patients to search clinical trials database and to request to be contacted. Around 3 in 10 (29%) people aged 75 and over in the UK in 2021 to 2022, the equivalent of around 1.7 million, have not used the internet for personal use or have no access to the internet[330]. This initiative risks excluding less digitally literate patients to participate in trials, including older members of the population. Policy teams are currently exploring mitigations to ensure inclusive access and engagement, particularly for those at risk of digital exclusion**.** In time however, clinical trial recruitment will be linked to personally controlled care records so that patients are proactively notified of clinical trials that might help them.

The expansion of the use of wearables and biotechnology are expected to allow continuous monitoring, pre-emptive interventions and more personal care delivery. This could have a mixed impact across age groups. Current users of wearable devices tend to be young and healthy, whereas those who are older are at higher risk of long-term conditions and greater need of healthcare interventions.[331] The chapter details plans to make remote monitoring standard for cardiovascular disease by 2028. Cardiovascular disease risk increases with age, however the mortality rate for those aged under 75 has also increased (by 14.3% from 2019 to 2022).[332] Wearable devices can provide objective parameters to allow monitoring of symptoms and earlier diagnosis of cardiovascular disease, reducing premature morbidity. This may have a particularly positive impact on older patients who are at higher risk of cardiovascular disease, and those who are below the age of 75 that could also be at risk.

As discussed in the assessment for Chapter 2, older patients may face barriers using digital tools such as wearables and biosensors and may be harder to engage in the adoption of them. This could exacerbate health inequalities that are already present, and if older adults generally make less use of digital health technologies, more data will come from younger, healthy individuals and the possibility to extrapolate medical information specific to the older population may be compromised.[333] To ensure equitable access,

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[330] Age UK (2024) 'Facts and figures about digital inclusion and older people' https://www.ageuk.org.uk/our-impact/policy-research/publications/reports-and-briefings/ Accessed 9 July 2025
[331] UK Parliament (2025) 'Consumer wearable devices and disease prevention' https://post.parliament.uk/research-briefings/post-pn-0741/ Accessed 9 July 2025
[332] GOV.UK 'Cardiovascular disease and diabetes profiles: statistical commentary 'https://www.gov.uk/government/statistics/cardiovascular-disease-and-diabetes-profiles-march-2024-update/cardiovascular-disease-and-diabetes-profiles-statistical-commentary#main-findings Accessed 9 July 2025
[333] S Canali and others, 'Wearable Technologies for Healthy Ageing: Prospects, Challenges, and Ethical Considerations' (2024) 13 The Journal of Frailty & Aging. https://doi.org/10.14283/jfa.2024.19

wearables will be made available for free in areas where health need is highest, which combined with the digital inclusion support outlined in Chapter 2, such as partnerships with library and community spaces to help people access digital tools, may help reduce the impacts of this so that older populations can benefit from the new generation of wearable technology.

Plans to expand adoption of surgical robotics will allow more people to access revolutionary and highly effective technology. This may have a positive impact on those who are at higher risk of surgery, such as older patients. A study has predicted that by 2030, one fifth of people aged 75 and over will undergo surgery in a year[334]. Older patients who are undergoing surgery could benefit from the increased precision and consistency that surgical robotics offers, resulting in better patient experiences and outcomes.

Disability

Proposals to establish a Health Data Research Service will enable a large range of research studies and support developments based on national-level data which is representative of the population. This will have a positive impact on patients where their condition has an increase in medical research. It could also result in better representation in clinical trials, although this may also require the establishment and monitoring of standards to ensure diverse representation in trials. Opportunity to participate is flagged as a frequent obstacle to the participation of people with disabilities in clinical trials.[335] Improving access through the app and allowing patients to search trial databases and request to be contacted, or be notified through the single patient record, will provide more opportunity to people less frequently represented in research, including those with disabilities. Through the organisation portal for Change NHS, Learning Disability England response highlighted that here is an opportunity to use technology to improve the quality of data on ethnicity to then improve understanding and quality of services. People with learning disabilities from Black Asian and Minority Ethnic backgrounds experience greater health inequalities. The average age of death for people with a learning disability who are from an ethnic minority is 34 years - just over half the life expectancy of white counterparts, at 62 years of age.[336]

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[334] AJ Fowler and others, 'Age of Patients Undergoing Surgery' (2019) 106 BJS 1012. https://doi.org/10.1002/bjs.11148

[335] Yoshiko Sakuma and others, 'Shining a Spotlight on the Inclusion of Disabled Participants in Clinical Trials: A Mixed Methods Study' (2024) 25 Trials 281 https://doi.org/10.1186/s13063-024-08108-7

[336] NHS Race and Health Observatory (2023) 'We deserve better: ethnic minorities with a learning disability and access to healthcare' https://nhsrho.org/research/review-into-factors-that-contribute-towards-inequalities-in-health-outcomes-faced-by-those-with-a-learning-disability-from-a-minority-ethnic-community/ Accessed 9 July 2025

The introduction of whole genome sequencing for newborns and proposals to sequence 150,000 adults will help identify genetic markers for disabilities early, which could lead to earlier interventions and support. While these advances offer significant potential benefits, it is also important to be mindful of concerns about possible stigmatisation or the unintentional reinforcement of negative attitudes towards disability

There are links between obesity and disability. People with a learning disability, physical disability or severe mental health problem are more at risk of obesity[19]. Those who are obese are also at risk of developing complications leading to disability due to their weight. The measures in the chapter to use genomics to explore personalised prevention of obesity and related conditions will allow those at highest risk of obesity to have proactive support, including early access to GLP-1s and digital behaviour support. This will have a positive impact on patients with disabilities who are at higher risk and are eligible for weight loss medications and treatment. The impacts of measures to tackle obesity are discussed in more detail in the assessment for Chapter 3.

