LONDON HEALTH INEQUALITIES STRATEGY

Delivery Plan, 2015-2018: Convening and Collaborating for Action
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MAYOR’S FOREWORD
How long and how well we live matters. It matters to our friends and family, it matters to our economy and it matters to how we relate to each other in our neighbourhoods.

In London, there are big differences between how long, and how well, different people live. The difference in life expectancy among men has fallen in London. It’s now much lower than it was in 2007-9. However in terms of how long we can expect to live in good health, there remains a 16 year difference between west and east London. We can’t let these differences persist.

I published London’s first Health Inequalities Strategy in 2010. There have since been huge changes in how public health and the NHS is organised in the city. Potentially, the most important is the move of public health from Primary Care Trusts to local authorities. These new structures also have associated duties and functions to help reduce health inequalities and promote overall health and wellbeing.

Reducing health inequalities is a complex issue that can’t be done by a single organisation or intervention. It requires actions by different partners. For example, we need secure housing and employment. We need health services that prevent illness like immunisations and supporting maternal health. We also need an environment that can help us look after our own health. That means streets that encourage walking and cycling, workplaces that promote good mental wellbeing and schools that promote healthy eating.

City Hall can and does lead on many of these areas, with responsibilities in transport, housing, air quality, economic development and planning. We also have a health team which works across London. In addition, public health in local authorities offers a unique opportunity to think about health inequalities across all functions at a local level. The voluntary sector, employers, education sector and others also have a big part to play in improving the population’s life chances. This plan reflects the need for us all to work together as a unified public health system to reduce health inequalities.

In this plan, we set out a range of indicators that describe how various factors can contribute to health inequalities in a Londoner’s lifetime. We’ll update these yearly so we can check progress.

We now want to take forward a number of the recommendations of last year’s London Health Commission enquiry. This delivery plan details which ones we will be progressing. It also outlines how these support commitments in London’s Health Inequalities Strategy.

I really hope this plan helps in your work to reduce health inequalities in London over the next three years. Together, we can make London an even better city for all who live here.

Boris Johnson
Mayor of London
Summary
The Health Inequalities Strategy Delivery Plan 2015-2018:

- sets out the overall approach the Greater London Authority (GLA) will take from 2015-2018 to tackle health inequalities
- aligns the Mayor’s response to the London Health Commission report Better Health for London (2014) with the Health Inequalities Strategy commitments
- describes what role Health and Wellbeing Boards, Clinical Commissioning Groups, Public Health England, NHS England, local public health teams, and voluntary and community sector have in tackling health inequalities
- develops a brief way of expressing health inequalities in London that elected members can understand and can be tracked over time
- maps GLA actions and programmes to reduce health inequalities against the commitments of the Health Inequalities Strategy 2010

The delivery plan headline proposals include:

- publishing 12 indicators yearly to support an understanding of health inequalities and how they change over time. This will be done via an online platform on the London Datastore enabling London boroughs and partners to review and use the data
- hold an annual Londonwide convention. This will bring together different parts of health care, social care, public health, and the wider system to talk about particular health inequalities themes based on the indicator set
- aligning the delivery plan with the recommendations from the 2014 London Health Commission report Better Health for London through having shared indicators for health inequalities and the report’s “10 aspirations”
- strengthening our statutory ‘health in all policies approach’ throughout the GLA to make policies and decisions more equitable across the population
Background
In 2007 the Greater London Authority Act gave the Mayor a statutory duty and power to lead on health inequalities in London. In 2010 the first Mayor’s London Health Inequalities Strategy (HIS) was published. This followed widespread engagement with over 600 organisations and a substantial public consultation. The report offers a framework for partnership action to reduce health inequalities in London over the next 20 years. It also includes a commitment by the Mayor to publish a series of delivery plans to help steer collective action to reduce health inequalities. The aims of the HIS are to:

1. improve the physical health and mental wellbeing of all Londoners
2. reduce the gap between Londoners with the best and worst health outcomes
3. create economic, social and environmental conditions that improve quality of life for all
4. empower individuals and communities to take control of their lives, with a particular focus on the most disadvantaged

The GLA Act defined health inequalities as ‘inequalities in respect of life expectancy or general state of health which are wholly or partly a result of differences in respect of general health determinants’

These determinants are described as:

a) standards of housing, transport services or public safety;
b) employment prospects, earning capacity and any other matters that affect levels of prosperity
c) the degree of ease or difficulty with which persons have access to public services
d) the use, or level of use, of tobacco, alcohol or other substances, and any other matters of personal behaviour or lifestyle that are or may be harmful to health
e) any other matters that are determinants of life expectancy or the state of health of persons generally, other than genetic or biological factors

Barton and Grant and the UK Public Health Association strategic interest group (2006) developed a health map based on Dahlgren and Whitehead’s earlier model (Dahlgren and Whitehead 1991). This shows how individual factors are situated within the wider determinants of health including lifestyle issues, social and community influences, living and working conditions and general socioeconomic cultural and environmental conditions (Figure 1). The health map (below) puts people at the centre and sets them within the wider environment. This includes the natural environment, built environment activities, local economy, community and lifestyle. These are the social, economic and environmental determinants of health.

It’s worth noting that the GLA’s definition of health inequalities doesn’t include the factors listed in the smallest circle (age, sex and constitutional factors). Instead, it focuses on the inequalities...
from social, structural and environmental conditions that can be modified via policy and action.

Health inequalities are complex and multifaceted. That means they will not be reduced by one action. Rather there needs to be action from different partners, through different environment settings and working with different population groups. This document updates the first HIS delivery plan, ‘First Steps to Delivery to 2012’. In 2012 the Health and Social Care Act led to major changes in the health and social care landscape. These included the abolition and creation of many organisations in the NHS and public health system, many of which were cited as key partners for delivering the HIS (see Chapter 2). The new plan supports a description of these new structures and

Figure 1. Barton and Grant 2006 developed from a concept by Dahlgren and Whitehead 1991
organisations as well as ways of better engaging with these bodies.

In addition to these overall changes to the system, there is a change of approach to this plan. The last delivery plan set out first steps to action on the 30 commitments of the strategy. Progress on these commitments is shown in Appendix B and in examples throughout this document. However, this plan aims to better reflect the role of the Mayor as a leader and convenor of partners in London, and how this is an opportunity to make even greater progress on reducing health inequalities. Where to focus effort and investment will continue to be based on the best available evidence and engagement with a wide range of partners and experts.

### Aims and objectives

The overall aim of this document is to present the new delivery plan for the London Health Inequalities Strategy for the period 2015-18. This practical guide has the following objectives:

1. To set out an overall approach the GLA will take from 2015-2018 to tackle health inequalities
2. To align the Mayor’s response to the London Health Commission recommendations (published in autumn 2014) with the Health Inequalities Strategy commitments
3. To describe what role Health and Wellbeing Boards, Clinical Commissioning Groups, Public Health England, NHS England, local public health teams, and voluntary and community sector have in tackling health inequalities
4. To develop a set of indicators to describe health inequalities in London that are meaningful to elected members (for example local councillors, Assembly Members and MPs) and can be tracked over time
5. To map the Mayor’s actions and programmes to reduce health inequalities against the commitments of the Health Inequalities Strategy 2010.
**Approach**

To guide this update we:

- set up a steering group to advise and guide the refresh.
- engaged with stakeholders including the GLA group and wider health system (see further information below).
- reviewed GLA policies, projects and programmes to date against the strategy commitment.
- consulted data intelligence teams from the GLA and Public Health England about developing an indicator set.

**Stakeholder engagement**

The objectives of the stakeholder engagement process were to:

a) make key partners aware of the proposed approach to refresh the HIS delivery plan
b) agree a group of indicators that help express health inequalities in London
c) agree a planned narrative within the delivery plan on the roles of organisations formed following the 2012 Health and Social Care Act in tackling health inequalities
d) refresh GLA and partnership actions from now on

All our stakeholders were fully aware that this consultation was aimed at refreshing the delivery plan for the period 2015-18. As such, the Health Inequalities Strategy objectives and commitments set out in the 2010 published strategy remain the same.

We carried out a stakeholder mapping exercise to identify key partners within the health system as referenced in the GLA Act 2007. These include the GLA group, NHS England, Public Health England, public health teams within local authorities, and clinical commissioning groups. We also identified a number of other stakeholder groups relating to the five objectives of the HIS and equality groups, largely from the voluntary and academic sectors. We engaged them through stakeholder meetings, going to existing network meetings, discussions and written correspondence. Stakeholders were informed of the delivery plan refresh and had a chance to shape its revised content.

Appendix A outlines the stakeholder groups identified, how they were engaged, and when they were consulted. In total, we consulted: 14 teams from the GLA group, six Mayoral advisory groups made up of mainly voluntary sector representatives, ten stakeholder groups from health bodies, and ten non-governmental organisations from the academic and voluntary sector.

The themes we identified directly informed the writing of this plan where relevant. Specific examples and case studies are used to illustrate best practice as well as the challenges in reducing inequalities in health in London. We will also use the themes from stakeholder engagement to inform planning of the annual health inequalities convention (Chapter 4) and the annual indicators report (Chapter 3).
1. THE MAYOR’S ROLE IN LEADING ACTION ON HEALTH INEQUALITIES
1.1. Introduction
The purpose of Chapter 1 is to describe the Mayor’s leadership role in London for reducing health inequalities. It describes the Mayor’s leadership strengths and the new delivery plan approach. It also highlights how the GLA’s response to the London Health Commission Report will also have an impact on health inequalities.

1.2 Expanding the delivery approach through the Mayor’s leadership
This new plan is underpinned by a look back at what the GLA has done to reduce health inequalities including work towards the 30 commitments in the 20-year Health Inequalities Strategy (Appendix B). By reflecting on work to date, six key leadership roles of the Mayor are identified that can promote good health and reduce health inequalities in London:

1. Coordinating collaborative action across London (for example, Well London, Healthy Schools London, the London Healthy Workplace Charter, Team London)
2. Instigating Londonwide leadership where required (for example, chairing the London Health Board and establishing the London Health Commission enquiry)
3. Building the case for action (for example, Early Years Intervention to Address Health Inequalities in London – the Economic Case (2010), London Mental Health: The invisible costs of mental ill-health (2014))
4. High profile preventative and information campaigns (for example promoting HIV testing, raising cancer awareness through pop up shops in town centres)
5. Integrating action in reducing health inequalities across plans and strategies (for example, Improving the Health of Londoners: Transport Action Plan (2014); health input into the supplementary planning guidance for the London Plan and co-authorship of the Social Infrastructure SPG).
6. Supporting the health needs of vulnerable groups (for example, commissioning services to assist rough sleepers, prioritising children leaving care in the Mayor’s education plan)

This highlights the Mayor’s capacity to bring different parts of the health and public health system together, to build understanding, to explore current practice, and transfer learning into action to reduce health inequalities. This was echoed by stakeholders who noted the GLA is a natural convenor for talks on
the social determinants of health and the Mayor can influence partners at multiple levels, including London-wide. The GLA group continues to take action on many fronts to reduce health inequalities. These include campaigning for the London Living Wage and the Mayor’s Decent Homes programme, as well as our core initiatives (Appendix B). We will use these identified strengths and powers of leadership of the Mayor to expand the work GLA’s work on health inequalities.

