



Report of:

Meeting of	Date	Agenda Item	Ward(s)
Health and Wellbeing Board	14th January 2015	Item	All

Delete as appropriate		Non-exempt
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SUBJECT: Response to *Better Health for London* – the report of the London Health Commission

1. Synopsis

This paper provides an overview of the London Health Commission's final report – Better Health for London – and a commentary of the recommendations that are directed at HWB partner organisations in Islington. The report is intended to provide a synopsis of the key issues for the Health and Wellbeing Board and serve as the basis of a discussion by board members about the recommendations and how it wishes to respond.

2. Recommendations

The Health and Wellbeing board is asked to:

- Note the aspirations, ambitions and recommendations set out in the report of the London Health Commission "Better Health for London".
- Discuss the implications of the report for Islington and potential areas for priority focus and action.
- Agree to convene a time-limited multi-partner working group to consider and respond to the recommendations of the LHC on behalf of Islington's HWB.

3. Background

3.1. The London Health Commission was an independent inquiry established in September 2013 by the Mayor of London. The Commission was chaired by Professor the Lord Darzi and reported directly to

the Mayor. The Commission examined how London’s health and healthcare can be improved for the benefit of the population.

- 3.2. Extensive engagement was undertaken in the preparation of *Better Health for London* including: the views of more than 9,000 people; more than 50 roadshow and NHS-based events (at least one in every borough); 250 written evidence submissions received; and 9 oral hearing sessions.
- 3.3. On 15 October 2014, the London Health Commission published *Better Health for London* which, amongst other things, proposes measures to combat the threats posed by tobacco, alcohol, obesity, lack of exercise and pollution.
- 3.4. *Better Health for London* is set within an international context and compares London’s performance with a selection of ‘global cities’ from across the world. It ranks London as number 7 out of 14 comparable cities around the world in terms of health, wealth and education. To achieve the commission’s aspiration of being the world’s healthiest major global city, the report sets out 10 aspirations for London supported by 64 full recommendations (see appendix B):

Our aspirations for London Our ambitions for London

1	Give all London’s children a <u>healthy</u> , <u>happy</u> start to life	Ensure that all of London’s children are school ready at age five Halve the number of children who are obese by the time they leave primary school and reverse the trend in those who are overweight
2	Get London fitter with better food, more exercise and healthier living	Boost the number of active Londoners to 80% by supporting them to walk, jog, run or cycle to school or work
3	Make work a healthy place to be in London	Gain 1.5 million working days a year by improving <u>employee</u> health and wellbeing in London
4	Help Londoners to kick unhealthy habits	<u>Have</u> the lowest smoking rate of any city over five million inhabitants
5	Care for the most mentally ill in London so they live <u>longer</u> , healthier lives	Reduce the <u>gap</u> in life expectancy between adults with severe and enduring mental illness and the rest of the <u>population</u> by 10%
6	Enable Londoners to do more to look <u>after</u> themselves	Increase the proportion of people who feel supported to manage their long-term condition to top quartile nationally
7	Ensure that every Londoner is able to see a GP when they need to and at a time that suits them	General practice in London to be open 8am to 8pm and delivered in modern purpose-built/designed facilities
8	Create the best health and care services of any <u>world</u> city, throughout London and on every day	Have the lowest death rates in the world for the top three killers: cancer, heart diseases and respiratory illness; and close the gap in death rates between those admitted to hospital on weekdays and those admitted at the weekends
9	Fully engage and involve Londoners in the future <u>health</u> of their city	Year on year improvements in inpatient experience for trusts outside the top quintile nationally
10	Put London at the <u>centre</u> of the global revolution in digital health	Create 50,000 new jobs in the digital health sector