The increase in investments into innovative medicines, particularly those that keep people out of hospital may have a particularly positive impact on patients with disabilities or long-term conditions who regularly take medication.

The expansion of the use of wearables and biotechnology are expected to allow continuous monitoring, pre-emptive interventions and more personal care delivery. This could help people with some disabilities or long-term conditions to monitor their health and enable independence, potentially by supporting strength and mobility for those with physical disabilities, which would improve quality of life.[337] Improving uptake and investment into wearables will allow more access to this technology, reaching more patients and improving outcomes.

Some patients with disabilities may face barriers using digital tools such as wearables and biosensors and may be harder to engage in the adoption of them. This could exacerbate health inequalities that are already present, and cause data to be unrepresentative of certain disabilities if uptake is particularly low. There is a correlation between disability and material deprivation. 44% of those in the most deprived tenth of the population are disabled, compared to 18% of the working population.[338] To ensure equitable access, wearables will be made available for free in areas where health need and deprivation are

[337] GOV.UK (2025) Research and development work relating to assistive technology: 2023 to 2024 https://www.gov.uk/government/publications/assistive-technology-research-and-development-work-2023-to-2024/research-and-development-work-relating-to-assistive-technology-2023-to-2024
[338] Stonewall (2018). 'LGBT in Britain – health' https://www.stonewall.org.uk/resources/lgbt-britain-health-2018 Accessed 9 July 2025

highest. This will have a particularly positive impact on disabled people who face financial barriers accessing new technology.

Plans to expand adoption of surgical robotics will allow more people to access revolutionary and highly effective technology. This may have a positive impact on those who are at higher risk of surgery. Some people with disabilities may experience higher rates of surgery related to their disability. These patients may benefit from the increased precision and consistency that surgical robotics offers.

Gender reassignment

There are potential positive impacts of improved access to data for this cohort. Research in transgender health issues is limited, such as the long-term impact of hormonal treatment. The streamlining of data may improve research in these areas.

Trans and non-binary adults are twice as likely to be experiences mental health difficulties. According to data collected in 2018, 70% of non-binary people have experienced depression and 71% of trans people have experienced anxiety[339].Increasing the proportion of the NIHR's budget invested into the detection of mental ill health is therefore likely to have a disproportionately positive impact on those with this protected characteristic. Further, expanding NICE's technology appraisal process to cover devices, diagnostics, and digital products, for mental health, including digital cognitive behavioural therapy, will help to address the most urgent needs.

Pregnancy and maternity

By opening access to pregnancy and maternity status through the Health Data Research Service, researchers will be better informed to understand the effects of new medical treatment and preventative treatments on new mothers and how this may affect their pregnancy. This is especially important for women accessing maternal medicine services and for patients with pre-existing medical conditions before pregnancy (1 in 5 pregnant women in the UK have multiple long-term conditions, which are associated with adverse pregnancy outcomes)[340]. Maternal Mental Health Alliance's response submitted to the Change NHS online portal reference their findings from 2024; they found that 33% of services weren't collecting information on the sexual orientation of their patients; 59%

[339] Stonewall (2018). 'LGBT in Britain – health' https://www.stonewall.org.uk/resources/lgbt-britain-health-2018 Accessed 9 July 2025

[340] Brophy S and others, 'Pregnant Women with Multiple Long-Term Conditions Involving Mental Health in Wales, UK (2000-2019): Sequence Clustering Approach in SQL Server Data Mining Using SAIL Databank' [2025] medRxiv (Cold Spring Harbor Laboratory). https://doi.org/10.1101/2025.03.30.25324916

weren't collecting information on gender reassignment and over a third did not track whether their patients were part of NHS inclusion groups.

Race

Ethnicity data is notably poor and inconsistent in the health system. In 2023, a study found that comparisons between ethnicity information captured in GP records or hospital statistics compared to the 2011 Census were varied between ethnic groups, with White British health data having the highest level of agreement with the Census (96%), compared to Mixed ethnic groups (less than 67%) and 'other' ethnic groups, such as Other Black (less than 16%).[341] While improving access to health data is a positive step, it is important that efforts are matched by a focus on strengthening the quality and consistency of ethnicity data. Otherwise, there is a risk that incomplete or inaccurate data could unintentionally perpetuate misrepresentation or disadvantage for some ethnic groups.

In response to the Change NHS exercise, the Race Equality Foundation referenced the challenge for ethnic minorities is the lack of data available at present. For example, there is poor data on people from an ethnic minority background with learning disabilities, as well as maternal needs. This makes it difficult to people from an ethnic minority who are at risk or would benefit from intervention to support better outcomes. Without a clear understanding of the specific needs of these people or a framework in which they are empowered and supported with the technologies they need, it remains a risk that developments in technology enable racial inequalities to persist. Their response suggested that one enabler to address this would be increased ethnicity recording such as updating the learning disability register in both the proportion of people with a learning disability included.

