Appendix 4

MAYOR OF LONDON

Dr Onkar Sahota
Chair of the London Assembly Health Committee
City Hall
The Queen's Walk
More London
London SE1 2AA

Our ref: MGLA130718-7541

Date: 07 AUG 2018

I am writing in response to your correspondence, following the Health Committee meeting of 28 June, at which my Senior Adviser on Health Policy, Dr Tom Coffey, and my Statutory Health Adviser, Professor Yvonne Doyle, were present and answered questions relating to the draft implementation plan for my forthcoming Health Inequalities Strategy.

Dr Coffey and Professor Doyle, as well as Health Team colleagues, have told me that the challenge you gave them in this session was useful and thought provoking, and several changes have been made to the implementation plan as a result. Indeed, more generally I would like to take this opportunity to thank you for your continuing input and advice, which has been extremely valuable as I have developed my Health Inequalities Strategy and implementation plan. I look forward to continuing to work with the Committee as the Strategy moves into the implementation phase.

In response to the letter sent to Professor Doyle and Dr Coffey on 4 July, please find below comments pertaining to the two key issues on which you sought further clarification:

1. **Whether all schools in London have drinking fountains for their students**
   Advice from Public Health England (PHE) is provided in an appendix to this letter. In short, Public Health England colleagues advise that in some schools, water is not as accessible as it could be to facilitate a shift away from consumption of sugar-sweetened beverages. As discussed during the meeting, action to further develop water fountain infrastructure in schools is being taken forward by PHE.

2. **Details of the city-wide plan to have London as a zero-suicide city, including when it will be published.**
   As you know, one of the objectives of my Health Inequalities Strategy is to see action taken to prevent suicide, and to ensure that all Londoners know where they can get help should they need it.

   There is a considerable amount of activity taking place on suicide prevention across London. Mostly, this is developed and led locally, reflecting the local context and needs, and articulated in borough suicide prevention plans. As Mayor, I seek to support local action and take opportunities for pan-London work where appropriate. For example, as you know, I am committed to supporting the roll-out of mental health first aid informed approaches across London, starting with our schools, to make sure more Londoners are able to spot the signs of mental ill health and have the confidence to intervene and direct others to specialist support as required.

The Thrive LDN movement aims to create a long-term shared vision for London as a 'zero-suicide city', and as a first step towards this London is aiming to meet the national target of a 10 per cent reduction in the number of suicides by 2021. There are also a number of pan-London activities which Thrive LDN is taking forward this year (funded by NHS England), and responding to your request I have now included these in my draft implementation plan.

Regarding a specific document outlining the London approach to suicide prevention, this work in being led by London Councils, and my officers are working with them to progress this.

In your subsequent letter, sent on 13 July, you asked that several points be addressed in advance of the Assembly plenary meeting, to allow time for consideration of the response before the plenary. I have responded to your recommendations below, as per your sub-headings:

Population health or health inequalities?
I agree it is very important that this strategy should focus on reducing health inequalities rather than improving health in general, since the latter carries the risk of exacerbating inequalities. I have asked officers to review the strategy and the implementation plan again with your suggestions in mind, and the results of this will be reflected in the final documents. For example, amendments have been made to the wording of some of my key ambitions to clarify the inequalities dimension:

The Mayor's key ambition is that all Londoners are doing the physical activity they need to every day to stay healthy, <u>with efforts focused on supporting the most inactive.</u>

Crucially, my Health Team is making sure this focus is at the forefront of deliberation and decisions when developing project and action plans, including importantly, when working with partners.

Bolder and more specific targets
You have challenged us on the ambition and the nuance of some of my targets, particularly referencing those for child obesity, Healthy Early Years London, the London Healthy Workplace Charter, and physical inactivity. I address each of these below.

<u>Child obesity:</u>
I agree that a 10 per cent reduction in childhood obesity by 2028 is not sufficiently ambitious. This target was derived from the Better Health for London target, and does not represent my current ambition. As you know, I have recently convened a London Child Obesity Taskforce that will be driving London-wide action on child obesity. The Taskforce is in the process of developing an ambition for child obesity in London, specifically in tackling the inequality that exists, and is likely to reflect the national target of halving levels of obesity by 2030. Further details of the ambition and the roadmap to achieving it will be published by the Taskforce in its forthcoming action plan. In support of this work, I am proposing to achieve an initial 10 per cent reduction in the proportion of children in reception who are overweight by 2023/24, with the view that this cohort of London's children will contribute to healthy weight outcomes in the population as they enter the sixth year of full time education - five years later.

<u>Healthy Early Years London:</u>
The Healthy Early Years London (HEYL) programme – which will be launched in the autumn - is focused on infants and children from birth to age 5, at which point it seamlessly joins up with the Healthy Schools London programme.