As well as our core work to meet the 30 commitments in Appendix B, the Delivery Plan 2015-2018 has two new main features. First, we will publish on an annual basis 12 indicators to support an understanding of health inequalities and how they change over time. This will be done via an online platform on the London Datastore. That will allow London boroughs and partners to review and use the data. The indicators and current London picture are presented in Chapter 3. Second, we will hold an annual convention, described in Chapter 4. This will bring together different parts of health care, social care, public health, and the wider system to hold a London-wide discussion on particular health inequalities themes based on our indicator set. We’re also committed to strengthening our statutory ‘health in all policies approach’ and aligning our delivery plan with the recommendations of the 2014 London Health Commission report Better Health for London, described below.

1.3 Health in all policies across the GLA

The GLA Act 1999 and 2007 states that the Mayor must produce seven strategies for London: health inequalities, transport, economic development, housing, spatial development (the London Plan), environment, and culture. The Mayor must consider public health when developing each of these strategies. It is the job of City Hall’s health team to support and help roll out this ‘health in all policies’ (HiAP) approach. Each strategy is also subject to consultation requirements and a statutory procedure (Localism Act 2011).

Many stakeholders we consulted said the Mayor must consider health in all areas of work. They believe we should measure what impact the Mayor’s policies, programmes and campaigns have on health inequalities. This should be routinely monitored, as should health inequalities in London. As a result of changes to the health and social care landscape (Chapter 2), stakeholders voiced that the HiAP approach needs to be improved. This will allow maximum opportunity for impact. It will also ensure that health inequalities are considered throughout the work of the GLA and its partners. In addition, stakeholder engagement identified a number of specific opportunities and recommendations for joint-working between the Health Inequalities Strategy Delivery Plan (Health Team) and other GLA teams to reduce health inequalities.

This plan aims to progress the HiAP approach of the GLA through the work of the health team. The team is led by a public health specialist whose role is to
liaise with and influence the GLA senior management team on population health matters and to work closely with Public Health England. We also have public health specialists who are based in and work closely with teams in Transport for London and the London Plan to bring a public health perspective and skills to the transport and spatial development strategies. The health team is continuing to build links with other departments, including the Mayor’s Office for Policing and Crime (MOPAC) and the Housing and Land directorate.

1.4 The Mayor’s response to the London Health Commission

The publication of the London Health Commission report Better Health for London is an important step change towards a city wide focus on health. It embraces new parts of the health system and includes a strong focus on public health. A health inequalities impact assessment (HIIA) took place alongside the London Health Commission’s work. This included an initial assessment of the recommendations. These are now being followed up by discussions with policymakers on how to maximise the positive health and health inequalities impact of each recommendation. The initial assessment concluded that most of the London Health Commission recommendations will have beneficial effects on health and will help reduce inequalities in health.

The Mayor’s response to Better Health for London sets out where he sees best use of resources at City Hall. Specific actions will be provided in greater detail in the action plan to be published in 2015. In relation to the Mayor’s Health Inequalities Delivery Plan, the GLA response can be mapped against the following Health Inequalities Strategy commitments as shown in Table 1.
## Table 1: GLA Response to the LHC mapped against HIS 2010 Commitments

<table>
<thead>
<tr>
<th>LHC Recommendation (by number as stated in report Better Health for Londoners)</th>
<th>GLA Response to the LHC</th>
<th>Health Inequalities Commitment</th>
</tr>
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<tbody>
<tr>
<td>3. The Mayor should launch a fresh crackdown on the trafficking in and selling of illegal tobacco.</td>
<td>The Mayor will support a crackdown on illegal tobacco through actions of the Illegal Tobacco Steering Group, involving a London-wide approach to tackling the issue bringing together trading standards, HMRC, London Fire Brigade (LFB), Border Forces and Public Health England.</td>
<td>Commitment 23 - Manage public places across London to be safer and more inclusive;</td>
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<td>7. The Mayor should invest 20% of his TfL advertising budget to encourage more Londoners to walk 10,000 steps a day, and TfL should change signage to encourage people to walk up stairs and escalators.</td>
<td>The Mayor will work closely with TfL to identify what more can be done to support Londoners to walk more as part of their daily routine</td>
<td>Commitment 2 - Motivate and enable Londoners to adopt healthier behaviours and engage in lifelong learning</td>
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| 9. The Mayor should encourage all employers to promote the health of Londoners through workplace health initiatives.  
10. The NHS should lead the way by introducing wellbeing programmes, including having a mental health first aider for every NHS organisation. | The Mayor to extend the reach of the London Healthy Workplace Charter to support half a million of London’s workforce. 
The Mayor to work with Public Health England to promote employee mental wellbeing. | Commitment 16 - Invest in health at work, promoting equalities and building both organisational and employee capacity for mental and physical wellbeing |
| 13. Health and care commissioners should jointly develop a new model to improve support for parents of vulnerable children under three.  
15. The GLA and Public Health England should work with Ofsted to ensure more data is published on school health and wellbeing. | Collaboration with local authorities, NHS England (London) and CCGs, along with Public Health England to improve children's health. 
Continue the rollout of Healthy Schools London. | Commitment 1 - Promote effective parenting, early years development, young people’s emotional health and readiness for learning |
<table>
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<tr>
<th>LHC Recommendation (by number as stated in report Better Health for Londoners)</th>
<th>GLA Response to the LHC</th>
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<tr>
<td>21. The Department of Health and NHS England should launch a five-year £1 billion investment programme in GP premises so that all Londoners are able to access care in modern purpose-built/designed facilities.</td>
<td>The GLA will support efforts to persuade the government to allocate revenue for London, to help London’s GPs meet the needs of an increasing population and the demand this puts on primary care services and facilities.</td>
<td>Commitment 7 - Lobby for a fair share of resources for London’s health and social care services and increase investment in public health prevention and early years intervention.</td>
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<td>31. Health and care commissioners should develop a pan-London, multiagency approach to healthcare for the homeless and rough sleepers, with dedicated integrated care teams, and commissioned across the capital by a single lead commissioner.</td>
<td>The GLA will enable and support collaboration between health and care commissioners, local councils and other providers of rough sleeping services to give homeless people in London the services they need, to help them get off and stay off the streets, and to prevent rough sleeping.</td>
<td>Commitment 8 - Influence the NHS and boroughs in London to make more equitable allocation of resources and promote more effective commissioning to improve services for disadvantaged</td>
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<td>41. The Mayor should create a Citizens’ Health Panel to oversee the engagement and involvement of Londoners, ensuring the capital’s existing expertise and community diversity is fully represented.</td>
<td>The GLA will consult with partners including boroughs on how to take forward the recommendation of a London-wide Citizens’ Panel.</td>
<td>Commitment 4 - Build public sector capacity to engage more effectively with individuals, communities and the VCS</td>
</tr>
<tr>
<td>LHC Recommendation (by number as stated in report Better Health for Londoners)</td>
<td>GLA Response to the LHC</td>
<td>Health Inequalities Commitment</td>
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<td>61. The Mayor should appoint a London Health Commissioner to champion health in the capital. This will be supported by combining the London region of Public Health England and the GLA health team; the Mayor should request the Department of Health for the Commissioner to receive a significant budget from Public Health England.</td>
<td>Pursue proposal for a revised London Health Board, chaired by the Mayor, to improve London’s health, care and health inequalities where political engagement at this level can really make a difference. This will include giving additional impetus to progress the ambition to make London the healthiest global city and supporting the ‘Better Health for London Next Steps’ flowing from the London Health Commission’s report.</td>
<td>Commitment 26 - Provide regional vision and leadership and support strategic partnership action, tracking and reporting on progress towards improved health outcomes for London.</td>
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<td>64. Once all the bodies named in this report have set out their responses, the Mayor should convene and personally chair a group to prepare a unified delivery plan. This group should then continue to oversee progress as the recommendations in this report are actioned.</td>
<td>The GLA proposes that a revised London Health Board, chaired by the Mayor, should provide strategic and political leadership for health and care at a Londonwide level. This will include oversight of actions flowing from the London Health Commission’s report.</td>
<td>Commitment 26 - Provide regional vision and leadership and support strategic partnership action, tracking and reporting on progress towards improved health outcomes for London.</td>
</tr>
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**1.5 Summary**

The Delivery Plan, 2015-2018 seeks to make the most of the Mayor’s role and key strengths to help tackle health inequalities. The GLA will publish an annual indicator set (Chapter 3) and also hold an annual convention (Chapter 4) on a particular theme chosen from the indicators. This will generate a Londonwide discussion to make a real difference in health inequalities. Finally, the GLA seeks to align its work on the response to the London Health Commission with the commitments of the Health Inequalities Strategy 2010 to again, realise the full benefits from investment into health and health inequalities.
2. REDUCING HEALTH INEQUALITIES IN THE NEW HEALTH AND SOCIAL CARE LANDSCAPE
2.1 Introduction
The 2012 Health and Social Care Act (HSCA) introduced major changes to the UK health system. Amongst these changes are specific duties in relation to health inequalities and new opportunities to embed a ‘social determinants of health’ approach within health-related structures and services.

There has also been change at the Greater London Authority (GLA) since the publication of the first Health Inequalities Strategy delivery plan in 2010, with the GLA increasing its delivery scope across London. This gives the GLA and the wider GLA group new opportunities to reduce health inequalities.

This chapter describes some of the new responsibilities as a result of the Act and provides a visual representation to help examine ways we can think about the new landscape in London. It also offers examples of how the new system is working together to reduce health inequalities.

2.2 Findings from stakeholder engagement
Stakeholders had mixed views about the new health and social care system. Different stakeholder groups raised the need to increase collaborative working and synergy between organisations and strategies. It was felt that the new system offered both levers and opportunities which would help with the delivery of the HIS, as well as challenges this plan could help to address.

Examples of new opportunities included the creation of NHS England, Public Health England, and public health teams based in local authorities, all had a role in reducing health inequalities. This cross-sectorial mandate was felt to be an important enabler of the Mayor’s plan. In addition, new legislation such as the Social Value Act and the protection of equality groups could be used to reduce health inequalities.

Stakeholders asked how voluntary sector organisations might best access the new system, citing particular challenges in engaging with London’s clinical commissioning groups (CCGs) and health and wellbeing boards. Some stakeholders within the health system, who felt that a more collaborative approach was needed, cited similar issues.

2.3 How can we visualise the new system?
Public health is a complex system with many interrelated networks, structures, organisations, and people. Figure 2 helps to visually show the different parts of the system in London that have a role in reducing health inequalities. Similar to the Barton and Grant health map (referenced in Chapter 1) it looks at the layers of influence on health. This includes individual lifestyle factors, social and community influences and a third layer of structural factors, including housing, working conditions and access to services. It does not convey the relationships between different networks and structures, which would cross over the different layers and sections.
As with the Barton and Grant health map, Figure 2 has the population at its core. This reflects the fact it’s essential to understand local needs in order to tackle health inequalities. You must have a range of qualitative and quantitative systems that capture this information at a community level or local population level. Within the new health and social care system there is specifically a role of joint strategic needs assessments (JSNAs) for local authority areas to capture and interpret this data. The JSNA in turn informs the local joint health and wellbeing strategy that sets the health and wellbeing priorities for collective action. The JSNA and joint health and wellbeing strategy can also describe inequalities in the local area and factors that influence them (for example poor housing, unemployment). Clinical commissioning groups as part of the health and wellbeing board are also an important stakeholder in preparing the JSNA as well as using the joint health and wellbeing strategy to inform their commissioning plans.