More transparency in data could help identify data gaps and areas of poor quality, which could drive change in the way data is collected and improve ethnicity data quality, resulting in better representation and more research into certain conditions where some ethnic groups may be at higher risk. This, along with the proposals to mainstream clinical trials could also result in better representation in trials, which will have a positive impact on individuals of certain ethnicities (aim 2). Currently, representation of certain ethnicity groups in trials is low. This was particularly highlighted during the pandemic - only 7% of individuals recruited for the COVID-19 vaccine trials were from ethnic minorities.[342]

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[341] ONS (2023) 'Understanding consistency of ethnicity data recorded in health-related administrative datasets in England: 2011 to 2021' https://www.ons.gov.uk/releases/understandingconsistencyofethnicitydatarecordedinhealthrelatedadministrativedatasetsinengland2011to2021 Accessed 8 July 2025

[342] Mayur Murali and others, 'Ethnic Minority Representation in UK COVID-19 Trials: Systematic Review and Meta-Analysis' (2023) 21 BMC Medicine. https://doi.org/10.1186/s12916-023-02809-7

The introduction of whole genome sequencing for newborns and proposals to sequence 150,000 adults will help identify genetic markers for genetic conditions early, which could lead to earlier interventions and support. However, genomic databases are often biased towards populations of European ancestry, which can lead to less accurate results for minority ethnic groups. This is discussed further in the assessment for Chapter 3.

Obesity prevalence varies across ethnicity groups due to various factors such as environmental factors, health behaviours, socioeconomic status, social marginalisation, access to healthcare or discrimination. The measures in this chapter target individuals from all ethnicities and are likely to have a positive impact across all ethnic groups. In 2022, 70.8% of black adults were overweight or living with obesity - the highest percentage out of all ethnic groups[343]. The measures in the chapter to use genomics to explore personalised prevention of obesity and related conditions will allow those at highest risk of obesity to have proactive support, including early access to GLP-1s and digital behaviour support. This will have a positive impact on patients who are at higher risk and are eligible for weight loss medications and treatment.

It will be important in increasing access to clinical trials that this doesn't inadvertently exacerbate inequalities if participation is low in certain groups. The improvement of access to trials through the app, including searchable databases and notification through single patient records could provide people in groups that are historically underrepresented in trials with the information and transparency to be willing to engage. It could also increase awareness for trials that might be relevant to their community or are frequently unsubscribed for certain ethnicities to increase participation.

The introduction of a single national formulary should ensure medicines are available in all areas. This will reduce variation in medicines provided by ICSs dependent on their budgets, which could potentially have a positive impact on patients that live in deprived areas where ICSs could have higher spending due to patient need. In 2023 to 2024, acute hospital trusts in the most deprived areas experienced steeper declines in their finances while more affluent areas experienced modest improvements[344]. Sometimes, patients who cannot access medicines in their region are forced to pay for them privately. The single national formulary will remove the need to do this, having a positive impact on those who face deprivation or have lower incomes.

The chapter details plans to make remote monitoring standard for cardiovascular disease by 2028. Research has shown that Black Africans, African Caribbeans and South Asians

[343] GOV.UK (2024). Overweight adults - Ethnicity facts and figures
[344] Nuffield Trust (2025). 'NHS provider deficits are back: how bad is the situation?' https://www.nuffieldtrust.org.uk/news-item/nhs-provider-deficits-are-back-how-bad-is-the-situation Accessed 8 July 2025

in the UK are at higher risk of developing high blood pressure or type 2 diabetes compared with White Europeans.[345] These both significantly increase the risk of developing cardiovascular disease. Wearable devices can provide objective parameters to allow monitoring of symptoms and earlier diagnosis of cardiovascular disease and associated conditions, reducing premature morbidity. This may have a particularly positive impact on patients from ethnic minorities who are at higher risk of cardiovascular disease.

There are financial barriers to wearables and biotechnology, and there is a correlation between ethnicity and deprivation. Patients whose race is other than White British are more likely to live in the most overall deprived 10% of neighbourhoods in England. This may impact patients' abilities to access new technology and would exacerbate the digital divide. This is further discussed in the assessment for Chapter 2. To mitigate this, the plan outlines proposals to provide free devices in areas where health need and deprivation are highest. This will provide more opportunity to those who are facing financial barriers to using this technology and could have a particularly positive impact on ethnic minorities who could be at higher risk of preventable conditions.

Religion or belief

These proposals are assessed to have no impact on people with the protected characteristic of marriage and civil partnership, in line with the public sector equality duty, which applies to this characteristic only in relation to the elimination of unlawful discrimination (aim 1).

Sex

Although women live 4 years longer than men on average, women spend a significantly greater proportion of their lives in ill-health when compared with men; women spend only 75.7% of their life in good health compared with 79.2% for men.[346] Historically health, care and research systems have neglected women's health conditions and voices. The economic cost of absenteeism due to severe period pain and heavy periods alongside endometriosis, fibroids and ovarian cysts is estimated to be nearly £11 billion per annum.[347] Improved data accessibility through the Health Data Research Service will enable more research studies and support developments for innovations for conditions,

[345] British Heart Foundation (2021) 'How your ethnic background affects your risk of heart and circulatory diseases' https://www.bhf.org.uk/what-we-do/our-research/research-successes/ethnicity-and-heart-disease Accessed 8 July 2025
[346] ONS (2021) 'Healthy life expectancy in England and Wales' https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/healthstatelifeexpectanciesuk/ Accessed 8 July 2025
[347] NHS Confederation (2024) 'Women's health economics: investing in the 51 per cent' https://www.nhsconfed.org/publications/womens-health-economics Accessed 8 July 2025

which could include women's health conditions. Increasing funding for prevention research may enable preventative medicines for women's health conditions, which would have positive impacts on the lives of women.