The focus for the HEYL programme in this initial stage is the engagement of boroughs and early years settings. Although the initial response to HEYL has been warm, I remain mindful of the considerable pressure that boroughs are under. This is reflected in the 10 per cent target for registered early years settings to be signed up to HEYL, which has been designed to be challenging, yet still achievable for boroughs, to avoid jeopardizing the current good will and enthusiasm among borough partners.

However, I do understand the Health Committee's point regarding a more 'stretching' target, and would like to rise to that challenge by introducing a 'stretch' target that 15 per cent of all registered early years settings in London be signed up to HEYL by 2020. This stretch target will be reviewed in light of progress during this first year, reflecting on the outcomes of the 'year 1' evaluation of the programme implementation, which will commence shortly.

The Committee also queried the HEYL target in terms of health inequalities. As I will outline in more detail in my forthcoming response to the Committee's recent report 'Healthy First Steps', the HEYL programme is targeted at health inequalities in a number of ways. For example, recruitment is focused on encouraging boroughs that have the poorest outcomes on a range of markers to sign up to HEYL – my officers have identified seventeen such priority areas which they are actively targeting. The HEYL Award itself specifically encourages settings to adopt a universal and targeted approach to improving outcomes across the whole setting, and for targeted groups of children, parents and carers. Further, as part of the programme, boroughs are also encouraged to actively focus on signing up settings in areas of greater health inequality or disadvantage.

It is reasonable for the Health Committee to call for a target which more clearly draws out the health inequalities focus of this programme. However, for the reasons outlined above, I do not feel it is appropriate in these early stages of implementation to set an additional inequalities target. This will however be fully explored with boroughs in light of the learning from the year 1 evaluation.

London Healthy Workplace Charter:

I note the Committee's suggestion that the target for the Charter should reflect the inequalities dimension, i.e. relating to an increase in the number of small businesses and those in lower paid sectors signed up to the London Healthy Workplace Charter. As you are aware, the Charter is being reviewed and refreshed over the coming months (including in relation to the forthcoming Good Work Standard), and this process will inform my ambition. Officers will reflect on the targets, particularly those relating to these priority groups, after this process, and will be happy to discuss with the Committee after this process is complete.

Active travel:

I note the Committee's view that the objective on "increasing active travel by 2041 is manifestly unambitious." To be clear, the target for this ambition is that: all Londoners will do at least the 20 minutes of active travel (e.g. walking, cycling) they need to stay healthy each day. I believe this target is challenging, given that the most recent data tells us only 31 per cent of adult Londoners report having walked or cycled for two ten-minute periods on the previous day[1].

[1] Transport for London (2017) Travel in London Report 10, page 115

This target is about reducing inactivity, rather than increasing activity, and actions must be focused on those who are inactive. My officers have reviewed the text of the relevant objective and ambition to try to more clearly reflect this commitment to addressing inactivity across the whole of London, i.e.

> Ambition: is for all Londoners to be doing the physical activity they need on a daily basis to stay healthy, with efforts focused on supporting the most inactive.
>
> Objective: All Londoners achieve at least the minimum level of daily activity needed to maintain good health

Further examples:
Regarding the further examples of targets offered by the Committee in your letter, my team have considered these, and some will be included in the implementation plan – for example, further information has been included on numbers of mental health first aiders. However, several of the items you identified are not within my remit and the development of any targets would be for the lead organisation to determine (and indeed, they may already have such targets). For example, individual London boroughs lead on getting businesses to sign up locally to the Healthier Catering Commitment, and NHS will lead on engagement with the Child Health Digital Hub and eRedbook. Progress on such partner led projects will be discussed with partners through the London Prevention Partnership Board as the strategy moves forward, but they are not appropriate for my own implementation plan.

Improve the clarity and consistency of the final set of documents
Thank you again for highlighting this – I am of course keen to ensure the strategy and supporting documents tell a clear and coherent story. The versions of the Strategy and the implementation plan provided to the Committee were still in draft, as I wanted the Committee to be able to influence and inform the final versions. Officers will reflect on your helpful feedback as the text is finalised. I recognise how important it is to map out commitments and supporting actions, and to reflect back on this as the work progresses to ensure that I am achieving what I have set out to.

It is important that this is seen within context however – this is a 10 year strategy, which provides a narrative about health inequalities in London, while making a series of high level commitments which require both mayoral and partner input. The implementation plan is a summary of proposed mayoral actions over the next one to two years, representing the first stages of working towards those commitments, but not providing a comprehensive action plan for how these 10-year commitments will be achieved, which would be unrealistic at this stage.

I would like to specifically pick up point 6, which refers to partners' accountability. The mechanism for monitoring the Strategy from a partnership perspective is the London Prevention Partnership Board – which is chaired by Professor Doyle. Over the next few months, officers will be working through the Board to establish appropriate ways of monitoring and reporting partner activity relating to the Strategy. It should also be noted that the Health Inequalities Strategy is a regular agenda item for the London Health Board, and the Strategic Partnership Board which reports into it.