The next layer of the diagram represents the structures and organisations into which this information feeds to inform strategies and service delivery. This references the new structures now in place following the 2012 Health and Social Care Act as well as previously existing organisations. The outer layer then provides examples of the services, strategies and strategic boards that all

Figure 2: London partners with health inequalities roles in London
have a role in reducing health inequalities in London. This diagram doesn’t attempt to show all services. Instead, it sets out to improve understanding of how current organisations and structures can have an impact on the different determinants of health. A main aim of the delivery plan from now on is to support conversations that ‘loosen’ up this new system, allowing new conversations to take place.

2.4 Organisations in London with powers in relation to reducing health inequalities
One reason we updated the Mayor’s Health Inequalities Strategy delivery plan is to describe the new system and help provide regional leadership to greater understand how we can work together to reduce health inequalities. Table 2 below describes existing and new organisations and structures that have formed after 2012 and their responsibilities in terms of reducing health inequalities in London. It should be noted that this isn’t a complete list of all the players who can help eliminate health inequalities in London, and who are also important partners as we progress. For example, the private sector plays a major role through employment opportunities, training and skill development, corporate social responsibility initiatives and sponsorship.

<table>
<thead>
<tr>
<th>Structure</th>
<th>Health inequalities duty and/ or function</th>
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<tbody>
<tr>
<td>Greater London Authority</td>
<td>The Mayor has statutory duties to promote improvements in the health of Londoners and to promote a reduction in health inequalities. This takes place through the Mayor’s Health Inequalities Strategy, other strategies and policies, and the Authority’s core business, as described in the GLA Acts of 1999 and 2007. City Hall has new structures and functions since the first Health Inequalities Strategy was published. These include the Mayor’s Office for Policing and Crime (MOPAC), Homes for London Board, London Enterprise Panel, and publication of the Mayor’s Education Programme Delivery Plan.</td>
</tr>
<tr>
<td>London Health Board</td>
<td>Refocused in March 2015, London Health Board is a non-statutory group chaired by the Mayor of London. It is made up of elected leaders, important London professional health leads, and key health partners. The aim is to propel improvements in London’s health, care and health inequalities where political engagement at this level can make a real difference. It will seek ways of giving additional impetus to progress the ambition to make London the healthiest global city.</td>
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<tr>
<td>Structure</td>
<td>Health inequalities duty and/or function</td>
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<tr>
<td>NHS England-London</td>
<td>NHS England London has an oversight role of NHS services in the capital, including a budget of more than £15 billion for specialised services. These include mental health, HIV treatment and healthcare for those in the criminal justice system. It is required to have regard to reducing health inequalities for patients in terms of accessing services and in terms of health outcomes. This is achieved through the provision of healthcare.</td>
</tr>
<tr>
<td>Public Health England (PHE)</td>
<td>Public Health England (PHE) is an executive agency of the Department of Health. Its statutory remit is to protect and improve the health of the population and reduce inequalities by enabling and supporting individuals and communities to improve their own health. The London office provides practical support to local authority public health teams and NHS establishments to reduce health inequalities and reduce inequality in access and outcomes of services.</td>
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| Local authorities                  | The 2012 Health and Social Care Act gave local authorities a key role in public health, with a director of public health and a specialist team transferred from the former Primary Care Trust to local government. This reflects the impact local authorities have across the ‘broader determinants of health’ as set out in Fair Society, Healthy Lives (2010), including the local environment, housing, transport, and jobs. Local authorities produce a Joint Strategic Needs Assessment and a Health and Wellbeing Strategy, to understand inequalities in the local area and form an action plan to address them. The work of PHE and local authority public health teams is guided by the public health outcomes framework (PHOF) that sets out indicators to help understand how well public health is being improved and protected. This includes two high-level outcomes:  
  - Increased life expectancy  
  - Reduced differences in life expectancy and healthy life expectancy between communities. |
<p>| Health and wellbeing Boards        | Established by local authorities, a partnership for councillors, commissioners and communities to work with wider associates to address the determinants of health and reduce health inequalities in their borough. Statutory membership for the boards include: the local authority directors of adult social services, children's services and public health, a representative from each CCG, one elected representative; and a local Healthwatch representative. It is recommended that boards include individuals with responsibility for the social determinants of health, for example those working in education, planning and economic development. |</p>
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<tr>
<th>Structure</th>
<th>Health inequalities duty and/ or function</th>
</tr>
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<tbody>
<tr>
<td>Voluntary organisations</td>
<td>There are roughly 60,000 voluntary and community sector organisations in London, providing a range of services and support. Many of these services support a reduction in health inequalities, for example through befriending, advocacy and advice, research, campaigning, fundraising and providing preventative health and care services including delivering NHS services in community venues.</td>
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</tbody>
</table>
| Healthwatch                                    | Healthwatch England is the national consumer champion in health and care. It has statutory powers to ensure the voice of the consumer is made stronger and heard by those who commission, deliver and regulate health and care services. All London boroughs have a local Healthwatch and they have a seat on the London borough health and wellbeing board. Healthwatch supports participation from local people in local policy and service, including NHS, social care and other local government responsibilities. It can help reduce health inequalities by influencing health and wellbeing boards, joint strategic needs assessments and clinical commissioning groups as well as other relevant policy and decision making structures.
| Clinical commissioning groups (CCGs)          | CCGs are locally based consortia of GP practices which commission care for the local community (for example community health services, maternity services, specific health care services for older people and children). London has 32 clinical commissioning groups (CCGs). They are supported by the London Clinical Commissioning Council that encourages collective working across London through the meeting of clinical leads and chief officers which liaise with NHS England (London), the GLA and London Councils. Each CCG is required to have regard to reducing health inequalities for patients in relation to accessing services and health outcomes through the provision of healthcare. In addition, each CCG needs to secure integration in the provision of health services, and health services with health-related services or social care services, where the CCG considers that this would improve the quality of the service or reduce inequalities in outcomes and access to services. Local authorities have a duty to provide specialist public health expertise and advice to NHS commissioners to support them in delivering their objectives to improve the health of their population. |
| NHS acute, primary and community care providers | NHS providers have a number of levers in terms of reducing health inequalities through their role as employers and purchasers and deliverers of a large number of services. The NHS Five Year Forward View (2014) sets out the need for a step change in terms of a focus on prevention and public health, alongside a vision of seven models of care, including providing joined up out of hospital care. |
Lines of accountability for these duties vary from organisation to organisation. For example, both NHS England and CCGs must include an assessment of how well they’ve performed their duties to reduce health inequalities in their annual reports. NHS England also assesses CCGs annually on their performance in reducing health inequalities.

Three other recent and important legislative bills for reducing health inequalities include the Equality Act 2010, the Social Value Act 2012, and the Care Act 2014.

The Equality Act 2010 places a statutory duty on public bodies to consider the impact of policies and services on the needs of individuals with the ‘protected characteristics’ of age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief and sexual orientation.

Social value is generally understood to refer to the ways in which commissioning can generate broader benefit for the wider population. The Social Value Act 2013 places a duty on public bodies to consider how proposed procurement and the procurement process might improve the economic, social and environmental wellbeing of the relevant local area. Social value can also include improvements in health outcomes. It can help to reduce health inequalities as it is likely to be linked to wider determinants of health. For example, a procurement framework might include a requirement to consider training and employing of local unemployed people to deliver goods and services.

In addition, the Care Act 2014 places a new series of duties and responsibilities on local authorities concerning care and support for adults, with the aim of improving people’s independence and wellbeing.

2.5 Case studies

Stakeholder engagement also captured useful examples of how the new system is working together to reduce health inequalities. For example, the Mayor’s Office for Policing and Crime is working with NHS England’s London Region to agree joint health and justice ambitions. This includes targeting health-related causes of crime, protecting and improving access to health support for victims and those affected by crime, and improving the experience and health outcomes of people in contact with the criminal justice system. The London Enterprise Panel (LEP) is one of England’s four trailblazers in the integration of support for unemployed individuals experiencing mental health problems. The West London Alliance (WLA) will develop and deliver the pilot in London covering the WLA boroughs (and Hammersmith and Fulham) on behalf of the LEP. The Mayor is keen that these initiatives become more visible and learning is shared from these partnership approaches across London.

Three further examples of practice to reduce health inequalities identified through stakeholder engagement are given overleaf.
**EXAMPLE OF PRACTICE: GP REGISTRATION, HOUNSLOW**

In 2011, a partnership emerged in the London Borough of Hounslow between health and criminal justice partners. Probation service users were facing difficulty in registering with GPs, due to a lack of address and other identifying documents. To recognise this problem, the public health department initiated a partnership with local GP management. Supportive GP surgeries with experience of working with offenders were identified. Probation service users of ‘no fixed abode’ could use the probation office as a proxy address and were given template letters to take to their GP.

The scheme was offered to service users on probation in the community as well as those on the Drug Intervention Programme. Probation officers were also trained to become Level 2 Health Trainers, offering support, guidance and referrals to health services.

[Provided by the charity Revolving Doors when responding to the delivery plan refresh].

**EXAMPLE OF PRACTICE: PUBLIC HEALTH ENGLAND LONDON FACTSHEETS**

PHE London has produced a series of ‘Health Inequalities, Briefing for London’ papers on the following topics, including its five strategic priority areas:

- tuberculosis
- mental health
- sexual health
- obesity
- childhood immunisation
- NHS health checks
- tobacco

The first three papers are on tuberculosis, tobacco and health checks. These briefing papers give a summary description of inequalities experienced by people with protected characteristics (under the Equality Act) and socioeconomic factors. The papers aim both to raise awareness of inequalities issues and inform decision making to address them, as well as supporting compliance with the Equality Act 2010.
**EXAMPLE OF PRACTICE: CITIZENS ADVICE BUREAU LONDON**

Some Citizen Advice Bureaux have received funding to provide advice to people on their social care options alongside other critical advice needs, such as housing and welfare benefits. This has resulted in support on subjects such as fuel poverty, which have a known impact on health. Examples of such interventions are set out below:

**Helping cancer patients in Southwark by providing welfare benefits and income maximisation advice**

This south east London service supports people affected by cancer in hospital settings, including Kings College Hospital, the Princess Royal, Guy’s and St Thomas’, Lewisham and Queen Elizabeth Greenwich. Around 800 patients are seen each year with a calculated increased income of between £3 and £4 million. Very high satisfaction rates are seen for the service, with clients better able to afford a good diet, clothing, heat their homes and keep hospital appointments owing to support with travel costs.

**Income maximisation at Mental Health Services**

The Kensington and Chelsea CAB mental health advice service provides advice within both health and local authority services. This includes in the St Charles Mental Health Unit and in local day centres. During 2012/13 the CAB service raised an additional £1.3 million per year in welfare benefit gains for 218 service users.