Despite making up 51% of the population, women are heavily underrepresented in medical research and clinical trials.[348] In 2019, women still only made up around 40% of participants in clinical trials for cancer, cardiovascular disease and psychiatric disorders and in 2020, only 5% of research and development funding worldwide was allocated to women's health research.[349] The Royal College of Obstetricians and Gynaecologists in their response to the Change NHS engagement exercise echoed this point. They said people who are female, from ethnic minority backgrounds, older or pregnant are often still under-represented in clinical studies, including in major disease areas like cancer and cardiovascular disease. In addition, some women's health conditions, and effective interventions to address inequalities, are under-researched, as are the barriers to participation in research. The increased access to data and mainstreaming of clinical trials in the UK could allow for better representation of the population in trials. This may require the establishment and monitoring of standards to ensure diverse representation in trials, and engagement to encourage women to participate. The improvement of access to trials through the app, including searchable databases and notification through single patient records could provide women with the information and transparency to be willing to engage, and the opportunity to volunteer for trials in research areas that particularly affect women, or where women are frequently underrepresented.

Sexual orientation

LGB individuals are at significantly higher risk of poor mental health, including depression, anxiety, and suicidal ideation. ONS research found that the age-standardised rate of intentional self-harm for people who identified with an LGB+ orientation (gay or lesbian, bisexual or other sexual orientation) was 1,508.9 per 100,000 people in England and Wales between March 2021 and December 2023, compared with 598.4 per 100,000 people who described themselves as straight or heterosexual.[350] A study also found that LGB adolescents are 5 times more likely to be depressed compared to their heterosexual

[348] ONS (2024) 'Estimates of the population for the UK, England, Wales, Scotland, and Northern Ireland' https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesscotlandandnorthernireland Accessed 8 July 2025
[349] Alexandra Z Sosinsky and others, 'Enrollment of Female Participants in United States Drug and Device Phase 1–3 Clinical Trials between 2016 and 2019' (2022) 115 Contemporary Clinical Trials 106718. https://doi.org/10.1016/j.cct.2022.106718
[350] ONS (2025) Self-harm and suicide by sexual orientation, England and Wales: March 2021 to December 2023 Accessed 30 June 2025

peers[351]. Advances in using AI for mental health support through the HealthStore may have a particularly positive impact on these individuals who may suffer from worse mental health.

Marriage and civil partnership (in relation to aim 1 only)

These proposals are assessed to have no impact on people with the protected characteristic of marriage and civil partnership, in line with the public sector equality duty, which applies to this characteristic only in relation to the elimination of unlawful discrimination (aim 1).

Productivity and a new financial foundation

Age

Older people are significantly more likely to use hospital services than other age groups. In 2022 to 2023, people aged 75 to 79 accounted for 1.9 million hospital admissions. People aged 50 and over made up 64% of all hospital admissions, despite representing less than half the total population[352]. This group is therefore more likely to be affected by financial and operational changes in the hospital system. These impacts will intensify over time as the number of people aged 65 and over in England is projected to increase by 3.3 million in the next 20 years and by 6.5 million in the next 40 years[353]. Age UK's response to Change NHS online portal highlighted that for years, the conversation around healthcare transformation has revolved around aligning incentives and resources to better support older people, yet progress has been inconsistent.

Reforms such as the Year of Care Payments (YCPs), which consolidate multiple services into a single payment and incentivise anticipatory, primary and community-based care, could improve outcomes and reduce avoidable hospital admissions among older people. If implemented effectively, this shift supports aim 2 of the PSED (advancing equality of opportunity) by reducing avoidable admissions and improving health outcomes for older people with long-term conditions or frailty (74% of 65 to 74 year olds have at least one long-term condition[354]). However, this depends on the availability and quality of local

[351] Rebekah Amos and others, 'Mental Health, Social Adversity, and Health-Related Outcomes in Sexual Minority Adolescents: A Contemporary National Cohort Study' (2020) 4 The Lancet Child & Adolescent Health Volume 36.
[352] NHS England (2023) Hospital admitted patient care activity https://digital.nhs.uk/data-and-information/publications/statistical/hospital-admitted-patient-care-activity/2022-23/ Accessed 8 July 2025
[353] Centre for Ageing Better (2025) State of ageing report https://ageing-better.org.uk/state-ageing-2025 Accessed 8 July 2025
[354] Age UK (2023). State of health and care of older people https://www.ageuk.org.uk/our-impact/policy-research/publications/reports-and-briefings/ Accessed 8 July 2025

neighbourhood and community health services. In areas where infrastructure is less developed, there may be challenges in fully meeting needs, which could limit progress towards equity goals. However, with the ongoing development of a neighbourhood health service and continued efforts to strengthen local services, these gaps are expected to be addressed over time.

The reform of capital investment, including a move toward formula-based allocations linked to population health need and the publication of a 10-year infrastructure strategy, has the potential to improve physical environments for older adults who are disproportionately affected by outdated facilities. However, capital formulas must account for the higher infrastructure needs of areas with ageing populations to avoid widening inequalities.

Proposals to tie financial incentives to population health outcomes and patient feedback may also create a more responsive care system for older people, who tend to interact more frequently with healthcare services (individuals aged over 50 accounts for 64% of all hospital admissions in 2022 to 2023[355]) and whose experiences vary widely across providers. This includes planned trials of mechanisms such as Patient Power Payments, where individuals (including older adults) will have a direct say in whether care providers receive full payment based on their satisfaction. If these systems are inclusive and accessible, they could help address some of the longstanding concerns expressed by older patients regarding respect, continuity and communication in care.

Incentives to improve productivity, such as shifting payment away from average costs toward tariffs based on best clinical practice, could result in more consistent and efficient care pathways for older adults. This population is more likely to experience complex care journeys, and the standardisation of evidence-based, high-quality practice may reduce variation and improve outcomes. However, careful monitoring will be needed to ensure such reforms do not inadvertently disincentivise providers from treating older patients with higher complexity or comorbidities.

