Just Space response to draft Health Inequalities Strategy (HIS)
30th November 2017

General approach

The Mayor must make a cross cutting commitment to health across all seven (7) Strategies for which the Mayor is responsible. For example, the Healthy Workplace Charter should fully integrate with the Good Work Standard in the Economic Development Strategy.

The HIS must be aware of and address the differentiated needs of diverse groups and encourage Boroughs and the NHS to include the full range of specific needs in the Joint Strategic Needs Assessments (JSNA) and the Mayor must use his power to elevate groups who are being excluded like Gypsies and Travellers and migrants.

Health inequalities do affect everyone and it is good that the Mayor wants to do things that are universal for the whole city. However, it is essential that the nine (9) protected groups under equality legislation are explicitly covered in the HIS. It is not acceptable to say "look in a different document if you are interested in the needs of specific equalities groups" when **this** is the Health **Inequalities** Strategy.

This failure to recognise the particular needs of marginalised groups in the Strategy leads on to a lack of safeguards and mitigation measures and then to the absence of inclusive mechanisms to enable the participation of marginalised groups in decision making, delivery and evaluation.

Some examples of particular needs and specific provision which should be mentioned in the HIS are:-

1. LGBT+ spaces, including queer venues and free community centres, to be protected, where lack of space combines with lack of mental health and other specialist services.

2. The needs of women to be understood in much more detail. It is important not to allow facts such as the relative longevity of women's lives in comparison with men, to lead to a dismissal of the many negative impacts on the good health of some women and girls that create inequitable health outcomes.

For example, girls living in poverty have been shown to be missing school during menstruation because they cannot access sanitary towels/tampons and are more likely, as a consequence, to suffer from depression. Equally, there are thousands of women and girls in London known to have undergone FGM. Health equality requires that Obstetrics, Gynaecology & mental health services, as well as child

protection teams, are equipped to address the current and predictable future health needs of those who have undergone FGM.

Victims of Domestic Violence (DV) need access to both refuges and to suitable move-on accommodation. The stability created by having suitable accommodation has considerable positive health impacts for women and children whose lives have already been traumatised by their experiences. In most cases, social rented housing needs to be available. This is currently not the case in a growing number of circumstances. Given the current shortage of such housing, the HIS should make the case for a clear priority for Survivors of Domestic Violence.

3. The Migrant Rights Network has pointed out that the National Health Service (Charges to Overseas Visitors) (Amendment) Regulations 2017, which include patient identity checks and up-front charging in hospitals and community health services, will lead migrants and BME communities to avoid healthcare because of fear. This ultimately leads to worse health outcomes for those individuals, but also for the communities they live in, for example, in the case of TB and other potentially infectious diseases. Another impact of allowing these regulations to be implemented is to put more pressure on A&E services and on the more expensive secondary heath services.

The Mayor should call for immediate oversight of how these regulations are being enforced. Work along the lines of that supported by the 2004 video 'Can I help you?' The Role of the Receptionist in Health Care'[1] might create an opportunity to allow positive interaction between staff and community that would limit the potential damage of the regulations.

These changes will make access to healthcare even more unequal and open to racist and discriminatory practices. Independent research by Kings College London's Department of Global health[2] found that over a third of Doctors of the World patients affected by NHS hospital charging had been deterred from accessing health care, including heavily pregnant women, people with cancer and diabetes and kidney failure patients.

For the Mayor to stitch together universalism, he has to accept at the outset that health care is full of restrictions, that health services are not being accessed by all and to put himself clearly on the side of health services being accessible for

[1] 'Can I help you?' The Role of the Receptionist in Health Care (2004) is a video produced by Camden Central Community Umbrella and Camden NHS Primary Care Trust. It was widely used by other trusts around the country as it is an exemplary statutory health sector/ community sector collaboration.
[2] https://www.doctorsoftheworld.org.uk/news/new-research-shows-nhs-charging-is-pushing-sick-and-pregnant-migrants-away

migrants and refugees. We would like to see the Mayor running public campaigns like the National Children's Bureau "Healthy Child" programme.