**One click for advice and information – Kingston**

Kingston Council and Kingston CAB will pilot an integrated advice and information services site in 2015 to meet requirements of the new Care Act. This is an extension of a recently introduced integrated advice service called ‘one click’ covering six voluntary organisations. One click provides automatic links to care websites, booking of services, and specific information on subjects such as fuel poverty and debt. Find out more at www.kingstononeclick.org.uk.

[Example provided by the Mayor’s Older People’s Advisory Forum]
2.6 Summary
The new health and social care system offers both opportunities and challenges in dealing with health inequalities. We need to bring together new organisations to explore these further, and take partnership action accordingly. The 2015-16 Delivery Plan can help with this. A starting point for these conversations is to understand the different duties and roles of organisations across London, as set out in this chapter. This includes understanding the new duties for addressing health inequalities on organisations as a result of the 2012 Health and Social Care Act. This could include new partnership approaches and practice, as well as new areas of challenge and opportunity. The annual convention (Chapter 4) will be one way to demonstrate this.
3. DESCRIBING AND TRACKING HEALTH INEQUALITIES FROM NOW ON
3.1 Introduction
Health inequalities are often expressed by the gap in life expectancy between different population groups. However there are other proxy indicators of health inequality like differences in employment rates, housing conditions and educational attainment. For the new delivery plan (2015-2018) of the Mayor’s Health Inequalities Strategy (2010), it was agreed that a set of health, and wider determinant, data indicators were chosen. The aim was to support a greater understanding of health inequalities, and to allow for monitoring over time. The indicator set was initially developed with colleagues at Public Health England (PHE), the Association of Directors of Public Health, and GLA colleagues in the Health, Housing, Economics and Intelligence teams. Further consultation was carried out with a wide range of partners and London organisations (see Appendix A for list of stakeholders engaged). This chapter describes, in Table 3, the selected indicators, their definitions, and the rationale for their selection. Table 4 describes the current data picture for each of these indicators at a Londonwide and London borough level.

3.2 Criteria for identification and selection of indicators
The Mayor’s Health Inequalities Strategy Delivery Plan 2015-2018 requires indicators that help to understand and monitor inequalities in both health outcomes and health determinants for the London population. The purpose of this is to support action to reduce health inequalities within the health care, social care and public health system. As a whole, the indicator set reflects the five strategic objectives of the Mayor’s Health Inequalities Strategy:

1. Empowering individuals and communities
2. Equitable access to high quality health and social care services
3. Income inequality and health
4. Health, work and wellbeing
5. Healthy places

In order to provide an accurate and useful picture of health inequalities in London, the indicators had to meet as many of the following specific criteria as possible to be:

- meaningful to stakeholders (including health and non-health professionals and the general public) illustrating both health issues and determinants of health
- relevant to the rapidly changing and future policy context.
- able to span the life-course for London’s population
- track-able over time
- useful as levers for action within regional and local authorities
- using the most accurate and valid data sources, available for both London as a whole and for London borough levels, and collected every year
- manageable in number, so up to a maximum of 12

It’s important to acknowledge that there will always be limitations to both the indicators selected and the data used for each one. It has not been possible to provide all information for a consistent time period because of the diverse data sources and nature of these indicators. It is impossible to sub-analyse each data
source by the protected characteristics included in the Equality Act, although we understand that these frequently contribute to health inequalities\textsuperscript{18}. The indicators are however a useful start towards developing a themed annual convention on health inequalities where extra information and data on the theme can also be presented.

It was also important that there is major consistency between these indicators and those being used by partner organisations and institutions in health inequalities. Therefore the choice of indicators was heavily influenced by, and where possible, the same as those used by:

- Professor Sir Michael Marmot at the Institute of Health Equity in their September 2014 health indicators report, the “Strategic Review of Health Inequalities Post 2010”\textsuperscript{19}
- Public Health England (PHE), in particular part of the Public Health Outcomes Framework (PHOF)\textsuperscript{20} and indicators in development for the London Health Commission 10 Aspirations
- GLA’s own intelligence team, in order to align with existing targets and priorities for the GLA group and integrate our dataset with the London Datastore for practical purposes\textsuperscript{21}
- London Health Commission indicators to track the ten ambitions and aspirations following the publication of Better Health for London.

### 3.3 Findings from stakeholder engagement

Overall, there was a lot of support for the idea of having an indicator set and an annual convention. However, there were concerns about overlap and competition with other similar indicator sets and whether this might be confusing and/or duplication of effort. Stakeholders also wanted to know how the indicators mapped on to the work of the GLA to reduce health inequalities more directly. Many stakeholders discussed the importance of subgroup analyses to examine potential interactions with gender, age and other characteristics. There were lots of comments and suggestions on specific metrics, although most feedback was positive or neutral about the chosen metrics.

### 3.4 The indicators

The 12 data indicators selected cover a range of determinants of health and health inequalities as well as including some health outcomes that feature health inequalities, like childhood obesity. They span the five objectives of the Mayor’s Health Inequalities Strategy 2010. It is important for the new delivery plan 2015-2018, that these indicators help to understand health inequalities in the London region and between London boroughs. Table 3 describes each of the 12 indicators and the rationale for choosing them.
### Table 3. Description of indicators

<table>
<thead>
<tr>
<th>Indicator name</th>
<th>Indicator definition</th>
<th>Rationale and link to strategy objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General measures of health inequality</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Slope index of inequality for life expectancy at birth</td>
<td>A single score representing the gap in years of life expectancy, across the social gradient from most to least deprived.</td>
<td>Describes how life expectancy varies with local deprivation, providing a general overview of health inequalities in mortality. Relates to all strategy objectives.</td>
</tr>
<tr>
<td>Healthy life expectancy</td>
<td>The average number of years a person would expect to live in good health, based on current death rates and the prevalence of self-reported good health.</td>
<td>Describes a ‘quality of life’ dimension to life expectancy, reflecting the degree of chronic ill health and poor wellbeing within a population. Relates to all strategy objectives.</td>
</tr>
<tr>
<td>Self-reported wellbeing. Separated into</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Happiness</td>
<td>The percentage of respondents who scored their life satisfaction, happiness, worthwhileness and anxiety between 0-4/10 (or =&gt;6/10 for anxiety)</td>
<td>Provides a snapshot of the population’s view on their own wellbeing, reflecting both their mental and physical health and resilience to ill-health. Relates explicitly to objective 4 of the strategy ‘Health, Work and Wellbeing’, but also to objective 1 and 3, ‘Empowering Individuals and Communities’ and ‘Income Inequality and Health’.</td>
</tr>
<tr>
<td>2. Life satisfaction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Worthwhileness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Anxiety</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Specific measures of health inequality</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>School Readiness at age 5</td>
<td>The number of children achieving a good threshold of development at the end of the early years foundation stage (EYFS) (aged five), as a proportion of the total number of children eligible for state-funded early year’s education.</td>
<td>Useful as a measure of a wide range of developmental areas in young children, which are associated with better health outcomes throughout life. Can also reflect social deprivation and to a limited degree the quality of early years services. Relates to all strategy objectives.</td>
</tr>
<tr>
<td>Indicator name</td>
<td>Indicator definition</td>
<td>Rationale and link to strategy objectives</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Educational achievement at GCSE level</td>
<td>The proportion of pupils at the end of Key Stage 4 in schools maintained by the local authority that have achieved five or more GCSEs at grades A*-C (including English and Maths) or equivalent.</td>
<td>A proxy measure of an individual’s labour market position, and therefore future income, housing, other material resources and health. Relates mostly to strategy objectives 1, 3 and 4 (‘Empowering Individuals and Communities’, ‘Income Inequality and Health’, and ‘Health, Work and Wellbeing’)</td>
</tr>
<tr>
<td>Antenatal late booking</td>
<td>The percentage of pregnant women whose antenatal care booking takes place after 12 weeks plus six days gestation.</td>
<td>To capture access to maternity services for a full health and social care assessment of their needs, risks and choices in pregnancy. More widely, a proxy measure of the family’s access to health and social care services. Relates mostly to strategy objective 2 ‘Equitable Access to Health and Social Care’.</td>
</tr>
</tbody>
</table>
| Influenza vaccination uptake for both >65 year olds, and those at risk <65 years old | The percentage of those eligible who received the influenza vaccination from within two groups:  
1. Individuals aged >6 months and < 65 years (excluding pregnant women)  
2. Individuals aged 65 and over | A proxy measure for access to health services for two groups of people, defined as vulnerable to influenza, which is a largely preventable disease. Relates mostly to strategy objective 2 ‘Equitable Access to Health and Social Care’. |
<p>| Vulnerable road user risk of death or serious injury.   | Rate of death and serious injury per billion passenger-kilometres for vulnerable road users (pedestrians, cyclists and motorcyclists), adjusted for transport mode-sharing within boroughs.                                      | A measure reflecting the danger risk level of London roads, for those using active travel that promotes physical and mental health (plus motorcyclists who are also a high risk groups for injuries on the roads). Relates most to strategy objective 5 ‘Healthy Places’. |</p>
<table>
<thead>
<tr>
<th>Indicator name</th>
<th>Indicator definition</th>
<th>Rationale and link to strategy objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homelessness</td>
<td>Three sub-indicators of homelessness: 1. The number of households in temporary accommodation per 1,000 households, all ages, all persons. 2. The rate of homelessness prevention (or relief) per 1,000 households. 3. The change in number of rough sleepers per borough per year</td>
<td>Represents size of homelessness problem and success of services to reduce homelessness. Since homelessness (especially rough sleeping) is associated with severe poverty, and results in adverse health, education and social outcomes, this is a measure of extreme health and social inequalities. Relates to all strategy objectives.</td>
</tr>
<tr>
<td>London Living Wage</td>
<td>The proportion of employees earning less than the London Living Wage by London borough, comparing resident and working populations.</td>
<td>Reflects the population’s ability to meet basic living expenses in the capital as defined by the London Living Wage, currently £8.80 an hour. A measure of the size of the income inequality that has the potential to affect Londoners’ health. Relates mostly to strategic objectives 1 ‘Empowering Individuals and Communities’, 3 ‘Income Inequality and Health’, and 4 ‘Health, Work and Wellbeing’</td>
</tr>
<tr>
<td>Unemployment rates</td>
<td>Modelled-estimates of unemployment rates (percentage of the resident population) for London boroughs, using estimates at regional and country level from the Annual Population Survey</td>
<td>A measure of income and economic status, and access to the social and emotional well-being benefits of employment. Relates mostly to strategic objectives 1 Empowering Individuals and Communities’, 3 ‘Income Inequality and Health’, and 4 ‘Health, Work and Wellbeing.</td>
</tr>
<tr>
<td>Indicator name</td>
<td>Indicator definition</td>
<td>Rationale and link to strategy objectives</td>
</tr>
<tr>
<td>-----------------------</td>
<td>--------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Childhood obesity</td>
<td>The proportion of children aged four to five years old classified as overweight or obese</td>
<td>Obesity represents one of the most widespread threats to health and wellbeing in the UK. Strong association with socioeconomic deprivation. Also reflects empowerment and access to healthy food and physical activity options and green space. Relates mostly to strategic objectives 1 ‘Empowering Individuals and Communities’, 3 ‘Income Inequality and Health’, and 5 ‘Healthy Places’</td>
</tr>
</tbody>
</table>
3.4. The London picture

Using the latest data available, Table 4 provides a broad overview of the London picture with respect to health inequalities. Following publication of this delivery plan we’ll share data on these 12 indicators Londonwide and for each London borough every year in order to track changes in health inequalities over time.