4. Themes and recommendations

3.6 Public health

Tobacco: Improvements have been made in recent years but smoking is still responsible for 8,400 deaths a year in the capital and 51,000 hospital admissions. Smoking tends to be higher among lower socio-economic groups, thereby contributing to health inequalities in the capital. There is evidence that the smoking ban has made a difference since its introduction in 2007, changing attitudes, stopping people starting smoking and saving lives and national efforts such as tax breaks for nicotine replacement products and legislation have also made a difference. The commission recognises the immense value of smoking cessation interventions and argues that they must continue to be supported and invested in. Given London's abundant green space (35,000 acres) compared with other comparable global cities, the commission argues that a smoking ban in parks and other public spaces owned by London's local and regional government could make a huge contribution to saving future lives (Recommendation 2). On illegal tobacco sales, the commission recommends a citywide coalition of local authorities, the metropolitan police, the London Fire Brigade, HMRC, trading standards, tobacco control alliances, crimestoppers, Public Health England (PHE) and the Mayor's Office for Policing And Crime (MOPAC) to coordinate action on the illegal sale of tobacco, map activity and share information (Recommendation 3).

Obesity: London is facing an obesity crisis with more than half of the adult population overweight or clinically obese. Although London performs better than England regionally on obesity rates, there is wide variation between the London boroughs. Obesity impacts both physical and mental health. The commission recommends the introduction of compulsory traffic light labelling in all London restaurants and cafes with more than 15 outlets nationally. GLA polling shows such an initiative is likely to prove popular with the public. There is evidence that traffic light labelling – as opposed to DRAs or calorie counting – works better at helping people identify healthy foods (Recommendation 4).

Alcohol: The commission recognises the role alcohol plays in the culture, economy and night life of London but also that alcohol-related hospital admissions and liver disease are rising. The commission's research shows that 'Binge drinking' has declined since 2009 but 'high risk' drinking is now concentrated in particular areas. The commission highlight research supporting a higher price per unit of alcohol in reducing deaths, illnesses, traffic fatalities, violence, crime, sexually risky behaviour and STIs and argues that London should follow the lead of cities like Newcastle and Liverpool which have introduced minimum unit pricing (MUP) using byelaws or voluntary agreements with vendors. Boroughs particularly affected should apply to the Secretary of State for Communities and Local Government to approve variations in licensing laws to enforce MUP in pilot areas. 50% of Londoners polled by the GLA supported MUP pilots. Such pilots could deliver substantial savings to the NHS in reduced hospital admissions. (Recommendation 5)

Taxation: The commission highlights the long history of employing taxation to reduce consumption of harmful substances and following the lead of other global cities around the world, argues that London boroughs should be given greater control over local taxation to incentivise healthy behaviours. (Recommendation 6)

3.7 Healthy workplaces

Whilst many Londoners are physically active, London lifestyles can contribute to sedentary behaviour. The commission argues that more needs to be done to make active travel easier for Londoners which would save lives and improve physical and mental health and wellbeing. The commission recommends a range of actions from employers, the Mayor, TfL and London boroughs. The commission highlights that despite significant potential gains to employers from workplace health schemes, that employers in the UK have less incentive to invest in employee health than in countries like the US or Germany (who pay for their staff's healthcare) because healthcare is provided by the NHS. The commission therefore sees a role for the Mayor, London boroughs and TfL in incentivising employers to promote health and healthy workplace schemes. (Recommendation 9)

3.8 Children's health

The commission recognise that healthy child development in the early years has huge importance for future health and happiness. London's children face particular challenges of extreme and concentrated poverty impacting on educational and health outcomes. The commission argues that parental learning programmes can ameliorate some of the impact of poverty and that a pan-London programme of evidence-based parenting support commissioned by health and care commissioners targeted from maternity to three years of age in the most vulnerable groups is needed. The programme would link midwifery, health visiting, Family Nurse Partnerships and would focus on supporting basic parenting skills (recommendation 13).