Will the Mayor be explicit about who exactly he means when he talks about wanting to improve "the physical and mental health of all Londoners"? We support Migrant Rights Network in recommending to the Mayor that "all Londoners" is explicitly defined in every one of his Strategies to include Londoners without legal status.

Aim 1 Healthy Children

We've noticed cuts to children's centres, youth clubs and play spaces across London but these are not mentioned in the HIS. Since only 3 Boroughs have a play strategy, the Mayor can do much to encourage the Boroughs, including a clear definition of what constitutes play space (roof top gardens being classed as children's play space is not appropriate) and promote initiatives like play streets.

This decline in facilities contributes to child obesity and depression. We support the aspiration of the *Alliance for Childhood London Forum* to make London a Child Friendly City and this requires all of the proposals in this chapter to be looked at from a child's point of view.

Aim 2 Mental Health

There must be an equalities approach to mental health policy which does far more than say that certain groups are disproportionately affected. The social determinants need to be spelt out and also the lack of take up of mental health services by particular groups.

BME men have great difficulty in both accessing mental health services and of getting good outcomes from their care in mental health services. We have had feedback that this is not being addressed by the Thrive LDN programme.

Gypsies and Travellers have mental health issues arising from their isolation from social networks and lack of culturally suitable accommodation. This trend has persisted even as most Gypsies and Travellers in London are settled in housing or on caravan sites and are registered with a GP. A significant amount of care work, particularly for children, older people and people with disabilities, happens within the Gypsy and Traveller community, and there should also be a recognition of the mental health support needed by carers themselves.

Older people are an important minority, with mental health needs that are due to social factors, such as heightened loneliness. Among young people, unemployment and homelessness are important social determinants of mental health issues. All of these needs should come through in this chapter of the HIS.

Aim 3 Place

In considering the spatial dimension of health inequalities, it's important to look beyond the difference in indicators between Boroughs and understand how the quality, affordability and suitability of housing, public space, social infrastructure and services respond to the needs and discrimination faced by equality groups.

Latin Americans have high concentrations in Haringey, Brent and Southwark where visible spaces are being gentrified and Latin American traders and services displaced. Local GPs and other public services recognise it is important to have translation and interpreting services in their areas and so support services have been gathered together but then the people they are for are moved out. There is an opening of services to the community but with displacement these services are under risk and the Latin American community is displaced to areas where there are no services.

Many communities are being displaced and there is a lack of research on the extent of this and the impact displacement is having on people's health, as well as the particular impacts on protected groups. A survey in Camden showed 70% of displaced people were BME.

Aim 4 Communities

Provision for particular communities, which we referred to at the beginning, should be picked up in this chapter with the Mayor championing accessible and inclusive health services.

The Mayor should be running a public campaign to make sure that interpreting service are available to migrants and refugees seeking to use the health service. Those working in health centres speak many languages and should be given incentives to provide an interpreting service, so that people whose first language is not English do not have to rely on their children to explain things. Schemes for recruiting bi-lingual people and training them as receptionists in GP surgeries have resulted in better primary care uptake, but these are far from a universal provision.

The Mayor should use his role in the London Regional Structures to remind partners of the need to enable and highlight the wide range of linguistic ability among health and care sector staff.

There is research on how migrants entitled to care are not receiving care unless they are legally advised. The Mayor should make available small budgets to support community based legal services which encourage access to primary care services by migrants and refugees.

These advice services could be included in social prescribing programmes.

There is a need for a clear, Plain English commonly understood definition in London as to what we mean when we are talking about 'social prescribing', including who is doing the prescribing. How social prescribing is defined and worked out in practice must come through discussions with the community, and not be a debate among clinicians.