Table 4: The London Data Picture

<table>
<thead>
<tr>
<th>Indicator name</th>
<th>London picture</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overall measures of health inequality</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Slope index of inequality of life expectancy (SII of LE) at birth</strong></td>
<td>Large variation between London boroughs’ slope index of life expectancy at birth.</td>
</tr>
<tr>
<td></td>
<td>In 2011-13, Highest Male SII of LE in Kensington and Chelsea (14.3 years); Lowest in Barking and Dagenham (2.4 years). Highest female SII of LE in Camden (8.9 years); Lowest in Redbridge (2.1 years).</td>
</tr>
<tr>
<td><strong>Healthy life expectancy (HLE)</strong></td>
<td>Average HLE at birth in London 2011-2013 slightly higher than England average.</td>
</tr>
<tr>
<td></td>
<td>London male and female HLE at birth was 63.4 years and 63.8 years respectively.</td>
</tr>
<tr>
<td><strong>Self-reported wellbeing</strong></td>
<td>London has lowest life satisfaction, worthwhileness and happiness, and the highest anxiety of any UK region.</td>
</tr>
<tr>
<td>1. Happiness</td>
<td>Large variation in self-reported wellbeing within London. In period 2011 to 2014, highest life satisfaction scores in Kensington and Chelsea (7.61), Richmond, and Bromley (both 7.54). Lowest scores in Hackney (7.03) Croydon (7.10) and Newham (7.12).</td>
</tr>
<tr>
<td>2. Life satisfaction</td>
<td>Hackney also has the lowest worthwhileness, and happiness scores and the highest anxiety scores in London.</td>
</tr>
<tr>
<td>3. Worthwhileness</td>
<td></td>
</tr>
<tr>
<td>4. Anxiety</td>
<td></td>
</tr>
<tr>
<td><strong>More specific measures of health inequality</strong></td>
<td></td>
</tr>
<tr>
<td><strong>School readiness at age 5</strong></td>
<td>Often (but not always) lower in areas of high deprivation.</td>
</tr>
<tr>
<td></td>
<td>Across London’s boroughs, indicator ranges from 52.5% in Hillingdon, to 72.9% in Bexley.</td>
</tr>
</tbody>
</table>
Educational achievement at GCSE level

Large variation between London boroughs
Ranges from 51.3% in Lewisham to 73.8% in Kensington and Chelsea
Data is presented by the schools in the borough not residents.

<table>
<thead>
<tr>
<th>Indicator name</th>
<th>London picture</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antenatal late booking</td>
<td>Higher in most London boroughs compared to most of UK. Significant gaps in data collection for populations served by different clinical commissioning groups. Of the data available, north west London seems to have high rates of late antenatal booking.</td>
</tr>
<tr>
<td>Influenza vaccination</td>
<td>Lower for the majority of London boroughs compared to England as a whole, in both at-risk populations. Reasonably high statistical certainty for these differences.</td>
</tr>
<tr>
<td>Vulnerable road user risk of fatality or serious injury</td>
<td>Nine London boroughs with considerably higher risk levels than average for London.</td>
</tr>
<tr>
<td>Homelessness</td>
<td>Large variation in all three components across London boroughs.</td>
</tr>
<tr>
<td>a. Statutory homelessness</td>
<td>a. For statutory homelessness, lowest rates in Camden n (0.8 per 1,000 households) and highest in Newham (12.5 per 1,000 households). Reasonable statistical certainty that borough values are truly different.</td>
</tr>
<tr>
<td>b. Homelessness prevention</td>
<td>b. Successful prevention of homelessness rates differ from less than 1 per 1,000 households in Hounslow, Wandsworth and Richmond upon Thames to 26 per 1,000 households in Barking and Dagenham and in Redbridge.</td>
</tr>
<tr>
<td>c. Change in number of rough sleepers</td>
<td>c. For numbers of rough sleepers from 2013/14 to 2014/15 Westminster showed an increase of 373 rough sleepers and Heathrow showed an increase of over 100, whereas Southwark showed a slight decrease of 18.</td>
</tr>
<tr>
<td>London Living Wage (LLW)</td>
<td>Large variation across employees in London boroughs from 9.5% in Tower Hamlets to 42.4% in Harrow of employees who are earning less than LLW. Values differ significantly if data is presented by workplace. Many boroughs with high proportions of employers not paying LLW are in outer London.</td>
</tr>
<tr>
<td>Unemployment rates</td>
<td>Large variation between London boroughs’ unemployment rates, from 4.5% in Richmond-on-Thames to 10.8% in Barking and Dagenham. Fourteen London boroughs have unemployment rates higher than England with reasonable statistical certainty of a true difference.</td>
</tr>
</tbody>
</table>
3.5 Summary

This chapter has described the 12 indicators chosen to track health inequalities in London over time and has provided a broad overview of the London picture. We’ll report on these indicators every year to reflect the London picture using the latest data available. These indicators are aligned with existing data sets and indicators, but focus solely on health inequalities.

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<table>
<thead>
<tr>
<th>Indicator name</th>
<th>London picture</th>
</tr>
</thead>
<tbody>
<tr>
<td>Childhood obesity</td>
<td>There are higher proportions of overweight or obese 4-5 year olds in 11 London boroughs compared to England for 2013/14, with reasonable statistical certainty.</td>
</tr>
</tbody>
</table>

GCSE attainment data: GCSE and equivalent attainment by pupil characteristics: 2014, Department for Education, January 2015
Rough Sleeper figures taken from CHAIN Annual Bulletin http://data.london.gov.uk/dataset/chain-reports/resource/6c740944-3816-4f21-bbcf-04505b59c76b# This includes figures by age, by sex and by nationality
4. THE GLA ANNUAL CONVENTION ON HEALTH INEQUALITIES
4.1. Introduction
This chapter sets out proposals for a GLA annual convention on health inequalities, including aim and objectives, intended participants and governance. The structure and governance of the annual convention will be further developed in the first few months after the delivery plan is published.

4.2. Feedback from stakeholder engagement
Stakeholders welcomed a dialogue about health inequalities in the form of an annual London convention. However, they had concerns about getting the right people to attend and how to ensure the event would lead to meaningful change. Stakeholders agreed that having a specific topic or theme for each annual convention was a good approach so that additional data might be considered including qualitative data and best practice case studies.

4.3 The Health Inequalities Annual Convention
As part of the Mayoral leadership role in addressing health inequalities in London, the Mayor will hold an annual convention bringing together different parts of the health, social care, public health and wider system to discuss and work on specific health inequalities issues. These themes will be developed and agreed by a working group convened accordingly on an annual basis. The working group will include the GLA health team, input from the wider GLA group (depending on the theme), London borough public health teams and other external partners. The working group will consult where appropriate the Mayor’s advisory panels and forums to ensure the relevance and success of the conventions.

The chief aim of each convention will be to bring together all relevant parts of the system to reflect on a particular area of health inequalities in order to discuss and agree action to address that inequality. Using the indicators from the Health Inequalities Strategy Delivery Plan as a basis, over time each metric will be examined and whole-system actions agreed with the aim of bringing about improvements.

The objectives of the annual conventions will be:

- to focus on one, or more, of the relevant indicators from the delivery plan and show deeper analysis (for example by protected characteristics, geography, etc) as a catalyst for a broader discussion on health inequalities in London
- to discuss sub-indicators on the chosen theme and share additional relevant quantitative data
- to identify future improvements in data measurement for health inequalities in London if needed
- to share qualitative data to better understand the context and causes of health inequalities
- to examine the evidence base for actions that can address these inequalities
- to share case studies of best practice in reducing health inequalities across London
- to host solution-focused workshops on health inequalities in London
- to highlight the statutory duties of partners and the new structures in
health care, social care and public health (including health and wellbeing boards and clinical commissioning groups) for better accountability and transparency purposes, and to ensure changes are achieved over time.

- to highlight and promote the Equality Act and importance of health inequality impact assessments, the Social Value Act, and the relevant charters that support health inequalities (such as the London Healthy Workplace Charter, British Deaf Association, Disabled Children’s Charter, St Mungo’s Homeless Health Charter)
- to stimulate ongoing action and gain commitment from the relevant parties to address the health inequalities considered

4.4 Participants
Invitees to the conventions will include:

- public health, social care and other relevant teams such as environment, housing, education appropriate to the theme from London boroughs and the GLA
- relevant voluntary sector organisations
- relevant NHS representatives
- other public sector such as fire brigade, police etc., as appropriate to the theme
- London borough councillors and London assembly members
- relevant private sector organisations
- charitable trusts

4.5 Governance
The GLA health team will organise the annual convention in consultation with a range of partners, including London borough public health teams, London’s voluntary sector, academic institutions, and Public Health England. A convention steering group will be established annually to ensure each convention sets ambitious and relevant objectives, draws from the most current and valid evidence base and is representative of London’s diverse population.

4.6 Summary
This chapter gives an overview of the aim and objectives of the annual conventions which will take place during the course of this delivery plan. It also sets out intended participants and a proposed governance structure for the convention, ensuring it is meeting its stated outputs. It is expected that the convention will provide a key means of convening and collaborating action on health inequalities in London.
The delivery plan marks a new approach to reducing health inequalities in London, alongside the ongoing programme commitments of the GLA. It takes advantage of the transfer of public health expertise to local authorities together with the creation of new structures, as set out in Chapter 2. This provides a timely focus on action on the wider determinants of health and how London’s public health system works together to achieve this.

Collaboration is a theme for this delivery plan, with a focus on opening up engagement points in the new system, exploring new ways of partnership working and profiling good practice. This will be developed through a health inequalities convention, held at City Hall once a year for the next three years. The conventions will focus on a key area of action for health inequalities.

We will also publish metrics on health inequalities each year. This supports understanding on the wide area of activity that needs to take place to reduce health inequalities. It also allows London at a pan and borough level to track progress on health inequalities over time.

Underpinning the above will be leadership from the Mayor, both from a health in all policies approach at the GLA and by convening action following the London Health Commission report Better Health for London (2014).