Challenging the NHS and other partners
It is indeed heartening to see the recognition in the new NHS mandate of NHS England's key role in reducing inequalities.

My advisers and I meet regularly with colleagues at NHS England - through the London Health Board and its subsidiary boards, as well as through a range of other forums (including regular meetings with the London Regional Directors of both NHS England and NHS Improvement) – where opportunities are taken to discuss approaches to, and expectations about, reducing health inequalities in London. I have also set out my stall clearly in the Health Inequalities Strategy and implementation plan – both of which make specific challenges and calls on the NHS for action which is vital to addressing inequalities. This includes an overview of what I see as the NHS' core roles in terms of health inequalities (see Figure 7) which has been amended in light of your comments to ensure that it clearly reflects primary and secondary prevention services provided by the NHS.

Supporting boroughs to achieve
I certainly agree with the Committee about the importance of boroughs being sufficiently resourced and able to play their crucial role in reducing health inequalities; they are a vital part of the jigsaw and I recognise this strategy cannot succeed without the support and commitment of London's local authorities and health and wellbeing boards. London Councils is a key partner in this Strategy, and my officers and I will continue to work closely with them to identify the most meaningful ways that I can support London's local authorities, particularly where value can be added through pan-London work. More generally, as the strategy moves into the implementation phase, officers will be working closely with borough partners to understand the most effective ways to engage and collaborate.

I would greatly value the Health Committee's help here, as with other aspects of the implementation, to support my officers at a local level in working with boroughs to reduce health inequalities.

I note the Committee's reference to public health funding. This is an area of vital importance. Public health needs to be sufficiently funded to allow local areas to take action on the determinants of health and address inequalities locally. I have added a specific call on the Government to ensure that public health funding is allocated on the basis of need, and that it keeps pace with London's population growth.

Are the population level indicators meaningful?
I note and understand the Health Committee's concern with identifying clear measures of success for the Strategy. As the Committee will be aware, the population measures have not been selected as a means of measuring the successful implementation of the strategy or the Mayor's implementation plan, but as a means of monitoring the picture of health inequalities in London. The measures selected are of high quality and regularly collected. They are the best data available to reflect the evidence informed themes of the strategy, and the long-term trends in terms of inequalities, but they are not necessarily (and are not expected to be) a perfect match for the objectives of the strategy.

As advised by Public Health England colleagues, success in reducing London's health inequalities, would be represented by an improving trend in reducing the gap between the most deprived and wider London populations. This point has been clarified in the implementation plan.

This information will be made available on London Datastore (note much of the data is already available through the public health outcomes framework 'fingertips' repository), and I invite all Londoners to engage with and explore the data for themselves.

Monitoring the actions that are not covered by key milestones
The Health Team will publish an annual report, demonstrating the progress made on the actions in the implementation plan, as part of the annual review cited in the draft implementation plan.

I hope that this clarifies some of your concerns regarding the Health Inequalities Strategy and its implementation over the next few years. I look forward to continuing to work with the Health Committee constructively as the Strategy moves forward, and I know my officers have been working hard to make sure that happens.

Thank you again for writing to me.

Yours sincerely,

Sadiq Khan
Mayor of London

Appx.

Appendix: Response to question - Do all schools have drinking fountains for their students?

This following text was provided by PHE
Information on the number of drinking fountains in London schools is not held centrally. However, in discussion with schools and borough leads, officers have found that in some schools, water is not as accessible as would be hoped to facilitate a shift away from consumption of sugar-sweetened beverages. Action to further develop water fountain infrastructure in schools along with public water fountains is therefore being taken. Consumption of sugar and sugar sweetened drinks is particularly high in school age children. It also tends to be highest among the most disadvantaged who also experience a higher prevalence of tooth decay and obesity and its health consequences.

Background:
There are currently two areas of work to promote Londoners to drink more water and fewer sugar-sweetened beverages:

1. **Public water fountains:** as part of the environmental work to reduce single-use plastic bottles in London, the Mayor has committed to delivering up to 20 new public water fountains across the city this year. This will also bring health benefits to Londoners by further improving the food environment by making the healthy choice the easier choice – filling up a water bottle over purchasing a sugar-sweetened beverage.

2. **Drinking water in schools:** Directors of Public Health are being supported to ensure that in schools in their borough funds from the sugar levy (Healthy Pupil Capital Fund) are spent on evidence based interventions; one recommendation being water fountains. To facilitate this PHE London has developed a toolkit for schools to support them in encouraging children to drink more water; this includes information on the benefits of hydration for both health and education. We will also work with Healthy Schools London towards the aim of having more 'water only schools' in the future.

Together, these actions will support large scale change and a shift in attitudes towards drinking water, particularly in those of school age, and thus help tackle the associated health issues, particularly for those suffering with the greatest inequalities in London.