Social prescribing must not be used as a means to get more for less out of community organisations; they need to be provided with the resources to deliver support, much of which they are doing already without sufficient resources or with no recognition.

There are concerns about how to evidence the effectivness of social prescribing projects. We recommend the Mayor recognises in the HIS that a lot of social prescribing is done by the community and supports the community providers of these services to evaluate in a common framework and pays for this to happen.

A great deal of work has been done by the voluntary and community sectors on health inequalities and it is important this is picked up by the HIS. The work of LVSC and the Race Equality Foundation may be well known, but there are many small initiatives that have come to our attention at the consultation events and usually these are not resourced by the health service.

An example was given of a health network in Lewisham made up of the older African Caribbean community who have been health workers and so have a great range of skills to offer. Another example was a small social enterprise that ran a self help group and reached 2,000 people.

The Peckham Experiment is a classic account of how good health is affected by community centred knowledge, social networks and the wider environment. The approach was holistic and participatory. There was easy access to a social club and the built environment/ infrastructure were seen as important with concern for nutrition and recycling.

How can health services be devolved to smaller areas to better meet people's needs? There is lots of interest in a more decentralised approach to bring care closer to home and to have more integration with local community networks that organise around social determinants. We can learn from the Peckham Experiment and the HIS should be featuring this as an important health legacy.

Implementation

We are informed by the approach of the World Health Organisation (WHO) that community development is a key part of good health. Communities can help to deliver better health care – see Ottawa Declaration - and should be brought to the forefront more.

Some very good work has been done in the past by collaborations between statutory health and care providers and the community. Public Health England[3] refers to the extensive evidence that connected and empowered communities are healthy communities and that communities that are involved in decision-making about their areas and its services have a positive on people's health.

But it is not at all clear that there is enough community involvement in the structures that commission or oversee health services in London. Most GP surgeries have patient participation groups (PPGs), but GPs and other health professionals are unfamiliar with Community Development. We don't know how representative or accessible these PPG's are. Its remit is the very local level, so how do participants exert any collective influence?

Each borough has a Clinical Commissioning Group. It sometimes involves PPG members in discussions. There is a Healthwatch in every local authority area who are doing outreach on health needs, especially with excluded groups. They work closely with the CCG and the local authority, and should be an important actor in the partnerships that the Mayor is seeking.

There's still a wide gap between recognition of the need for involvement in health and mechanisms to drive it. It is unclear how and whether the NHS Sustainability and Transformation Partnerships (STP's) will engage with communities.

How can community groups persuade Local Authorities to put things that matter to us about health services in their plans or JSNA or Health and Wellbeing Strategy? If the Mayor is serious about the HIS creating a platform for community groups, then there needs to be a recognition of particular needs in the HIS so that their importance is recognised and signaled to Local Authorities and we can then advocate for their inclusion at the Borough level.

What else can the Mayor do to help partnership working with the community sector and to realise our "pledges" to help deliver the HIS?

[3] See for example 'A Guide to community-centred approaches for health and wellbeing' Public Health England 2015

The Mayor certainly has the power to do things about health. The plan for devolution to the London regional level of responsibility for health services was published in 2015. We have produced briefings showing the role of the Mayor in bringing together all the strategic players under the London Health and Care Devolution Agreement and describing the five pilots that were established.

However, the London Health Board which the Mayor chairs and structures related to the devolution of health and care, do not appear to have any role for communities. There are Healthwatch groups at Borough level, albeit not immensely well resourced, but some are doing excellent work. We have looked at both Camden and Southwark. A London regional tier of Healtwatch is the minimum needed to bring some of the community voice necessary to tackle health inequalities in the London region.

We recommend that the Mayor call a gathering of community groups to look at what structures would best enable communities to feed into the London Regional Health and Care structures and to oversee the implementation of plans to tackle health inequalities in London. We want to see the Mayor commit to a real collaboration between statutory and community bodies on the future development of London's Health and Care services.