MDA No.	1	1	4	5

Title: Health Inequalities Strategy

Executive Summary

At its meeting on 22 January 2020, the Health Committee resolved:

That authority be delegated to the Chair, in consultation with the Deputy Chairman, to agree any output from the discussion. [Health Inequalities Strategy]

Following consultation, the Chair of the Health Committee wrote to the Mayor with a number of recommendations. The letter will be formally noted at the Committee's next appropriate meeting.

Decision

That the letter on the Mayor's Health Inequalities Strategy be agreed.

Assembly Member
I confirm that I do not have any disclosable pecuniary interests in the proposed decision and take the decision in compliance with the Code of Conduct for elected Members of the Authority.

The above request has my approval.

Signature **Date** 18/05/20

Printed Name
Dr Onkar Sahota AM, Chair of the Health Committee

Decision by an Assembly Member under Delegated Authority

Notes:

1. *The Lead Officer should prepare this form for signature by relevant Members of the Assembly to record any instance where the Member proposes to take action under a specific delegated authority. The purpose of the form is to record the advice received from officers, and the decision made.*

2. **The 'background' section (below) should be used to include an indication as to whether the information contained in / referred to in this Form should be considered as exempt under the Freedom of Information Act 2000 (FoIA), or the Environmental Information Regulations 2004 (EIR). If so, the specimen Annexe (attached below) should be used. If this form does deal with exempt information, you must submit both parts of this form for approval together.**

Background and proposed next steps:

At its meeting on 22 January 2020, the Health Committee resolved:

That authority be delegated to the Chair, in consultation with the Deputy Chairman, to agree any output from the discussion. [Health Inequalities Strategy]

Following consultation, the Chair of the Health Committee wrote to the Mayor with a number of recommendations. The letter will be formally noted at the Committee's next appropriate meeting.

Confirmation that appropriate delegated authority exists for this decision			
Signed by Committee Services	Lauren Harvey	Date	23/03/20
Print Name: Lauren Harvey		Tel:	4383

Financial implications **NOT REQUIRED**			
Signed by Finance	N/A	Date	.....
Print Name	N/A	Tel:	.....

Legal implications The Chair of the Health Committee has the power to make the decision set out in this report.			
Signed by Legal		Date	24/03/20
Print Name	Emma Strain, Monitoring Officer	Tel:	X 4399

Additional information should be provided supported by background papers. These could include for example the business case, a project report or the results of procurement evaluation.

Supporting detail/List of Consultees:

Steve O'Connell AM (Deputy Chairman of the Health Committee)

Public Access to Information

Information in this form (Part 1) is subject to the FoIA, or the EIR and will be made available on the GLA Website within one working day of approval.

If immediate publication risks compromising the implementation of the decision (for example, to complete a procurement process), it can be deferred until a specific date. Deferral periods should be kept to the shortest length strictly necessary. **Note:** this form (Part 1) will either be published within one working day after it has been approved or on the defer date.

Part 1 – Deferral
Is the publication of Part 1 of this approval to be deferred? No

Until what date: (a date is required if deferring)

Part 2 – Sensitive information

Only the facts or advice that would be exempt from disclosure under FoIA or EIR should be included in the separate Part 2 form, together with the legal rationale for non-publication.

Is there a part 2 form - No

Lead Officer/Author

Signed	Dan Tattersall	Date: 14/5/20
Print Name	**Dan Tattersall**	Tel: x1328
Job Title	**Senior Policy Adviser**	
Countersigned by Director	E. Williams	Date 15.05.2020
	.....	
Print Name	**Ed Williams**	Tel: x4399

Chair of the Health Committee

Dr Onkar Sahota
London Assembly member

City Hall
The Queen's Walk
London SE1 2AA
Switchboard: 020 7983 4000
Minicom: 020 7983 4458
Web: www.london.gov.uk

Sadiq Khan
Mayor of London
(Sent by email)

19 May 2020

Dear Sadiq,

Health Committee investigation – one-year review of the Health Inequalities Strategy

In January 2020, the London Assembly Health Committee examined progress you have made since the publication of the Health Inequalities Strategy (HIS) in September 2018. We heard from a range of representatives which included Dr Tom Coffey (Mayoral Health Advisor), Professor Paul Plant (former interim Regional Director, Public Health England and interim Statutory Health Advisor to the Mayor), Dr Nicole Klynman (Public Health Consultant for the London Borough of Hackney and City of London Corporation), Dr Jessica Allen (Deputy Director at the UCL Institute of Health Equity), Dr Vin Diwakar (NHS Regional Medical Director for London) and Dr Neil Churchill (Director of Experience, Participation and Equalities at NHS England).