Success of the delivery plan will be measured through governance of the London Health Board, with key principles identified following delivery plan publication. This will inform learning for subsequent delivery plans as the Mayor’s 20 year Health Inequalities Strategy is progressed.
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<thead>
<tr>
<th>Abbreviation</th>
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<tr>
<td>DP</td>
<td>Delivery Plan</td>
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<tr>
<td>GLA</td>
<td>Greater London Authority</td>
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<td>HI</td>
<td>Health Inequalities</td>
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<tr>
<td>HiAP</td>
<td>Health in All Policies</td>
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<td>HIS</td>
<td>Health Inequalities Strategy</td>
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<td>LA</td>
<td>Local Authority</td>
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<td>LHC</td>
<td>London Health Commission</td>
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APPENDIX A: STAKEHOLDERS ENGAGED
Stakeholder groups
GLA group
GLA diversity and social policy
GLA economic development team
GLA education and youth team
GLA environment team
GLA health team
GLA housing team
GLA intelligence team
GLA peer outreach team
GLA skills and employment
London Assembly Health Committee
London Fire Brigade
Mayor’s Office for Policing and Crime
Team London
Transport for London

Mayor’s advisory panels
Annual Trans Stakeholder Group
Deaf and Disabled Forum
LGBT community organisations
Mayor’s Older People’s Advisory Forum
Mayor’s Refugee Advisory Panel (migrant and refugee community organisations)

Health organisations
Directors of Public Health Inequalities Event
London CCG Council
London Health Chief Officers Group (CCGs and NHS England)
NHS England – National Health Inequalities Team
NHS England (London) – Health and Justice
NHS England (London) – Primary Care Commissioning for NW, NC and East London
Public Health England – Health Equity Team
Public Health England – Knowledge and Intelligence Team Network
Public Health England – London Drugs and Alcohol Team
Public Health England – London Region

Non-governmental organisations
Citizens Advice Bureau
Institute of Health Equity
London Gypsy and Traveller Unit
London Voluntary Service Council
Men’s Health Forum
Poverty and Child Health Seminar
Revolving Doors Agency
Stonewall Housing (LGBT housing advice and support)
The King’s Fund
Trust for London
Women Like Us
APPENDIX B: TAKING ACTION ON HEALTH INEQUALITIES: A REVIEW OF DELIVERY SINCE 2010
Summary
There has been lots of activity to address health inequalities in London across the GLA group since the Mayor’s Health Inequalities Strategy was published in 2010. This section reflects work largely led by the GLA and helps highlight specific ways the GLA can support local authorities, CCGs, and NHS partners, within the new policy landscape, to take action on health inequalities. It describes projects and programmes against the five objectives and the cross cutting commitments and sets out work that has taken place to date.

Each section begins with a definition of one of the five objectives of the Mayor’s Health Inequalities Strategy. The tables below then clearly set out examples of delivery, helping describe the strengths of activity to date. This is a useful framework for reviewing what activity has taken place since publication of the strategy and where further resources are needed.
Empower individuals and communities

For all Londoners to thrive, individuals and communities must have the knowledge, skills and confidence to take control of the factors that affect their health, and to play an active role in the wellbeing of others. This involves understanding the main health awareness issues for London, creating and supporting opportunities to engage with people and build on community assets that support health and wellbeing. It also means working in partnership, for example with schools and the voluntary sector.

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| 1. Promote effective parenting, early years development, young people’s emotional health and readiness for learning. | Healthy Schools London takes a whole school approach to improving the health and wellbeing of children and young people encompassing physical activity, healthy eating, emotional health and wellbeing and Personal Social health Education (PSHE). Launched in April 2013 as a GLA coordinated programme, it has now engaged 60 per cent of London schools with 1395 registered. The programme includes an award system that encourages schools to plan, implement and evaluate their own projects to demonstrate improvements in the school as a healthy environment and better health outcomes amongst the pupils. 30 out of 32 London boroughs have re-invested in a local Healthy Schools Programme or the equivalent support for schools.

The GLA published ‘Early Years Intervention to Address Health Inequalities in London – the Economic Case’ in 2010. This document makes an evidence-based economic and business case for local investment in early years’ services, to support local authorities and health professionals choose the best and most cost-effective ways to make a positive impact on the lives of young Londoners. |
<p>| 2. Motivate and enable Londoners to adopt healthier behaviours and engage in life-long learning. | The Mayor’s Sports Legacy Programme has invested £22.5 million in sport involvement projects. This includes the Mayor’s Sports Participation Fund that supports grassroots sports organisations across every London borough. Over 250,000 individuals have benefited from activities such as BMX to dance to rugby, with more than ten per cent of the people involved being previously inactive. Some of the projects have been using sport to help tackle specific social issues. In addition it has trained 13,000 sports coaches and officials from voluntary organisations across London. |</p>
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<td>3. Build knowledge about health and wellbeing, tackling stigma and taboo in the process.</td>
<td>An HIV awareness-raising and health promotion programme began in June 2010, with the support of Annie Lennox as the Mayor’s London HIV Ambassador. Activities have included training, campaigning and networking to help increase people’s knowledge about HIV and sexual health, improve health outcomes and earlier diagnosis, prevent onward transmission of HIV, and save health system and societal resource. More recently, GLA officers have worked with a number of partners including the National Aids Trust, the Terence Higgins Trust, Change 4 Life teams, and London borough public health teams, to support work on HIV. In 2010, the Mayor hosted an exhibition at City Hall telling the stories of Londoners affected by HIV through the photography of Rankin, the renowned British fashion photographer, and in 2011, the Mayor supported Body &amp; Soul’s ‘Life in my Shoes’ campaign which tackled stigma through the stories of young people affected by HIV. Other GLA-led health awareness campaigns and surveys have included those for breast cancer, supported by Zandra Rhodes, the Mayor’s London Breast Cancer Ambassador since July 2013, and the appointment of Emma Thompson as the Mayor’s TB Ambassador in 2015. The London Drug and Alcohol Policy Forum organised the London Drink Debate, the largest ever survey (7,500 respondents) of Londoners’ views and experiences in relation to alcohol use.</td>
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<td>4. Promote community development approaches to improve health, and actively support the role of the third sector.</td>
<td>The Well London programme, coordinated by the GLA since 2007, is an asset-based approach to health and wellbeing, working to empower and engage people to strengthen their own and their community’s foundations of good health. To date, £12 million of funding from the Big Lottery has allowed the delivery of programmes in 31 of London’s most deprived neighbourhoods, targeting around 80,000 people. Measurable improvements have taken place in participants’ mental well-being, physical activity, diet, knowledge and skills, confidence and social networks. The programme is also achieving wider social benefits such as uptake of training and volunteering opportunities, employment, and greater community cohesion.</td>
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<td>5. Build public sector capacity to engage more effectively with individuals, communities and the voluntary sector.</td>
<td>London’s voluntary and community sector plays a significant role in empowering individuals and communities. Community Voices for Health, a network of over 100 small London voluntary and community organisations, was launched by the Mayor in March 2010. Five events were delivered in 2011 to build the capacity of a diverse range of community organisations and to influence decision-makers in organisations that impact on health and wellbeing, in particular, local councils and the NHS. The Community Voices for Health Working Group is now run by London Voluntary Services Council.</td>
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### Equitable access to health and social care

Equitable access to high quality health and social care supports the health and wellbeing of all Londoners, with large potential benefits for more disadvantaged population groups. Mayoral initiatives to tackle unequal access to services include the appropriate allocation of resources, improved community empowerment to shape future commissioning for specific health and social needs, and increased awareness of health service entitlements for protected groups.