The commission also support the intervention by the Mayor in planning guidance to support local authorities to impose tighter controls on junk food businesses within 400m of schools (recommendation 14). The commission also recognises the importance of good health education and argues that more needs to be done by local authorities, the Mayor and the NHS working with Ofsted to capture information about the health of London's schools that would allow comparison around how health and wellbeing is supported. (Recommendation 15)

3.9 Health and care

The report's section on better care highlights the tension between universal and personalised care services. It contends that better care is personal care i.e., care that reflects the individual wants and needs of the person, including the design of their own care by patients (recommendation 18) and empowers both the individuals that use care and the professionals and providers who deliver it. It highlights the tension between personalisation and the principle of universality – that access to healthcare should be based on need, not ability to pay – as universal services have often meant care that is the same regardless of individual needs. The commission argue that different people want different things from their care and that people should be grouped into cohorts of similar need (e.g., older people, people with long-term conditions etc) and that the system in which care is provided be similarly arranged to provide for groups of similar individuals, in which people are treated as "...unique and complex, not as an ailment, condition, or piece of anatomy." In practical terms, the commission advocates more joint teams in the community, more joined up working, and more integration between health and social care. This could mean that, rather than referring people with multiple long-term conditions to an array of outpatient appointments with different hospital-based specialists, that there is a team of specialists based in the community providing specialist advice directly to patients and GPs. (Recommendation 17) (see diagrams and graphics pgs. 43-47)

3.10 Engagement and empowering people to take control of their own health

The commission contend that there is much to be gained from empowering Londoners to take greater care of their own health. Local and regional government, the health service, the voluntary sector, employers, schools and colleges, transport, and the wider public and private sector all have a role to play in providing the information and support required to empower Londoners to make better choices about their own health. But at the same time, there is an expectation that Londoners must also contribute to and take responsibility for improving their own health and that of their communities. The commission argues that the NHS has been poor historically at listening and responding to people's concerns and views and that the NHS must do more to actively engage with and seek out the views of people, especially London's diverse and hard to reach communities.(Recommendation 1). The commission advocates the promotion and implementation of shared decision making, care and support planning, education for self-management, personal health budgets and access to health records by health and care commissioners and the voluntary sector so that London becomes an exemplar in improving people's participation in their own care and treatment (recommendation 19). It also recommends that NHS England should develop a single Londonwide online platform to encourage and inform people about how they can actively participate in discussions and decisions about health, care and services, building on the NHS Citizen Initiative and the

Imagine Healthy London brand (recommendation 40) and recommends the Mayor create a Citizen's Health Panel to oversee the engagement and involvement of Londoners (recommendation 41).

3.11 GP services

The commission recognises that GPs play an invaluable role in the health system and as the main point of contact for most people using the NHS, must be at the heart of any system-wide attempt to improve the health of London. The commission also recognises the immense pressures on GPs in the capital from historical under-funding as a proportion of overall NHS spend, critical workforce challenges, poor access for patients, low satisfaction levels of London patients and the poor condition of many GP premises. Consequently, the commission recommends: a £1bn investment programme in GP premises over the next five years to modernise facilities (Recommendation 21) with investments led by a partnership of CCGs, NHS England, and local authorities exploring opportunities to include wider public services (such as employment, child care, libraries and education); an increase in the total proportion of London NHS spending dedicated to GPs and primary and community services and facilities (Recommendation 22), and ambitious new service and quality standards for GPs in London tailored to the population groups they serve (Recommendation 23). The commission also recommends GPs working in networks to provide a wider range of services and more convenient appointment times (recommendation 24), allowing patients to move freely between GP networks (recommendation 25) and arrangements allowing new providers to set up new GP premises in areas where there has been persistently poor provision (recommendation 26).

3.12 Mental health

Huge numbers of Londoners experience mental health problems, including children. People with a mental health problem are much less likely to receive treatment and are more likely to report poor satisfaction with treatment. People with severe and enduring mental health die more than a decade earlier than those without. The costs to healthcare and employment of not addressing mental health are also significant. The commission highlights that health and care commissioners need to do more to provide innovative support for young people suffering mental illness that utilises the technologies that are widespread among young people (recommendation 28), increase access to good psychological therapies and early intervention services within primary care (recommendation 29) and develop a pan-London multi-agency model of care for adult and child mental health patients in crisis (recommendation 30).

3.13 Better care for the homeless

There are large numbers of homeless people and people rough sleeping in the capital and funding cuts to the VCS and local authorities mean that numbers are rising. The homeless can expect to live almost half as long as the general population and tend to be beset by a host of complex inter-related health problems including mental illness, substance misuse and physical health problems. Low levels of education and the transitory nature of being a homeless person make the homeless less able to manage their own care. The commission recommends a pan-London approach to tackle homelessness, appointing a single integrated care commissioner led by NHS England (London) or one of London's CCGs that would work closely with local authorities and the health service (recommendation 31).