Guests provided insights into how your Health Inequalities Strategy is informing local level service delivery. We also heard how you, as Mayor, have the possibility to develop the Strategy further to ensure it is best addressing the most pressing health inequalities.

Since the initiation of this investigation the COVID-19 crisis has had significant implications for health inequalities for Londoners that are slowly emerging. Initial stages of the spread of the disease have seen rapid changes to society's functioning, including to the UK's labour market, our social and cultural norms and huge and increasing demand on our health

services.[1,2,3] In light of this rapid shift it is likely that pre-existing inequalities will worsen. Whilst at this stage there is insufficient data to be able to determine the impact COVID-19 will have on inequality, the social and economic factors which lead to poorer health outcomes, such as employment, housing, early childhood experiences and educational attainment, have the potential to worsen, resulting in wider and more entrenched inequalities. It is widely acknowledged that chronic or lifestyle conditions disproportionately affect the most socioeconomically deprived.[4] Determinants of ill health also determine poor lifestyle behaviours and choices, which is reflected in the higher levels of smoking, alcohol and drug addiction concentrated amongst the more deprived groups.[5,6,7] Higher mortality rates in more deprived areas from circulatory, cancer, and chronic lower respiratory diseases account for more than 60 per cent of the total gap in life expectancy in London for both sexes. Addressing these diseases is likely to make a big impact on continuing to reduce inequalities in life expectancy.[8] In the current climate socio-economic determinants of health conditions may therefore impact negatively on more deprived groups as chronic diseases represent important risk factors in mortality deriving from COVID-19.[9]

Both access to, and quality of, employment contribute to health outcomes. Poor employment or unemployment leads to higher levels of poor physical and mental health.[10] Poor quality jobs remain a crucial issue for health inequalities as they are concentrated at the lower end of the social gradient.[11] In 2018, 875,000 Londoners were paid below the London Living wage. This is one in five of London's working population.[12] In-work poverty occurs when a working household's total income does not meet their need.[13] The latest available data for London's Poverty Profile shows that 1.3 million Londoners in poverty live as part of a working family, which is a 50 per cent increase over the last decade. [14] Many of these Individuals who are on low pay are part of the gig economy described as where "labour markets are characterised by prevalence of short-term contracts or freelance work".[15] London in particular has been reported as having the highest number of self-employed people in the UK.[16] These workers are not eligible for statutory sick pay and

[1] GLA Economics, London's Economy Today , March 2020
[2]NHS England, COVID-19 Daily Deaths, (*The Daily file contains only deaths from the latest reporting period, 5pm 2 days prior to publication until 5pm the day before publication. The Total file contains all reported deaths*)
[3]The Guardian, UK economy could shrink by 35% with 2m job losses, warns OBR, 14 April 2020
[4]UCL Institute of Health Equity, Fair Society, Healthy Lives, The Marmot Review, February 2020
[5]ONS, Likelihood of smoking four times higher in England's most deprived areas than least deprived, 14 March 2018.
[6] NHS Digital, Statistics on Smoking, England, 2019.
[7] Mayor of London, Health Inequalities Strategy, September 2018.
[8]GLA, HIS Annual report 18/19, October 2019.
[9]World Health Organisation (WHO), COVID-19 Situation 51, 11 March 2020.
[10]Public Health England, Local action on health inequalities, Promoting good quality jobs to reduce health inequalities, September 2015.
[11] UCL Institute of Health Equity, Fair Society, Healthy Lives, The Marmot Review, February 2020
[12] Employees earning below the London Living Wage, London datastore
[13] Nuffield Foundation, In-Work Poverty in the UK: Problem, policy analysis and platform for action, May 2017
[14] Trust for London, London's Poverty Profile 2017, October 2017
[15] House of Lords Briefing, the gig economy, 21 November 2017
[16] London Assembly Economy Committee, Low pay and in work-poverty, December 2019

conditions of such employment are highly insecure as such contracts do not guarantee a minimum number of paid hours. Consequently, these workers may be in a position where they continue working and will be at a high risk of exposure to the virus.[17]

Furthermore, self-isolation itself may pose challenges to the high numbers living in insecure and overcrowded housing. In 2018 there were approximately 370,000 children (under 16) in London living in households that are considered overcrowded. Poor housing of this type has shown to impact negatively on mental health.[18] The Committee are aware that the longer children are exposed to these conditions, the worse their health is likely to become.[19] Research has found that children's risk of ill health is increased by a quarter when living in substandard housing, particularly when exposed to cold temperatures, damp and mould over a sustained period of time.[20]