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<td>6. Call upon local political leadership to champion action on health inequalities and to lead the discussion locally on enhanced collaborative working with the relevant Primary Care Trust and local community leaders.</td>
<td>The GLA hosted the first Health Leadership summit for London in November 2010. Two hundred senior representatives across a wide range of sectors came, including the NHS, local authorities and voluntary sector organisations. This was a unique opportunity for London’s leaders to share views and solutions to challenges of equitable access. In May 2013, in response to the significant changes affecting the delivery of health services, the Mayor of London alongside London Councils and the London NHS, established the London Health Board, a new strategic board to look at health issues of citywide concern. Reducing health inequalities is a primary aim of the board, being taken forward through its established work streams, focusing on: • reducing inequality in the representation of certain population groups in the study of medical conditions within clinical research • procurement of digital support for mental health and resilience • appropriate allocation of public health resources • reinvestment of surplus NHS estate funds into geographical areas where health inequalities are high and services under-resourced.</td>
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<td>7. Lobby for a fair share of resources for London’s health and social care services and increase investment in public health, prevention and early years’ intervention</td>
<td>In February 2012, the Mayor brought together a group of London mental health stakeholders, with Professor Michael Porter of Harvard University, to discuss how to achieve ‘value’ in mental health care, as defined as the cost of mental health services as a proportion of the self-determined value of the service by the patient. The debate highlighted the importance of public mental health initiatives, early access to intervention and integration of services. The Mayor’s report ‘London Mental Health: The Invisible Costs of Mental Ill Health’, produced in January 2014, quantified the cost of mental ill health in London, through the wider economic and social impacts of mental ill health. This work made the economic case for a public health and community approach to maintaining good mental health, requiring early and equitable access to integrated health and social care.</td>
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<td>8. Influence the NHS and boroughs in London to make more equitable allocation of resources and promote more effective commissioning to improve services for disadvantaged groups and areas.</td>
<td>The 2012 Alcohol Treatment: Pathways and Outcomes event and accompanying report, organised in partnership with the London Drug and Alcohol Policy Forum and the Department of Health, advocated for more equitable commissioning of alcohol services. The commissioning of successful and feasible provision of Alcohol IBA interventions in sexual health settings, by Alcohol Concern and Brook, is also being taken forward by the Safe Sociable London Partnership (SSLP), of which the GLA is a major partner.</td>
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| 9. Improve the accessibility of health and social care services and invest in provision of advocacy, information, advice and language support to enable excluded groups to make effective use of relevant services. | The London Health Improvement Board, chaired by the Mayor between 2011 and 2013, worked to improve equitable access to health information and preventative services through the following projects:  
- For alcohol misuse, a pharmacy based and online ‘Identification and Brief Advice’ (IBA) and awareness-raising scratch cards about alcohol misuse, which also signposted prevention information and support.  
- For cancer, the training of more than 1,800 stop-smoking service practitioners to a London standard, a targeted bowel cancer screening campaign, partnership work with major London employers to communicate the importance of prevention and early diagnosis of cancer, and two ‘Get to Know Cancer’ pop up shops engaging more than 6,000 Londoners in talks around cancer awareness.  
The Immigration and Asylum team within the Diversity and Social policy team at the GLA, has worked with partners across sectors on the following projects for reducing health inequalities:  
- Organising a series of training events on healthcare access and entitlement and healthcare reforms.  
- Organising a conference entitled ‘Meeting the Health Needs of London’s Refugee and Migrant Communities’ at City Hall in February 2012 on two work streams - maternity and mental health care.  
- Producing a booklet called ‘How Can I Get Medical Help in London?’ that outlines GP registration and primary care entitlements. This resource was highly welcomed by community organisations, health agencies and health professionals.  
- The Mayor’s London Strategic Migration Partnership is now running a series of five local workshops to support migrant and refugee community organisations and public health/ TB professionals to work together to deliver TB prevention and treatments.  
The Mayor’s Rough Sleeping Commissioning framework for the period 2011-15 identified as a priority the need to achieve equitable access to health and social care services for the homeless. Funded projects include:  
- the Health Service Project, run by Pathway, to expand its support network for specialist homeless health hospital teams and Care Navigators and to help set up London’s first pan-London homeless health intermediate care unit, for hostel residents leaving hospital  
Homeless Health Peer Advocacy Project run by Groundswell, hereby peer mentors support homeless people to access healthcare  
- the No Second Night Out project where rough sleeper’s needs, including health needs are assessed and appropriate services are identified |
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<td>10. Track and report progress to improve quality and accessibility of health and social care services.</td>
<td>The award winning health website, myhealthlondon, was developed by the GLA with NHS London, London Councils and the Londonwide local medical committees. Londoners benefit from better access to information on health services, the chance to compare services more easily, find those that suit their needs the most, and receive up-to-date news and publicity for events on particular health topics.</td>
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<td>Income Inequality</td>
<td>Income inequality is shown to underpin inequalities in health. Reducing income inequalities and the negative health impact of relative poverty is the third objective of the Mayor’s Health Inequalities strategy. Work in this area includes improving employment and professional prospects of disadvantaged groups, supporting Londoners on pensions and benefits to receive an appropriate ‘living income’ for London, and encouraging healthy lifestyles for those whose low-income circumstances put them at risk of adverse health consequences.</td>
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<td>11. Tackle barriers to employment and promote access to work for excluded groups.</td>
<td>The London Enterprise Panel (LEP) adopts a strategic approach to skills development that includes those furthest away from the jobs market. In terms of supporting young people into work, the Mayor’s Apprenticeship Campaign has doubled the number of apprenticeships in London in a single year (2010/11), from 20,000 to 40,000. The campaign has also increased awareness of the benefits of apprenticeships amongst London employers and developed a pipeline of apprenticeship opportunities in key target and emerging sectors. Research by the Organisation for Economic Cooperation and Development (OECD) has highlighted this as a best practice example of a public engagement campaign in addressing the inequalities of skills opportunities available. The Mayor’s Education Programme also supports children and young people improve their chances of economic success in the city, including providing support to young people at risk of becoming NEET (not in education, employment or training), through the Mayor’s Scholars, London Academies and apprentices schemes.</td>
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<td>12. Maximise incomes for those not in paid employment by raising awareness and supporting take-up of entitlements, with better access to advice in a wider range of community settings.</td>
<td>Free debt advice services and London’s credit unions are promoted annually via the Mayor’s Know Your Rights campaign via the GLA website. The GLA also works closely with members of the Capitalise Debt Advice Partnership to analyse the latest client data with a view to identifying and mapping current debt trends. The Know Your Rights campaign aims to maximise income among London’s pensioners, helping them claim entitled benefits and receive extra help with paying their bills and keeping warm this winter. A number of GLA programmes are also helping address fuel poverty, including RE:NEW, funding energy efficiency measures in London’s fuel poor homes, and the Better, Environment, Better Health Guides.</td>
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<td>13. Work towards achieving levels of household income necessary to sustain a healthy lifestyle.</td>
<td>The Mayor recently celebrated that over 20,000 workers in the capital now benefit from over 400 accredited employers paying the London Living Wage, with another 90 employers working towards accreditation (and a number that have chosen not to be accredited). There is increasing evidence that employers who pay the London Living Wage experience lower staff turnover, lower sickness absence, and higher staff morale, with employees experiencing higher levels of wellbeing, and family and financial benefits. The Mayor has lobbied government during the introduction of welfare reform to ensure that concessions are made that reflect the increased costs of living in London. These include increased Discretionary Housing Payments, Targeted Affordability Funding and Homelessness Prevention Funding. The GLA health team has worked with the London Health Inequalities Network (LHIN), a group of Directors of Public Health from London’s most deprived areas, to protect income amongst London’s more vulnerable communities. This includes publishing Responding to the cumulative impact of betting shops: a practical discussion guide for London boroughs (LHO, 2013), providing a framework for licensing authorities to assess and consider the merits of introducing a cumulative impact policy statement (CIPS) within the existing licensing and planning regulatory framework. In relation to this, the Mayor brought forward alterations to the London Plan supporting boroughs to develop local policies to manage clusters of uses that have negative impacts on the objectives of the plan including impacts on health and wellbeing. The alterations state that over concentrations of betting shops and hot food takeaways can give rise to particular concerns. The Mayor has also published further guidelines on these matters in his Town Centres Supplementary Planning Guidance (SPG). The LHIN also produced a number of reports on protecting the health of low income groups, including Keeping well in hard times: protecting and improving health and wellbeing during an income shortfall and Planning Capacity of Welfare Benefit Advice in GP Practice: a Toolkit.</td>
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<td>14. Improve financial inclusion and literacy and increase financial security for people at points of transitions in their lives.</td>
<td>The GLA has instigated financial literacy support for young people, with the Personal Finance Education Group being awarded £75,700 through the Mayor’s London Schools Excellence Fund to work with 102 teachers in 12 London secondary schools to help improve their financial literacy skills. These teachers are now working with other schools across the capital to share successful methods for teaching Financial Education, which became part of the National Curriculum in September 2014. So far, 46 teachers and 2,180 pupils have engaged in the project.</td>
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<td>15. Work with partners to improve the affordability of opportunities that promote health and wellbeing.</td>
<td>Work to improve food access for all Londoners is a priority for the London Food Board. The first Community Shop in London opened at West Norwood, in the London Borough of Lambeth, in December 2014. Community Shop sells food to its members, all of whom are local residents on low incomes, at a fraction of the normal retail price, as well as offering a range of services to members, including debt counselling and employability support. Community Shop hopes to open more London branches in 2015. The London Food Board, in partnership with Alexandra Rose Charities, is supporting the piloting of Rose Vouchers in Greenwich and Hackney, and is now extending into other boroughs including Lambeth. Rose Vouchers enable new and expectant parents on low incomes to double their financial value when they are spent on fruit and vegetables.</td>
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# Health, work and wellbeing

Work has the potential to greatly increase a person’s physical and mental health. Whilst a regular income is very important, there are many other benefits of employment, including a sense of purpose and access to social networks. In addition there are health benefits of unpaid work, such as volunteering. There is also a need to support people carry out other valuable roles such as caring for others.

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<td>16. Invest in health at work, promoting equalities and building both organisational and employee capacity for mental and physical wellbeing.</td>
<td>GLA Economics group produced London’s Business Case for Employee Health and Well-being report which found that an average London firm of 250 employees loses around £4,800 per week (or around £250,000 a year) due to sickness absence. This business case, published in June 2012, sets out the data and evidence for investment in employee health, demonstrating how it improves organisational productivity in addition to benefiting our wider society. The London Healthy Workplace Charter, introduced by the Mayor in November 2012, is a self-assessment framework and award scheme hosted and coordinated by the GLA to recognise and support business investment in staff health and wellbeing. It supports a wide range of employers, including SMEs and public sector organisations to engage employees in workplace wellbeing activities which support public health goals around physical activity, healthy eating, smoking cessation and reduced sickness absence. The charter has so far benefited around 39,000 employees, via 44 employers in London with a further 50 employers working actively towards these standards. Thirty London boroughs are engaged in supporting the delivery of the London Healthy Workplace Charter at a local level, and the GLA group has led the way with Transport for London achieving excellence against the Charter in 2013 and the Greater London Authority Achievement in 2014.</td>
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<td>17. Promote effective ways to improve retention and in-work support for carers and people living with illness or impairment.</td>
<td>The Mayor is engaged in supporting the health needs of carers by having instigated a Mayor’s London Carers Advisory Group. This group consists of individual carers and statutory and third sector organisations seeking to raise the profile of carers, and improve the health and social inclusion of London’s carers. The GLA supported the Carers UK ‘State of Caring Survey’ in 2014, which aims help to identify the needs of carers.</td>
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<td>18. Support home-based workers, including unpaid carers, to ensure that they obtain the benefits of ‘good’ work.</td>
<td>An employment support for carers programme is being developed as a priority of London’s 2014-20 European Structural and Investment Funds (ESIF). This is being strategically led by the London Enterprise Panel (LEP). The GLA was a member of Employers for Carers for five years from 2009 and a GLA staff carers network is currently being developed. Transport for London, the London Fire Brigade and the Metropolitan Police Service are also Employers for Carers members.</td>
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<td>19. Improve provision of timely, effective support to help people with health problems back into sustainable employment.</td>
<td>Two events were held by the GLA health team with the London Mental Health Employment Partnership between 2011 and 2012, bringing together health practitioners, welfare reform policy and programme leads and commissioned organisations providing back to work support. These events helped build understanding amongst local decision makers on how to support people with health problems back into sustainable employment, and explore ways to build partnerships amongst these sectors.</td>
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<td>20. Promote the individual, social and economic benefits of volunteering and increase opportunities for Londoners to volunteer in a more diverse range of settings.</td>
<td>The 2012 Olympic and Paralympic Games saw the profile of volunteers and volunteering rise greatly. Through the work of Team London, the Mayor has maintained enthusiasm and momentum behind volunteering. This approach has made volunteering easier and improved its profile, using the Games to inspire a new generation of volunteers and has provided continual support to existing volunteering projects with an emphasis on ensuring that volunteers are given the skills they need to find work. To date there have been over 120,000 unique users of the Team London website, almost 1.7 million page views, and over 26,000 volunteers registered. Over 600 organisations are signed up to offer volunteering opportunities on the website.</td>
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Healthy Places

There is a powerful relationship between the quality of our physical environment and the state of our health. Transforming London's housing, neighbourhoods and public spaces into healthy places will create conditions which are more conducive to individual and community health and wellbeing. There are also large inequalities in the quality of the physical environment in which people live, contributing to disparities in health outcomes between population groups.

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| 21. Ensure new homes and neighbourhoods are planned and designed to promote health and reduce health inequalities in order to be in general conformity with the London Plan. | The Outer London Fund (OLF), launched in 2011, is an investment of over £175 million dedicated to strengthening the vibrancy, growth, character, quality, and economic vitality of high streets and town centres in the capital, through revitalising empty buildings for use by local communities; hosting high-street events that boost social cohesion; engaging locals in the re-design of high street public realm; boosting businesses with volunteer schemes; and improving public transport to high streets. In addition, the 2013 London Town Centre Health Check assessed over 200 of London’s town centres using a selection of indicators, some reflecting structural determinants of health for local residents. This has informed the Mayor’s ‘Further Alterations to the London Plan’ (FALP) (2015).

Recognising the importance of urban design on the public’s health, the Mayor hosted the international ‘Fit Cities Conference’ in 2013, bringing together over 175 planners, designers, developers, and public health professionals to explore links between building design and policy decisions and prevention of diseases such as obesity, diabetes, heart disease and some cancers. |
| 22. Improve the quality of London’s existing homes and neighbourhoods especially in those areas with the poorest levels of health. | The Mayor’s Housing Strategy acknowledges the health impact of the home upon a person, family and population. The strategy aims to increase the supply of homes of all tenures, and ensure all Londoners find somewhere decent and affordable to live in the capital. It targets the housing access and quality needs of Londoners in both extremes of age, and those most disadvantaged by the housing crisis - homeless and rough sleepers. The strategy includes the affordable housing programme; funding for boroughs to implement the Decent Homes Standard by 2016; and the introduction of the London Rental Standard to promote professional letting standards in the private rented sector, raise the profile of accreditation, and aim to increase the number of accredited landlords and agents to 100,000 by 2016.