A related area of impact is the Carr-Hill funding formula, which currently allocates primary care funding with a weighting toward older populations. The chapter includes a proposal to review how health need is reflected in nationally negotiated contracts and payment mechanisms for providers, such as the Carr-Hill formula. If adjusted, this could improve primary care services for younger populations - particularly those in underserved areas with high deprivation or complex health needs that are not captured by age alone. This may advance equality of opportunity (aim 2 of the PSED) for groups whose needs are currently underrepresented in the funding model. However, any changes would need to be

[355] NHS England (2023) Hospital admitted patient care activity https://digital.nhs.uk/data-and-information/publications/statistical/hospital-admitted-patient-care-activity/2022-23/ Accessed 8 July 2025

carefully managed to avoid unintended impacts on older populations who continue to have disproportionately high care needs and greater risk of poor outcomes.

Plans to remove deficit support funding will free up funding to allow investment into areas of highest need. This is expected to have a positive impact across all age groups. Depending on how high need is determined, this could have a particularly positive impact on certain age groups. As evidenced earlier in this section, older patients tend to have higher rates of hospital admissions than other age groups. Children ages 0 to 4 are the highest hospital users among all age groups under 45, with over 1.2 million admissions in 2023 to 2024.[356]. This redistribution could therefore have a positive impact on these groups, improving quality of service and patient outcomes.

The introduction of multi-year budgets and actuarial-based funding approaches (designed to maximise healthy life expectancy and reduce risk across the life course) may also benefit older populations if the models are effectively calibrated to forecast and mitigate future disease burdens linked to ageing. This could support both efficiency and equity by directing resources toward early intervention and long-term planning for those most likely to require care.

Reforms to the capital regime have relevance for age, particularly in how funding is distributed across regions and systems to support infrastructure investment. Older adults, who use hospital services more frequently (people aged 50 and over made up 64% of all hospital admissions.[357]), are more exposed to the consequences of outdated equipment, poor estate condition or limited diagnostic capacity. At the same time, younger populations, especially in high-growth or deprived urban areas, may experience poor access to modern care environments if capital is not allocated equitably. The move toward a formula-based capital allocation model combined with a long-term national infrastructure strategy, is intended to reduce the unpredictability of central funding and support more responsive local investment. If these formulas and the strategy reflect age-driven health needs as well as broader indicators of deprivation and unmet demand, they could help advance equality of opportunity for both older and younger populations. However, if age-weightings are deprioritised or local systems lack the capacity to secure or deploy capital effectively, there is a risk that infrastructure gaps widen in areas with the greatest need.

The ambition to build a neighbourhood health centre in every community, is likely to have a positive impact on people across all different age groups. Localised health centres will

[356] NHS England (2023) Hospital admitted patient care activity https://digital.nhs.uk/data-and-information/publications/statistical/hospital-admitted-patient-care-activity/2022-23/ Accessed 8 July 2025
[357] NHS England (2023) Hospital admitted patient care activity https://digital.nhs.uk/data-and-information/publications/statistical/hospital-admitted-patient-care-activity/2022-23/ Accessed 8 July 2025

be more accessible for older people who may have mobility issues and for families with young children who often find it difficult to travel to distant facilities.

Measures to improve transparency and productivity are likely to have a positive impact on those that use healthcare services the most, so this may have a disproportionate benefit for older patients who are more likely to experience variations in experience through more frequent attendance to healthcare settings.

Children and young people may benefit from the shift of resources from acute to community care, particularly through the development of the neighbourhood health service. Community services are heavily used by paediatric populations - especially children with disabilities or long-term conditions - and ensuring growth in this sector can help improve access and outcomes.

Disability

In England, around 17% of the population is disabled[358]. This group is more likely to have multiple health needs, rely on regular and coordinated care and face barriers to access including transport, cost, digital exclusion and long waits[359]. Several proposals in the financial chapter have potential benefits for disabled people, provided that implementation is inclusive and responsive to need.

The plans to consider wider mechanisms for allocating resources - including general practice contracts (the Carr Hill formula) and provider payment methods - may also offer indirect benefits for disabled people. The review will consider how formulas could better account for unmet need and health inequalities within primary care settings[360]. While the chapter does not explicitly mention disability within this review, there is potential for some indirect positive impact: if the formula were adjusted to better reflect measures such as the Indices of Multiple Deprivation, where disability is one of the underlying domains, this could result in greater resource allocation to populations with higher prevalence of disability and complex need. However, this is contingent on the methodology adopted in the review, and the degree to which disability-related factors are captured. There is also a correlation between age and disability. The current formula allocates more funding to areas with older populations who use more healthcare (those over 70 have 5 times more

[358] ONS (2021) Disability, England and Wales: Census 2021 https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandwellbeing/bulletins/disabilityenglandandwales/census2021 Accessed 10 July 2025
[359] Dikaios Sakellariou and Elena S Rotarou, 'Access to Healthcare for Men and Women with Disabilities in the UK: Secondary Analysis of Cross-Sectional Data' (2017) 7 BMJ Open https://doi.org/10.1136/bmjopen-2017-016614
[360] BMA (2024) Global sum allocation formula https://www.bma.org.uk/advice-and-support/gp-practices/funding-and-contracts/global-sum-allocation-formula Accessed 8 July 2025

GP appointments on average than teenagers[361]) and are more likely to be disabled (67% of people ages 85 and over reported having a disability, compared to 23% of working age adults)[362]. While any adjustments to the formula could have implications for resource allocation to older populations - who often have complex healthcare needs and higher rates of disability - the actual impact will depend on the specific methodology and criteria adopted as part of the review.