Early data and findings from experts have started to reveal the relationship between COVID-19 and socioeconomic deprivation. Research carried out by Food UK showed that across the UK one per cent of adults say they are relying on food banks and three per cent of adults (around 1.7 million) say they are not managing to get the food they need.[21] In addition, the survey looked at economic vulnerability to the virus and found that 12 per cent of adults (6 million) are struggling to stay at home due to the loss of essential income.[22] Worryingly, 54 per cent of children who are entitled to receive free school meals aren't receiving any provision.[23] Prior to COVID-19, access to healthy and nutritious food has been reported as a huge issue in the capital. The Mayor conducted a survey in 2019 which showed that almost two million Londoners experience food insecurity. Around 1.5 million adults and 400,000 children in London have low food security.[24] There have been early suggestions from other parts of the country that certain areas which have been hotspots for the virus could be linked to factors such as deprivation. Helen Carter, Deputy Director of Public Health England West Midlands, indicated that "high levels of historical deprivation and smoking, combined with the region's industrial past, could be leading to a higher than normal rate of coronavirus-related deaths."[25]

The Committee is aware of your own focus on the issue of inequality and COVID-19, particularly in relation to how the pandemic is disproportionately affecting BAME communities. We note the recent article you wrote[26] which explores the underlying socioeconomic factors that may be attributable to the disproportionate mortality rate experienced by BAME communities. As Professor Yvonne Doyle, Public Health England's

[17] UCL Institute of Health Equity, Fair Society, Healthy Lives, The Marmot Review, February 2020
[18] Ministry of Housing, Communities and Local Government, English Housing Survey, 2018
[19] Coley, et al, Early Exposure to Environmental Chaos and Children's Physical and Mental Health. Early Childhood Research Quarterly, 2015
[20] Marsh et al The impact of poor housing on health, The Policy Press, 1999
[21] Food Foundation, The impact of coronavirus on food, an online survey of 2070 adults in Great Britain conducted on 25th-26th March 2020 by YouGov Plc.
[22] ibid
[23] ibid
[24] City Intelligence, Food Security in London, June 2019
[25] The Guardian, Temporary mortuary being built at Birmingham airport, 27th March 2020
[26] The Guardian, More BAME people are dying from coronavirus. We have to know why, 19 April 2020

(PHE) Medical Director, has stated, there is currently limited recording of ethnicity in datasets.[27] The Committee therefore welcomes calls from yourself and a number of MPs, healthcare leaders and equality groups[28] for central Government to routinely collect and publish data on the demographics of everyone impacted by the coronavirus,[29] and for ethnicity to be recorded on death certificates:[30] these are important steps in identifying the most vulnerable communities and ensuring appropriate measures can be taken to protect them. A national review[31] is analysing how different factors, including ethnicity, gender, obesity and homelessness, can impact on people's health outcomes from COVID-19. It is being led by PHE and conducted by analysing the thousands of existing health records of people who have had COVID-19. The findings will be published by the end of May. We hope that you will be able to engage with this review, and act upon its findings to sustain action on behalf of London's BAME and vulnerable communities.

We note that the crisis has arisen after this initial Health Committee investigation started, and as such our findings here reflect the original scope of the investigation, intended to review progress one year on from implementation of the health inequalities strategy. The Committee believes that in light of the current and potential impacts on inequalities that the recommendations contained within this letter become even more pressing to consider, to ensure that variations in health outcomes do not worsen. The Committee believes that the COVID-19 crisis will exacerbate the present inequality challenges in society and as such it is important that the Mayor and his health advisors monitor developments closely and consider any mitigating actions in the most urgent areas.

Engagement from Health Partners

The Committee heard about the approach which you have taken to engage health partners in the implementation of the HIS locally, including most notably the design of a set of guides for the voluntary sector, local authorities, the NHS and business, which highlight health inequalities priorities. The Committee welcome the inclusion of a series of workshops designed to share learning more widely, as we recognise the importance of such events to help share best practice and offer advice and guidance to areas who may need more support with implementation.[32] The Committee calls on you to ensure that learning from these workshops can be utilised and embedded, where appropriate, at a borough, Sustainability and Transformation Partnership (STPs) and city-wide London level. At a local level through STPs, this learning can be useful to understand how boroughs are incorporating HIS priorities in their area and where they may need support. At a regional level, learnings may be useful to further inform STPs plans and at a London level this may support strategic decision-making at an NHS board level.