3.14 Data and information

The commission highlight the important role data analytics and health information can play not only in assisting people to manage their own health and wellbeing, but also the huge potential benefits to health professionals of good quality, up to date information in helping them deliver better, safer care and plan better services. 86% of people polled agreed the people involved in their care should be able to access and share information on them and their health when necessary. Despite the benefits the commission recognises the challenges. It highlights how NHS IT systems are "bewildering" and "complex"; that information governance regulations are often a source of anxiety and an excuse for inaction; and that

information is too often 'pushed' from above rather than 'pulled' from the frontline to improve the quality of care. The commission therefore recommends that Academic Health Science Networks (AHSNs), CCGs and NHS England should work together to create matched patient-level data sets and real-time information sharing to improve both care delivery and service planning, with robust safeguards for privacy and confidentiality (recommendation 42) and that Health and care commissioners should embrace advanced data analytics to better understand care needs and to commission higher quality care (recommendation 44).

3.15 Funding

The commission point out that the way CCG budgets are currently allocated in London does not accurately reflect needs and that this can be seen in the differences in surpluses and deficits between London's CCGs with a pattern of inner-London CCGs being over-funded and outer-London CCGs being under-funded. Acknowledging that reform of complex allocation formulae will take time, the commission stresses the urgency that many London CCGs face in needing to deliver 'whole-systems transformation programmes' now. To address immediate funding issues, the commission urges CCGs and Strategic Planning Groups (SPGs) to jointly commission with GPs, hospitals and other providers what patients need in a more intelligent way and where appropriate, follow the lead of CCGs in north-west London who have developed joint financial strategies reflecting inter-connectedness and promoting financial stability (recommendation 46). The commission also argues that gains could be made by improving long-term clarity about budgets and extending the time-horizons for strategic planning in London to allow commissioners and providers to invest in improving services (recommendation 47).

In order to deliver the recommendations of the commission including investment in and reform of general practice (recommendations 21-26) and new ways of commissioning and listening to people, the commission recognise that significant investment of time, energy and money is required. The commission argues that commissioners are best positioned to lead these changes and that a dedicated team should take them forward. The commission therefore propose that NHS England and CCGs should establish a shared London Transformation Fund for investment in strategic change, jointly managed by NHS England (London) and CCGs with investments agreed with sub-regional health economies (recommendation 48)

The commission argues that the way the NHS budget is currently distributed to care providers has advantages, but it also has drawbacks too, especially for the care of people with complex needs which can lead to duplication of similar services funded by separate organisations, gaps in provision, different service priorities and not enough of a focus on preventing people from becoming sick in the first place. One way other countries have sought to address these challenges is via capitated payment systems – where a single provider or consortium of providers working together are made accountable for the care needs of particular groups and are allocated the whole budget for these groups along with a single agreed set of quality outcomes. Such an approach carries risks for providers and to work requires data to calculate the capitated budget, joint working across health and social care to pool, procure and manage integrated care, the development of new care models and co-design with people who use services. Despite the risks and challenges, the commission recommends that NHS England should work with CCGs and local authorities to trial capitated budgets for specific population groups (recommendation 49).

The commission argues that one possible reason why care can sometimes be unresponsive to individual needs is that we pay for the NHS indirectly via taxes rather than as individuals who can take our custom elsewhere if unsatisfied. One area highlighted for poor performance London is maternity care where on measures of satisfaction with maternity care, London trusts scored lower than the national average in 41 out of 44 cases and where the maternal mortality rate is twice that of the UK. As a result, the commission recommends that NHS England should lead the trial and development of Personally Controlled Payments in London, starting with a pilot with 12.5% of payments for maternity care controlled directly by individual mothers (recommendation 50). This would mean that individuals would be able to decide whether or not a

hospital receives a portion of its income relating to their own care based purely on subjective experiences of care. Money would be non-transferable and would be reinvested by commissioners in the NHS.