Chapter 8 also introduces the concept of an 'actuarial' approach to health funding, where anonymised data are used to allocate resources based on predictive health risk. If these models explicitly incorporate disability-related indicators (such as prevalence of long-term conditions or complex care pathways), this could improve forward-planning and targeting of resources. However, it will be essential to ensure that 'actuarial' does not become synonymous with risk-aversion to complexity or cost, which could unintentionally deprioritise disabled patients with higher support needs.

The proposed Year of Care payment model consolidates funding for people with long-term conditions, covering primary care, community services, mental health, outpatient care and emergency attendances into a single upfront payment. This represents a significant shift in how services are funded and delivered. For disabled people, who often rely on support across these settings, this model could lead to more joined-up and anticipatory care. However, if the payment structure does not adequately reflect the complexity of disability-related needs, or if there are perverse incentives created through such a model, there is a risk that providers could deprioritise certain patients (such as those with higher needs) in favour of those who are simpler or cheaper to care for. Policy teams are currently considering mitigations to ensure that payment models are inclusive and do not inadvertently disadvantage patients with more complex needs.

Proposals to revise tariff structures (moving away from average costs and toward reimbursement based on best clinical practice) could improve care for disabled people if high-quality pathways for complex or long-term conditions are fully defined and resourced. This may improve standardisation, reduce unwarranted variation and ensure that best-value care includes disabled patients. However, there is a risk that the definition of "best clinical practice" may underrepresent conditions that are less prevalent, complex or not easily quantified. Tariffs already make adjustments for the complexity of the patient, or for specific conditions, and these adjustments would also be used when implementing tariffs

[361] NHS England (2023) Deliver plan for recovering access to primary care https://www.england.nhs.uk/long-read/delivery-plan-for-recovering-access-to-primary-care-2/ Accessed 8 July 2025
[362] GOV.UK (2024) Family resources survey: financial year 2022 to 2023 https://www.gov.uk/government/statistics/family-resources-survey-financial-year-2022-to-2023 Accessed 8 July 2025

based on best clinical practice to ensure the price reflects the complexity of the patient or condition

Reforms to capital investment may indirectly support accessibility improvements if modernisation of the estate prioritises inclusive design. Disabled patients are more likely to be affected by inaccessible or outdated facilities. Furthermore, the proposal to establish a neighbourhood health centre in every community has the potential to significantly improve health outcomes for people with disabilities by bringing essential services closer to their homes and reducing dependency on hospitals.

Plans to remove deficit support funding will free up funding to allow investment into areas of highest need. This is expected to have a positive impact on all patients. Depending on how high need is determined, this could have a particularly positive impact on patients with disabilities who have higher healthcare usage. The impacts that patients will experience will also depend on how the funding is invested, for example through improving access for those with sensory impairments.

Proposals to introduce a formula-based capital allocation, simplify approvals, and publish a long-term infrastructure strategy could support the delivery of better environments for disabled people, especially if population need and disability prevalence are factored into planning. The reforms proposing enhanced financial autonomy for new NHS foundation trusts (FTs), including the ability to retain and reinvest surpluses, may have indirect impacts on disabled people. Higher-performing trusts are often concentrated in more affluent areas, which tend to serve populations with better baseline health. People in the most deprived parts of England were twice as likely to wait more than a year for elective treatment as people who lived in the most affluent areas[363]. Furthermore, acute hospital trusts in the most deprived areas experienced steeper declines in their finances (2023 to 2024), while more affluent areas experienced modest improvements[364]. If FT reforms lead to more rapid or greater capital investment in these settings, this could widen infrastructure and service access gaps between populations - particularly where disabled people are overrepresented in deprived or underperforming areas (in England, a higher percentage of people indicated that they were disabled in the most deprived areas compared with the least deprived areas)[365]. If FT reforms are thoughtfully designed and prioritise inclusive investment, they have the potential to improve health experiences and outcomes for

[363] The King's Fund (2023). Tacking health inequalities on NHS waiting lists https://www.kingsfund.org.uk/insight-and-analysis/reports/health-inequalities-nhs-waiting-lists Accessed 8 July 2025
[364] Nuffield Trust (2025) NHS provider deficits are back: how bad is the situation? https://www.nuffieldtrust.org.uk/news-item/nhs-provider-deficits-are-back-how-bad-is-the-situation Accessed 8 July 2025
[365] ONS (2021) Disability by age, sex and deprivation, England and Wales: Census 2021 https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/disability/articles/disabilitybyagesexanddeprivationenglandandwales/census2021. Accessed 8 July 2025

disabled patients by modernising facilities, increasing local access to essential services, and addressing specific barriers faced by disabled people. To ensure equity, the implementation of these freedoms should include safeguards to prevent further entrenchment of geographic health inequalities and ensure that disabled communities in all areas benefit from capital and service investment.

The introduction of policies to make better use of the NHS estate (including disposal of under-used assets and retention of receipts) could have positive or negative consequences for accessibility. Where modern facilities are built or refurbished, this could significantly improve the physical accessibility of services. However, estate rationalisation could also lead to service centralisation or travel burdens if not carefully managed with disability-accessible transport and communication systems in place.

This chapter also outlines a commitment to improving productivity, including through administrative automation and better use of data. While this may release clinical capacity, there is a risk that efficiency drives standardisation over flexibility, meaning consideration will need to be given to disabled people with complex or non-standard needs.

Several proposals to empower patients, such as Patient Power Payments and experience-linked funding, may improve responsiveness and accountability, but may not be equally accessible to all. People with disabilities are overrepresented among those who are digitally excluded or who face communication barriers[366]. For example, digital engagement may not be feasible for those with sensory impairments, learning disabilities, or low literacy. However, there is also evidence that disabled people are more likely to engage with health technology[367]. Unless alternative mechanisms (for example, paper-based or in-person feedback tools) are offered, these innovations may risk underrepresenting the voices of disabled patients in performance-linked funding decisions.