Furthermore, the Committee is aware that STPs plans are the vehicle for delivering the strategy locally. We are aware of the work undertaken so far to promote the use of the

[27]The Guardian, Failure to publish data on BAME deaths could put more lives at risk, MPS warn, 16 April 2020
[28] The Guardian, Failure to publish data on BAME deaths could put more lives at risk, MPS warn, 16 April 2020
[29] The Guardian, More BAME people are dying from coronavirus. We have to know why, 19 April 2020
[30] Mayor of London, Mayor calls for more transparency to tackle COVID-19 inequality. 7 May 2020
[31] Public Health England, Review into factors impacting health outcomes from COVID-19
[32] London Assembly Health Committee, January 2020

Mayor's six tests (SK6) when assessing STPs plans and significant service reconfiguration in London. The Committee has heard that this has been, on the whole, effective with certain areas consulting in advance of drawing up plans to ensure that they are compliant with the SK6 tests.[33] The Committee calls on the Mayor to proactively focus on engagement with STP leads to ensure that all STPs conduct an equality impact assessment on any service changes. In light of the current COVID-19 crisis and the necessary reconfigurations of services which will take place to respond to the crisis, it is vital that equality impact assessments are carried out to ensure a sustained focus on health inequalities.

Recommendation 1: To support embedding health inequalities priorities further, the Committee recommends that learning from workshops with local authorities is utilised and implemented where appropriate, at a borough, STP and London-wide level to better understand how the strategy is working on the ground. The Mayor should provide an implementation plan to be shared with the Committee by the end of September 2020.

Recommendation 2: The Mayor should proactively focus on engagement with STP leads in order to ensure that the upcoming plans have a sustained focus on health inequalities. As part of this the Mayor should ensure that all STPs conduct an equality impact assessment when carrying out any service changes. A commitment should be made on doing so by the end of July 2020.

It is well evidenced that the public health approach is effective at delivering better health outcomes and can be more targeted toward those who are most exposed to inequalities.[34] As the Kings Fund note in their 2013 report on Public Health approaches, "the Marmot Review into Health Inequalities in England stated in its report, Fair Society, Healthy Lives (Marmot et al 2010), the 'broader determinants of health'– people's local environment, housing, transport, employment, and their social interactions – can be significantly influenced by how local authorities deliver their core roles and functions."[35] Research from 2014 shows that tobacco control directed at children can generate £15 of benefits for every £1 invested.[36] Furthermore, drug and alcohol services are both proven to have benefits for people's health and wellbeing and support a reduction in crime. [37] Particularly in relation to childhood obesity, the Committee heard the first point of contact with families is vital to embed good habits and prevent increasing the risk of obesity later in life. Evidence strongly suggests that early intervention in the first 100 days can prevent children becoming overweight in reception and subsequently overweight or obese in year 6.[38] As we heard from Dr Nicole Klynman, Public

[33] Ibid
[34] Public Health England, Reducing health Inequalities system scale and sustainability, 2017
[35] The Kings Fund, Improving the public's health, 2013
[36] Ibid
[37] Institute of Public Policy Research (IPPR), Hitting the poorest worse? How public health cuts have been experienced in some of England's most deprived communities, 2019
[38] Centre for Social Justice, Off The Scales Obesity, Tackling Childhood Obesity Crisis, 2017

Health Consultant, these interventions come from locally commissioned services, which require additional funding for public health.

"I would also support the Healthy Early Years London programme HEYL and campaigning for public health budgets, because we commission health visiting services and that is really the most important first point of contact, and then obviously that continued contact for those vulnerable families." (Dr Nicole Klynman, Public Health Consultant, London Borough of Hackney and City of London Corporation).[39]

We also heard the most effective approach to tackling nicotine dependence requires both hospital intervention and intensive and ongoing support from local services commissioned by the local authority.[40] Overall, the evidence highlights that the success of the many of the overarching objectives and associated policies and programmes within the HIS rely on local service provision and support and approaches which are firmly rooted within the remit of Public Health. The Committee heard that localised interventions, such as smoking cessation clinics, community champions or HIV services, which often sit under the remit of public health provision, are effective at addressing inequalities as they can be tailored to the specific need of that local population. As Dr Vin Diwakar, Regional Medical Director for the NHS, stated "*health inequalities are located and nested in communities and in individuals, so you have to commission and go to them and say, "What is it that matters to you?" and design your services around them.*" [41]

The Committee, therefore, believes that equitable public health funding is a necessary condition to ensure improved health outcomes universally and to an even greater extent for the most deprived communities. Research published by the Institute of Public Policy Research (IPPR) shows that the areas with the highest need have faced the highest cuts. Almost £1 in every £7 cut from public health services has come from England's ten most deprived communities - compared to just £1 in every £46 in the country's ten least deprived places. The total, absolute cuts in the poorest places have thus been six times larger than in the least deprived. In relative terms, the poorest ten places have lost approximately 35p in every £1 of their budget, compared to approximately 20p in every £1 of their budget cut in the least deprived places. In London specifically, the share of the Public Health Grant has fallen to £630 million in 2019/20, representing a per head funding reduction from £80.75 in 2015 to £68.61 in 2019, a fall of 15 per cent and the biggest regional reduction in England.[42,43] As the IPPR state, we know less about the demographics and communities which are most affected by the cuts.[44] The Committee urges the Mayor to work with local