The Mayor’s 2015 ‘Further Alterations to the London Plan’ supports action to reduce health inequalities through housing design standards and areas for regeneration, tackling spatial concentrations of deprivation, further development of ‘lifetime neighbourhoods’ and by advocating for the use of health impact assessments for developments to the urban realm. |
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<td>23. Manage public places across London to be safer and more inclusive.</td>
<td>Transport for London (TfL) published the world’s first Transport Health Action Plan in 2014. Improving the health of Londoners: transport action plan, describing transport’s impacts on health inequalities in London, and how a ‘Healthy Streets’ approach can help. The plan supports TfL to better consider and reflect health inequalities in all policies and programmes. TfL’s Road Safety and Accessibility programmes, and the investment in improving the public realm, are also helping to tackle health inequalities. The Mayor’s Air Quality Strategy (December 2010) aims to reduce emissions from transport, homes, workplaces and new developments, and explain how Londoners can reduce their own emissions and risk of exposure, reducing inequalities in air quality. It includes retrofitting over 60,000 homes and public buildings with energy efficiency measures, improving information for the most vulnerable, and record investment in cycling to encourage less polluting forms of travel. Barts Health Cleaner Air Project is a partnership between Barts Health NHS Trust, the GLA London boroughs of Newham, Tower Hamlets, Waltham Forest, City of London Corporation, and behaviour change experts Global Action Plan (GAP). It is an innovative project to improve the health of those who live and work in east London. The aim is to reduce air pollution within the boroughs in which the trust operates, actively reducing the number of patients admitted with air quality exacerbated health problems. Work to date has included; reducing community emissions; measuring the impacts of protecting patients from poor air quality at and around trust’s sites; and commissioning a provider to encourage staff to walk/cycle to work, where practicable.</td>
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<td>24. Deliver new and improved opportunities for healthier lifestyles.</td>
<td>Following the publication of the independent School Food Plan in July 2013, by the Secretary of State for Education, Michael Gove, the Department for Education (DfE) committed to support the GLA to work with the London Food Board and the Mayor’s Fund for London, to launch two Flagship Food Boroughs in London, under the name of ‘Lighter London’. Lighter London boroughs, Lambeth and Croydon were competitively selected to improve health and attainment through food. The benefits in tackling obesity and access to healthy foods in London will be learnt and shared across the whole city and beyond. Similarly, the GLA’s Takeaway toolkit 2012, contain tools, interventions and case studies to help London boroughs develop a response to the health impacts of fast food takeaways, another factor at the root of some health inequalities.</td>
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<td>25. Raise awareness of the health benefits of access to nature and green spaces and extend these benefits to all Londoners.</td>
<td>The All London Green Grid Supplementary Planning Guidance (2012) provides the green infrastructure framework for London. The concept of green infrastructure promotes and integrated approach to the design and management of green spaces (and other features such as green roofs and street trees) to promote, amongst other things, healthy living. The Mayor leads on several initiatives that recognise how health inequalities stem from differences in access to green space and greener neighbourhoods. Programmes including the Mayor’s Pocket Parks and Big Green Fund have resulted in improvements to run-down parks and the greening of public realm across London. Similarly, RE:LEAF, a partnership campaign to protect the capital’s trees, aims to increase tree cover by five per cent by 2025, and has already achieved the planting of over 20,000 additional street trees and several new community woodlands and orchards.</td>
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## Cross cutting commitments

A Londonwide reduction in health inequalities requires mainstreaming action into strategies and programmes, which focus on the social and economic determinants of health and ongoing work with partners, on evaluation, regional vision, and leadership to support this agenda.

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<td>26. Provide regional vision and leadership and support strategic partnership action, tracking and reporting on progress towards improved health outcomes for London.</td>
<td>The Mayor provides a regional focus on partnership action to improve health outcomes for London through chairing the London Health Board, and establishing the London Health Commission, an independent inquiry to examine how London’s health and healthcare can be improved for the benefit of the population. The London Health Commission published its report Better Health for London in October 2014.</td>
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<td>27. Support the development of local leadership expertise and capacity to influence and ensure effective action to reduce health inequalities.</td>
<td>Development of local leadership and expertise has been supported through the Institute for Health Equity’s (IHE) Marmot team. They were commissioned and funded by the Mayor to help support the development programme for London’s health and wellbeing boards by providing tailored consultancy support on health inequalities in 2012. The IHE worked with 18 London boroughs to help each of them embed a social determinants of health approach in their joint strategic needs assessments (JSNA) and joint health and wellbeing strategies (JHWS).</td>
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<td>28. Ensure health inequalities considerations are systematically embedded in strategies, programmes and investment decisions.</td>
<td>Health inequality impact assessments have been carried out on key GLA health team programmes, such as Healthy Schools and the London Healthy Workplace Charter as well as the recommendations of the London Health Commission inquiry report Better Health for London. The Mayor has a health team at the GLA, who offer public health expertise to departments dealing with the structural, social and economic determinants of health, such as planning, transport, and housing.</td>
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</table>
| 29. Specify intended health inequalities outcomes and develop programme-specific targets in strategies and programmes impacting on social and economic determinants of health. | Skills and employment metrics in the Mayor’s Jobs and Growth plan (2013) include:  
- ensure that Londoners from disadvantaged groups have the necessary skills they need to succeed  
- ensure that skills growth occurs in the most deprived parts of London as part of the wider convergence agenda  
- ensure job opportunities are accessed in the most deprived areas of London |
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<th>Commitment</th>
<th>Examples of delivery to date</th>
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<td>30. Build a stronger evidence base on effective interventions and the economic case for action on health inequalities, openly sharing learning and building knowledge.</td>
<td>The GLA intelligence unit provides insight and analysis to many City Hall work streams. Through a wide range of approaches, this data availability, manipulation, and presentation help to develop an understanding of health inequalities in London. This includes the publication of the London dashboard and quarterly borough partnership meetings to help with data sharing. The London Assembly Health Committee is tasked with reviewing health and wellbeing across London, including reviewing progress against the Mayor’s Health Inequalities Strategy, and work to tackle public health issues such as obesity and alcohol misuse. Its work has included the publication of a number of reports with pertinence to health inequalities, including food poverty, homelessness, type 2 diabetes, childcare affordability and fuel poverty.</td>
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APPENDIX C: GLA PROGRAMMES AND REPORTS
EMPOWER INDIVIDUALS AND COMMUNITIES

Healthy Schools London
www.healthyschoolslondon.org.uk

Early Years Intervention to Address Health Inequalities in London – the Economic Case (2010)
https://www.london.gov.uk/sites/default/files/early_years_report_opt.pdf

The Mayor’s Sport Legacy Programme
https://www.london.gov.uk/priorities/sport/sports-legacy-programme

London Drink Debate
http://www.lho.org.uk/LHO_Topics/Health_Topics/Lifestyle_and_behaviour/londondrinkdebate.aspx

Well London
www.welllondon.org.uk

EQUITABLE ACCESS TO HEALTH AND SOCIAL CARE

The London Health Board
www.londonhealthboard.org.uk

London Mental Health: The invisible costs of mental ill health (2014)
https://www.london.gov.uk/priorities/health/publications/london-mental-health-the-invisible-costs-of-mental-ill-health

How can I get medical help in London? (2012)
https://www.london.gov.uk/priorities/health/publications/access-to-primary-health-care

The Mayor’s Rough Sleeping Commissioning Framework 2011-2015

myhealthlondon
www.myhealth.london.nhs.uk

INCOME INEQUALITY

London Enterprise Panel
https://www.london.gov.uk/priorities/business-economy/working-in-partnership/london-enterprise-panel

The Mayor’s Education Programme
http://www.london.gov.uk/priorities/schools-and-education/our-vision/gla-education-programme

Know Your Rights campaign
http://www.london.gov.uk/priorities/equalities/older-people/pension-credit

RE:NEW making London’s homes more energy efficient
http://www.london.gov.uk/priorities/environment/energy/re-new-home-energy-efficiency

https://www.london.gov.uk/priorities/health/focus-issues/better-environment-better-health-guides-for-london-boroughs
Delivering London’s Energy Future: the Mayor’s climate change mitigation and energy strategy (2011)

London Living Wage
https://www.london.gov.uk/priorities/business-economy/vision-and-strategy/focus-areas/london-living-wage

Town Centres Supplementary Planning Guidance (SPG)
https://www.london.gov.uk/priorities/planning/publications/town-centres-supplementary-planning-guidance-spg

The London Food Board
https://www.london.gov.uk/priorities/business-economy/working-in-partnership/london-food-board/london-food-board

HEALTH, WORK AND WELLBEING

London’s business case for employee health and well-being (2012)
https://www.london.gov.uk/sites/default/files/GLA%20economics%20London’s%20business%20case%20for%20workplace%20health%202012.pdf

The London Healthy Workplace Charter
www.london.gov.uk/healthyworkplace

Mayor’s London Carers Advisory Group
https://www.london.gov.uk/priorities/equalities/carers

Team London
https://www.london.gov.uk/priorities/volunteering

HEALTHY PLACES

Outer London Fund
http://www.london.gov.uk/priorities/regeneration/high-streets/funding-programmes/outer-london-fund

London Town Centre Health check
https://www.london.gov.uk/priorities/planning/publications/2013-london-town-centre-check

London Housing Strategy (2014)
https://www.london.gov.uk/priorities/housing-land/draft-london-housing-strategy

Further Alterations to the London Plan (2015)
https://www.london.gov.uk/priorities/planning/london-plan/draft-further-alterations-to-the-london-plan

Improving the health of Londoners (Transport for London, 2014)

Transport and health in London (GLA, 2014)
http://www.london.gov.uk/priorities/health/focus-issues/transport-and-health

Mayor’s Air Quality Strategy (2010)
http://www.london.gov.uk/priorities/environment/publications/mayors-air-quality-strategy
Takeaways Toolkit (2012)
https://www.london.gov.uk/priorities/health/publications/takeaways-toolkit

All London Green Grid (2012)
https://www.london.gov.uk/priorities/environment/greening-london/improving-londons-parks-green-spaces/all-london-green-grid

Pocket Parks programme
https://www.london.gov.uk/priorities/environment/greening-london/improving-londons-parks-green-spaces/pocket-parks

Big Green Fund

RE:LEAF
http://www.london.gov.uk/priorities/environment/greening-london/re-leaf

CROSS CUTTING COMMITMENTS

The London Health Commission
www.londonhealthcommission.org.uk

London Assembly Health Committee reports
http://www.london.gov.uk/mayor-assembly/london-assembly/publications/health-community
1. Public Health Outcomes Framework (PHOF) - February 2015
3. For a full list of contributors see the GLA website, http://www.london.gov.uk/priorities/health/tackling-inequality
4. Examples are set out in more detail in Appendix B and links to reports and programmes in Appendix C
5. South, J; Hunter, D; Gamsu, M, What Local Government needs to know about Public Health: A Local Government Knowledge Evidence Review (February 2014)
8. Working for Health Equity: The Role of Health Professionals (UCL Institute of Health Equity, 2013)
14. Communities Count: The Four steps to Unlocking Social Value (Social Enterprise UK, 2014)
17. Barnet, Brent, Ealing, Harrow, Hillingdon and Hounslow
19. Institute of Health Equity; Sept 2014; Marmot Indicators: A preliminary summary with graphs; Strategic Revies of Health Inequalities post 2010