Gender reassignment

There may be minor indirect positive impacts from policies that link funding to patient experience, such as Patient Power Payments and performance incentives, in the event that they lead to more responsive care.

[366] Sense (2024). Potential and possibility 2024: addressing digital exclusion https://www.sense.org.uk/about-us/research/potential-and-possibility-research/potential-and-possibility-2024-addressing-digital-exclusion/ Accessed 8 July 2025
[367] ONS (2020). Internet access – households and individuals, Great Britain: 2020 https://www.ons.gov.uk/peoplepopulationandcommunity/householdcharacteristics/homeinternetandsocialmediausage/bulletins/internetaccesshouseholdsandindividuals/2020

No other policies from Chapter 8 (for example, capital reform, tariff changes, multi-year budgets, NICE powers, or estate optimisation) are expected to have direct or disproportionate impacts on people who have undergone gender reassignment.

Pregnancy and maternity

Year of Care Payments (YCPs), although not directly targeted at maternity, could potentially be adapted to support women with long-term postnatal conditions (for example, postnatal depression, pelvic floor dysfunction) by promoting more integrated care pathways that cross between primary, mental health, and community care settings

The reform of capital investment, including new capital formulas and long-term infrastructure planning, may improve maternity care environments over time if allocations are responsive to population need and local birth rates

The shift to a value-based financial framework that includes performance incentives linked to patient experience may indirectly benefit maternity care by creating a broader culture of accountability and responsiveness across services. However, this benefit will only be realised if maternity services are explicitly included in outcome tracking and patient voice mechanisms

Race

These proposals are assessed to have a positive impact for people with the protected characteristic of race, particularly where reforms aim to address underlying inequalities in access to care and resource allocation.

Ethnic minority communities in England continue to face systemic health inequalities, including poorer access to services, worse health outcomes, and lower levels of trust and satisfaction with the healthcare system. For instance, Black and Asian women face significantly higher maternal and neonatal mortality risks, and ethnic minority groups are more likely to live in deprived areas with under-resourced healthcare. According to the Office for Health Improvement and Disparities, over 30% of Bangladeshi and Pakistani people live in the most deprived neighbourhoods in England – that is 3 times the national average[368].

Higher mortality and neonatal mortality risks are also the case that when excluding for level of deprivation for Black and Asian women. Women from minority ethnic backgrounds, particularly Black and South Asian women, face significantly worse maternal health

[368] Stephen Jivraj and Omar Khan, ‘How Likely Are People from Minority Ethnic Groups to Live in Deprived Neighbourhoods? Cambridge University Press 2015 199

outcomes. There was a nearly 3-fold difference in maternal mortality rates among women from Black ethnic backgrounds and an almost 2-fold difference among women from Asian ethnic backgrounds compared to White women[369]. Chapter 8 includes several proposals that may help tackle these inequalities if designed and implemented with a strong equity lens.

The review of nationally negotiated contracts (such as the Carr-Hill formula) and broader NHS funding allocations has the potential to improve resource distribution to communities with greater health need, which often include higher proportions of ethnic minority residents. If deprivation and health inequality are more accurately factored into primary care funding, this could advance aim 2 of the PSED (advancing equality of opportunity) by redirecting resources to underserved populations, particularly in inner-city and deprived areas. However, the actual impact will depend on whether the revised model sufficiently addresses the structural disadvantage faced by communities with higher proportions of ethnic minority residents.

Broader performance-related funding mechanisms (for example, Patient Power Payments) linked to patient experience may also encourage providers to be more responsive to the needs of ethnic minority patients - particularly in services where disparities are well documented, such as maternity, mental health, and long-term condition management. However, success will depend on the design of engagement tools. Feedback mechanisms that rely solely on digital platforms, English-language formats, or long written surveys may risk excluding populations, including non-native speakers and those with lower health literacy. This could inadvertently reinforce inequities unless mitigated through inclusive design and targeted outreach.

The chapter's commitment to a fairer capital allocation system, guided by population health need and linked to a 10-year infrastructure strategy, may help improve care environments in underserved areas, many of which have high proportions of ethnic minority residents. If the capital allocation formula accounts for deprivation and demographic need, it may help reduce longstanding infrastructure gaps, such as in urban communities with older, overcrowded or under-maintained facilities. However, the benefits will depend on local systems having the capacity to plan and deliver capital improvements effectively.

Similarly, plans to remove deficit support funding will free up funding to allow investment into areas of highest need. Depending on how high need is determined, this could have a

[369] MBRRACE-UK (2024). Saving lives, improving mothers' care 2024 – Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2020-22 https://www.npeu.ox.ac.uk/mbrrace-uk/reports/maternal-reports/maternal-report-2020-2022 Accessed 8 July 2025

particularly positive impact on patients who live in areas of high deprivation. Patients whose race is other than White British are more likely to live in the most overall deprived 10% of neighbourhoods in England[370]. Increasing investment into areas with higher levels of deprivation may therefore disproportionately impact patients from ethnic minority groups, improving experience and patient outcomes.

The introduction of value-based medicine deployment, driving rapid and equitable adoption of the most clinically and cost-effective innovations, could also help reduce disparities if they lead to more consistent access to effective treatments across all populations. However, there is a risk that "withdrawal of non-cost-effective treatments" could disproportionately affect groups already facing access barriers, if not carefully equality-assessed. Ensuring treatment guidelines and decommissioning decisions incorporate evidence on differential impact across racial and ethnic groups will be important for avoiding unintended discrimination.