[39] London Assembly Health Committee, January 2020.
[40] London Assembly Health Committee, January 2020
[41] Ibid
[42] London Councils, Public Health funding, 2019 https://www.londoncouncils.gov.uk/our-key-themes/health-and-adult-services/public-health/public-health-funding-0
[43] Government pledges extra 1.6 billion for councils (*As of 18 April 2020 the Government have pledged 3.2 billion for councils to respond to COVID-19)
[44] Institute of Public Policy Research (IPPR), Hitting the poorest worse? How public health cuts have been experienced in some of England's most deprived communities, 2019

authorities to obtain better data on public health need across London in order to address health inequalities.

Recommendation 3: The Mayor should work with local authorities to obtain better data on the public health need across London. The Mayor should:

a) conduct local level impact assessments to understand the wider impact which public health funding allocations from central government are having on the status of local population health inequalities, and councils' ability to implement the necessary policies to tackle and address health inequalities and the wider determinants.

b) ensure that this data is shared and collated in the GLA/at a London level and utilised to inform lobbying central government ahead of the next spending review.

A commitment to doing so should be made by the end of September 2020.

Health in all policies

The underlying importance of the wider determinants of health and their impacts on health inequalities is widely acknowledged by health professionals. In particular, the Marmot Review, 10 years on, acknowledges that the health of the population is not just a matter of how well the health service is funded and functions. Health is closely linked to the conditions in which people are born, grow, live, work and age and inequities in power, money and resources – the social determinants of health.[45] The 'health in all policies' approach is a significant step toward systematically addressing wider determinants. Whilst we recognise the firm commitments in your strategy and implementation plan on urban environment, transport, housing and pollution, the Committee believes that there needs to be clear processes in place to track and monitor how effectively the 'health in all policies' approach is working in practice. As discussed above, the issues of overcrowded or insecure housing have become even more acute in light of COVID-19, with people spending extended periods of time at home and the ability to self-isolate being a key component of infection control. The Committee therefore urges you to ensure that your housing policies are designed in a way that best supports delivering on your health commitments.

The Committee heard that cross-sector mechanisms, in place to tackle health inequalities, could be strengthened and there are other sectors which could be involved.[46] According to guidance published in 2017 by Public Health England, interventions to produce measurable change in inequalities at population level will usually be multi-sectoral and involve whole systems. [47] For example in Coventry, where they have taken significant steps to reduce health inequalities, they have worked with multiple partners including fire and emergency

[45] UCL Institute of Health Equity, Fair Society, Healthy Lives, The Marmot Review, February 2020
[46] London Health Assembly, January 2020
[47] Public Health England, Reducing health Inequalities system scale and sustainability, 2017

services, several council departments, Public Health and Voluntary, Community and Social Enterprise (VCSE).[48] In doing so they have implemented an approach whereby they are working both cross-sector and across systems such as local authorities, STPs, health and wellbeing boards (HWBs), and accountable care organisations (ACOs).

The Committee therefore calls on the Mayor to report back on how policies across the other mayoral strategies are incorporating metrics to measure impact on health. Further to this the Mayor should seek to undertake a review on the most effective ways to strengthen the cross-sector mechanisms currently in place.[49]

Recommendation 4: The Mayor should report back on how policies on planning, transport and environment are incorporating metrics to measure impact on health. Furthermore, the Mayor should seek to examine ways to strengthen the cross-sector mechanisms which are in place to support better health outcomes and the public health agenda. An update on how the Mayor is doing so should be provided by the end of September 2020.

Recommendation 5: The Mayor should examine policies on overcrowding and family-sized homes, particularly in light of COVID-19, to ensure that they match up with the objectives of his health policies. An update on the compatibility of these policies should also be provided by the end of September 2020.

Healthy children

The Committee heard that there have been multiple approaches to working with the food and drinks industry both through PHE and the Childhood Obesity Taskforce. The Committee welcomes the approaches being taken, which includes: working with national industry to remove sugar at source; working with the food industry to explore options to changing menus to make sure they are healthier; and reformulation of products to take more sugar out of their diet.[50] However, currently there is no evidence to suggest how you, as Mayor, have engaged with the food and drinks industry or worked with PHE in order to understand which are the most effective interventions. The Committee believes that the Mayor should adopt a more proactive approach in opening a dialogue with the food and drinks industry to

[48]UCL Institute of Health Equity, Coventry Marmot City Evaluation, 2020,
[49] Public Health England, Reducing health Inequalities system scale and sustainability, 2017
[50] London Assembly Health Committee, January 2020

support the introduction of policies which are effective in addressing childhood obesity and related health issues.

Recommendation 6: The Mayor should work more closely with Public Health England to develop an aligned approach for engagement with the food and drinks industry in order to promote evidence-based interventions which tackle childhood obesity. A commitment to doing so should be provided by the end of September 2020.

The Committee is aware of the variable coverage across London of the Healthy Early Years London programme (HEYL). According to the HEYL one-year evaluation, it is encouraging to see that out of the 17 priority boroughs identified by HEYL in 2018, 16 have confirmed, or are committing, local resource to the HEYL programme.[51] Whilst the Committee welcomes this development, we heard that there is still a lot more work to be done to unblock issues for specific schools and reach more deprived areas. We heard from Professor Paul Plant, former Statutory Health Advisor, who stated that:

"*My experience of these sorts of things is that they snowball once people can see success. Show people success. Do not tell them what a good scheme might be. The more we circulate that; I think we will unblock. You can do it in deprived areas. "Look at this school here." They will know the team doing the Healthy Schools. There is a particular approach to sharing that good practice, circulating it around, networking people in to unblock very specific issues for very specific schools.".*[52]

The evaluation found that although borough leads are very focused on this issue, they require more time and resource to be able to reach out to recruit and influence more settings in deprived areas.[53] It is encouraging that the HEYL program has met its 2020 target early and signed up 10 per cent of early years settings, but it is clear that more must be done to ensure that once signed up areas are better supported in the implementation and design of the programme.[54] The Committee believes that the Mayor must take action to support boroughs to ensure that the learning and best practice is shared in order to encourage a greater number of early years settings based in more deprived communities to both commit to the programme and be supported to deliver on its aims. The Committee, therefore, calls on the Mayor to develop an approach to enable shared learning between boroughs and an offer of enhanced support to areas experiencing challenges with implementation.

Recommendation 7: The Mayor should develop an approach to enable shared learning between boroughs on the implementation of the HEYL program. The approach should give particular focus to reaching out and sharing best practice with the settings in the most deprived communities. An implementation plan should be provided by the end of September 2020.

[51] Cavill Associates, HEYL year one evaluation, 2019
[52] London Assembly Health Committee, January 2020.
[53] Cavill Associates, HEYL year one evaluation, 2019
[54] Ibid

Healthy minds

The Committee believes that public sector bodies, including the NHS, should review their supply chains to ensure they also adhere to the same standards as the Mayor's Good Work Standard and the London Healthy Workplace Award. The Committee heard that there are clear examples of health institutions that are specifically looking at this area and systematically at the social value, which their employment policies and procurement practices add.[55] This is a practice already widely used and adopted across local authorities through the Public Services Social Value Act 2012, which supports embedding social value in procurement. The benefits of this can have a direct impact on the wider determinants of health, such as, supporting new employment opportunities in turn helping decrease unemployment and break the cycle of deprivation.[56] The Committee, therefore, urges you as Chair of the London Health Board to advocate for improvement of public sector supply chains, and in particular to use the platform of the NHS Long-Term plan boards[57] to create opportunities for review.

Recommendation 8: As Chair of the London Health Board the Mayor should a) advocate for the improvement of public sector supply chains to ensure that both their employment and procurement policies add social value i.e. create good employment opportunities. b) promote a review of contracting practices and supply chain practices to be undertaken as part of the work of the NHS long-term plan boards. To be delivered by the end of September 2020.

The Committee heard that there are currently barriers for small and medium sized enterprises (SMEs) in accessing the London Healthy Workplace Award. The schemes and the way in which they can be accessed are currently more accessible to larger companies with greater infrastructure and the means to offer their employees' the required workplace benefits. As we heard, within London, over 95 per cent of businesses are SMEs and some of the lowest paid workers are in the smallest organisations.[58] As such, if these awards are to be effective levers for change in setting workplace standards, it is vital that they are adapted to offer something more viable for SME's who have less resource and capacity than larger organisations. The Committee heard from Dr Tom Coffey, your Health Advisor, that there is more targeted work underway with the London Healthy Workplace Awards aimed at small companies and companies who have people on lower incomes, to promote improvements in workplace practices which are supportive of employees' health. We also heard that further work is underway to review how the London Healthy Workplace award can be accessed for small organisations, classified as having employees of 20 or less. The

[55] London Assembly Health Committee, January 2020.