There is strong evidence that Black, Asian, and minority ethnic communities experience significant health inequalities, often linked to structural barriers in access to services[371] [372]. The creation of neighbourhood health centres in every community (beginning in the most deprived communities) may help to address these disparities by tailoring services to local needs, offering culturally appropriate care, and providing language support. Further evidence on the impacts of the new neighbourhood health model can be found in the EQIA for Chapter 1.

Religion or belief

The policies in Chapter 8 focus on NHS financial frameworks, capital and estates, productivity and incentive structures. These are not expected to differentially affect individuals based on their religion or belief. There is no evidence from the policy proposals that religious groups would be disproportionately impacted, either positively or negatively.

Some proposals, such as linking funding to patient experience, may be beneficial if they result in more inclusive and culturally responsive care. However, these benefits will depend on how feedback tools and engagement mechanisms are designed, including whether they allow for religious considerations in care (for example, food, modesty, or end-of-life care preferences) to be meaningfully reflected.

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[370] GOV.UK (2020). People living in deprived neighbourhoods - Ethnicity facts and figures
[371] The King's Fund (2023). The health of people from ethnic minority groups in England https://nhsrho.org/research/patient-experience-and-trust-in-nhs-primary-care/ Accessed 8 July 2025
[372] NHS Race and Health Observatory (2025) Patient experience and trust in NHS primary care https://nhsrho.org/research/patient-experience-and-trust-in-nhs-primary-care/ Accessed 8 July 2025

Sex

Women are generally more likely to use health services than men, particularly during reproductive years (among people aged 20 to 39, community health services use is higher in women, reflecting services related to children's health[373]). However, most of the reforms in Chapter 8 are not sex specific.

Linking funding to patient voice - such as through Patient Power Payments, patient experience-linked reimbursement, and value-based incentives - could offer an opportunity to enhance care quality for women, particularly in areas where they have historically reported poorer experiences or outcomes. These include chronic pain, reproductive health, menopause, and some autoimmune or musculoskeletal conditions[374] [375] [376]. However, the impact will depend on whether women's experiences are accurately captured and reflected in the metrics used to guide funding.

The introduction of best-practice tariffs may have indirect effects where care pathways are dominated by female patients, male patients or conditions more prevalent in either women or men. Conversely, if best-practice tariffs are designed using sex-disaggregated evidence, they could help improve quality and consistency for men and women.

Actuarial and multi-year funding models based on projected health risk and life-course outcomes could also have implications by sex. Women have longer life expectancy and are more likely to live with multiple chronic conditions or disability later in life[377] [378] [379]. If predictive models account for these factors, the reforms could support a more appropriate distribution of resources. However, models that prioritise high-cost, short-term episodes over long-term wellbeing could disadvantage women by failing to reflect common female health needs such as osteoporosis, continence issues, or post-menopausal complications.

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[373] Nuffield Trust (2023). The state of community health services in England https://www.nuffieldtrust.org.uk/resource/the-state-of-community-health-services-in-england-0-0 Accessed 8 July 2025
[374] Women and Equalities Committee (2024) Women's reproductive health conditions https://publications.parliament.uk/pa/cm5901/cmselect/cmwomeq/337/report.html Accessed 8 July 2025
[375] Dr Louise Newson and Dr Rebecca Lewis, 'Delayed diagnosis and treatment of menopause is wasting NHS appointments and resources', Royal College of GP Annual Conference, London, UK (2021)
[376] Health Equity Evidence Centre (2025) What works: Health and care interventions to support people from disadvantaged backgrounds with musculoskeletal conditions https://www.heec.co.uk/resource/what-works-health-and-care-interventions-to-support-people-from-disadvantaged-backgrounds-with-musculoskeletal-conditions/ Accessed 8 July 2025
[377] ONS (2024). National life tables - life expectancy in the UK Accessed 17 December 2025
[378] NHS England (2023). Health Survey for England, 2021 part 2 - section on Adults' health: General health, acute sickness, and longstanding conditions. Accessed 17 December 2025
[379] ONS (2023) Census 2021: Disability by age, sex and deprivation, England and Wales Accessed 17 December 2025

Reforms to capital investment and estate optimisation may indirectly impact women through changes to service location, infrastructure quality, or transport access. Women - especially those with caring responsibilities - are more likely to require local, accessible services. Estate consolidation or sale must be managed in a way that ensures community-based services remain within practical reach, particularly in underserved or rural areas.

Beyond that, broader proposals, such as funding formula reviews and capital reform are not expected to have disproportionate impacts on people based on sex.

Sexual orientation

The policies in Chapter 8 do not reference sexual orientation and are focused primarily on funding flows, estate reform, productivity and performance incentives. These are not expected to systematically disadvantage or benefit people based on their sexual orientation.

However, people from LGBT communities report poorer experiences of healthcare[380] [381]. Proposals to link funding to patient experience, such as Patient Power Payments and performance-related incentives, could offer some benefit if they result in more responsive care and accountability. This impact would depend on how inclusive and accessible feedback mechanisms are, and whether they reach individuals less likely to engage through conventional channels.

Marriage and civil partnership

These proposals are assessed to have no impact on people with the protected characteristic of marriage and civil partnership, in line with the public sector equality duty, which applies to this characteristic only in relation to the elimination of unlawful discrimination (aim 1).

[380] NHS (2024). Sexual orientation https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/mental-health-services-data-set/submit-data/data-quality-of-protected-characteristics-and-other-vulnerable-groups/sexual-orientation. Accessed 8 July 2025.

[381] The term LGB is used throughout this document in the sexual orientation sections. Where cited sources use broader terms such as LGBT, LGBT+, or LGBTQ+, those terms are retained to reflect the original language of the source.