[56] Social Enterprise UK, The Social Value Guide, Implementing the Public Services Social Value Act, 2012

[57] NHS Long-Term plan boards are developed at an integrated care systems (ICS) level and should include a non-executive chair (locally appointed, but subject to approval by NHS England and NHS Improvement) and arrangements for involving non-executive members of boards/ governing bodies. More detail can be found here. (page 30)

[58] London Assembly Health Committee, January 2020.

Committee looks forward to the work being undertaken and strongly urges that the Mayor shares this work and further progress updates on this as soon as possible. The Committee is also aware that the Good Work Standard is currently only targeting a few sectors and has been effective at reaching, again, larger organisations. The Committee therefore recommends that the work underway to review access of SMEs to the London Healthy Workplace awards is also expanded to include broadening the reach of the Good Work Standard.

Recommendation 9: The Committee recommends that the Mayor provides an update on the work being undertaken to address barriers to accessing the London Healthy Workplace awards for SME's. The Committee also recommends that this work incorporates a review of the Good Work Standard. This should be provided by the end of September 2020.

In 2020, 36 per cent of UK employees report having a low-quality job. The analysis also shows that people in low-quality jobs are much more likely to have poor health and twice as likely to report their health is not good.[59] The issue of low-quality work remains an entrenched and widespread problem within our society. This is particularly alarming to the Committee, given that it is well-evidenced that work, both, access to it and quality of it, remain a significant factor in determining poor or good health outcomes.[60] The Committee, therefore stresses the need for the Mayor to undertake a broader review of The Good Work Standard and The London Healthy Workplace Awards to determine how effective they are in ensuring the widespread adoption of high-quality workplace standards.

Recommendation 10: The Mayor should undertake a broader review of the workplace programmes, both the London Healthy Workplace awards and the Good Work Standard, to determine how effective they are as levers for change in setting high quality workplace standards and ensuring widespread adoption of these across London. This should be provided by the end of September 2020.

Healthy places

The Committee welcomes the focus in the Health Inequalities Strategy on the importance of creating healthy environments in order to promote good mental and physical health. The Committee is aware that the future London Plan has a clear role to play in establishing this through the application of Policy GG3, "Creating a healthy city". This policy sets a framework for developers and planners to create a healthier city through applying and embedding health considerations in planning guidance. These standards seek to ensure that planning guidance accounts for the promotion of active and healthy lives and minimises inequalities in access to healthy environments.[61] The Committee believes that these standards should also be of serious consideration in planning applications made within land directly owned by

[59] The Health Foundation, One in three employees report being in low quality jobs, 2020
[60] UCL Institute of Health Equity, Fair Society, Healthy Lives, The Marmot Review, February 2020
[61] Mayor of London, The London Plan Spatial Development Strategy for Greater London, Intend to Publish, 2019

your own development corporations, and as such calls on the Mayor to update the Committee on how good design policies and health considerations are being applied in the work of the mayoral development corporations.

Recommendation 11: The Mayor should update the Committee on the work of the mayoral development corporations; London Legacy Development Corporation and the Old Oak and Royal Park Development Corporation, to include detail on:

a) how they are supporting boroughs to embed health considerations within planning applications and support new developments which have health as a central aim; and

b) how the Mayor is ensuring they are exemplars of good design principles.

A commitment to doing so should be provided by the end of September 2020.

The Committee recognises that the Healthy Streets Approach can have a very positive impact on Londoner's health, as well as producing huge cost savings to the NHS. Research shows that if every Londoner walked or cycled for 20 minutes a day, it would save the NHS £1.7bn in treatment costs over the next 25 years.[62] The Committee heard that you have created 18 Healthy Streets Officers who are working with boroughs to identify opportunities to support the implementation of the Healthy Streets programme. We welcome this development, as we understand that individual boroughs will apply the approach according to the needs and aspirations of their residents and the individual differences in the set up and design of their streets. In 2017, the Healthy Streets Survey results showed measurable increase in people's satisfaction with their environments where improvements had been made to the street, which demonstrates the positive impact which the Healthy Streets programme, and the interventions underpinning it, have on people's perceptions of their environments.[63] The Committee welcomes this data as it provides useful feedback on how such an approach is working at a local level, but we believe that more data and feedback should be provided in order for us to assess progress. The Committee, therefore, calls on the Mayor to provide an update on the programme through learning gathered across the 18 Healthy Streets Officers.

Recommendation 12: The Mayor should provide an update on what the Healthy Streets Officers have found so far in their work with boroughs to embed the Healthy Streets programme in their areas. The update should include:

a) coverage of the programme across London;

b) the impact across the capital;

c) challenges which boroughs have encountered through implementation; and

d) plans for shared learning and best practice between boroughs.

The update should be provided by the end of September 2020.

[62] GLA, London set to become the world's most walkable city, 2018
[63] TfL, Healthy Streets Survey, 2017

Healthy Living

The Committee welcomes your ambition to reduce the serious harm caused by addiction to tobacco, alcohol, drugs and gambling. The Committee heard that whilst smoking rates are declining, there are higher rates among more deprived communities. Additionally, severe addiction is also experienced greatly by already vulnerable individuals and they require intensive support from NHS services which extend beyond prevention.[64] The Committee is also aware that those adults classified as routine and manual workers were most likely to be current smokers (25 per cent) and those in managerial and professional occupations were least likely (10 per cent).[65] On the whole, we believe this is an indication that more work should be done to reach and target the most vulnerable. In your own Health Inequalities Strategy, you state the harms caused by both alcohol and drug abuse and the disproportionate affect they have on more deprived communities. "Deprived communities are likely to experience five to seven times the amount of alcohol-related harm as the general population; disadvantaged groups experience greater harm from the same or even lower levels of alcohol consumption." [66]

Alcohol is also a significant factor in contributing to crime, domestic abuse and the onset of mental illness.[67] The consequences associated with both legal and illicit drugs are significant. According to research, the vast majority of drug-related deaths involve opiates. While nearly half of these deaths are caused by overdose, people who use drugs are far more vulnerable to other illnesses and other causes of death as well – cancer, cardiovascular disease, respiratory disease, liver disease, suicide and homicide. There is also a proven link that opiate users are 12 times more likely to be the victim of homicide than the general population.[68] The Committee, therefore, believes there is an urgent need to develop a set of key performance indicators, with a key focus on deprived groups, which will help monitor the effectiveness of the current policies in place to address the harms associated with drug, alcohol, tobacco and gambling addiction.

Recommendation 13: The Mayor should develop a set of Key Performance Indicator's (KPI's) related to drug, alcohol, tobacco and gambling addiction. The new set of KPI's should be included in the updated implementation plan and form part of an update to the deliverables for 2020-2022. A commitment to doing so should be provided by the end of September 2020.

Healthy Community

The Committee welcomes the role you have played in advocating for the rollout of social prescribing across London in 2018 through your Social Prescribing Vision for London Strategy. This strategy sets a clear long-term vision for social prescribing over the next ten years.[69] We recognise the pivotal role which social prescribing plays in supporting vulnerable

[64] London Assembly Health Committee, January 2020.
[65] NHS Digital, Statistics on Smoking, England, 2019
[66] Mayor of London, Health Inequalities Strategy, September 2018,
[67] World Health Organisation, Factsheet alcohol, 2018
[68] House of Commons, Health and Social Care Committee, Drugs policy, 2019
[69] Mayor of London and Healthy London Partnership, Social Prescribing: Our Vision for London 2018-2028, 2018

people to seek out support within their community.[70] We therefore believe, if implemented well, social prescribing can play a critical role in helping to join up services and provide more integrated care for the individual. The Bromley by Bow social prescribing service is a well-known model embedded firmly within the community. The Committee heard that the model is effective as it provides local services close to where people need them, in the heart of their community. The Mayor's Next Steps for Social Prescribing outlines the clear role which the VCSE, housing associations and local government play in ensuring an effective social prescribing model, including the core aim of bringing people closer to support in their local community.[71]

The Committee welcomes the ambitions set out in the document. However, we believe there are challenges which prevent this vision translating into reality. One of the biggest challenges is that primary care estate is not located near to local government resource, and as such it is harder for people to access the social and welfare services they need in their community. The Committee, therefore, urges you to use your role as Chair of the London Estates Board and the London Health Board to encourage co-location of primary care and local government resource to enable better integrated services.

Recommendation 14: The Mayor should use his role as Chair of the London Estates Board and the London Health Board to encourage co-location of primary care and local government resources to enable better joint working between shared primary care and local government resource. A commitment to doing so should be provided by the end of September 2020.

I would be grateful to receive a response to our findings and recommendations by the end of September 2020 for all recommendations except for Recommendation 2, for which we would I would be grateful to receive a response by the end of July 2020. Please also send your response by email to the Committee's clerk, Lauren Harvey (lauren.harvey@london.gov.uk).

Yours sincerely,

Dr Onkar Sahota AM

Chair of the Health Committee

[70] The University of York, Evidence to inform the commissioning of social prescribing, 2015

[71] Mayor of London and Healthy London Partnership, Next Steps for Social Prescribing in London, October 2019