3.16 The NHS Estate

The NHS is one of largest owners of land in London with an estate worth more than £11bn. Despite the scale of the estate, the quality is variable with 40% hospitals more than 30 years old and a large proportion of the GP estate unfit for purpose. Assessments of capital efficiency indicate NHS assets may be under used by around 15% (with the majority in acute hospital trusts) which if unlocked would be worth around £1.5bn. This would also have the added benefit of reducing running costs by around £200m annually. The causes of this inefficiency include fragmented and complex rules about decision making and funding of the NHS estate and the fact that there is no London-wide strategic overview of how land and associated issues should be managed to best help patients. Given that 80% of patient contacts with the NHS are in GP practices, and 70% of the assets are in hospitals, the Commission proposes prioritising improvements in these two parts of the NHS

Overhauling the GP estate in London: As set out in recommendation 21-26, significant investment is required by the GP estate in London. Going further, the commission recommends a closer link between funding of the GP estate and the quality to which it is maintained and recommends that NHS England should reform the rent reimbursement system for GP premises, offer modern facilities for all practices and require practices to comply with disability access requirements or accept new facilities (recommendation 51)

Overhauling the hospital estate in London: The commission advocates three steps: incentives to encourage more efficient use of capital; more options for Trusts for disposal of assets; more joined up planning across the NHS and with local authorities

- **Incentives:** because capital charges are low and asset price inflation is high, trusts have little incentive to use capital efficiently. This can lead to 'land banking' – holding on to surplus assets to hedge against future deteriorations in financial position. Incentives need to change to encourage efficient use of capital, investment in high-quality facilities and free up land for housing and other economic growth. Starting with derelict and unused buildings the commission recommends ending from 2016/17 the public subsidy through lower capital charges (3%) meaning trusts would need to pay the market cost of capital on these assets (8%) (recommendation 52). At the same time the commission argues that the current rules for retention of capital receipts can lead to inaction by NHS trusts and so in the future, trusts should automatically receive 50% of receipts with the remaining 50% needing to be agreed with HM Treasury and the Department of Health (recommendation 53).
- **Disposals:** more options for disposal should be open to trusts including the option of transferring assets for redevelopment and disposal with receipts reverting back to trusts (recommendation 54) and the ability for transformation programmes to apply for asset transfers across the public sector (recommendation 55).
- **Planning and coordination:** To address the gap in strategic capital planning the commission proposes that Strategic Planning and Capital Boards are developed by NHS commissioners, providers and local authorities and work in conjunction with NHS Property Services and Community Health Partnerships to ensure that estates planning and a comprehensive asset database are part of strategic planning (recommendation 56)

3.17 Systems leadership and governance

The commission recognise that the complexity of the change required from moving to more integrated care requires skilful leadership and leaders. It highlights the poor record of the NHS in London on diversity

amongst NHS leadership and senior management. As a result the commission recommends recruiting a wider range of NHS and social care professionals to the Darzi Fellowship Programme (recommendation 60)

The Commission recognise that better health cannot be delivered by the NHS in isolation and must be delivered in conjunction with local authorities and Public Health England. Nevertheless, it also recognises that greater coordination of efforts and action are required to deliver results, and as a result, proposes the appointment of a London Health Commissioner to champion health in the capital, supported by combining the London region of Public Health England and the GLA health teams; with the Mayor lobbying the Department of Health for the Commissioner to receive a significant budget from Public Health England (recommendation 61).

Whilst recognising that partnerships between CCGs and local authorities should remain the principal point for commissioning health and care services, the commission also recognises that at time improvements could be better made by multiple CCGs and local authorities working together across larger multi-borough geographies or even on the footprint of large acute hospitals that serve multiple boroughs. In such instances, the commission argues that NHS England (London region) should devolve more decision-making powers to CCGs and local authorities to allow them to collaborate, including through pre-existing SPGs where appropriate (recommendation 62).

To improve transparency of decision making in the NHS and ensure that leader's respond to feedback, the commission recommends new measures to ensure that London's health system includes representation of people who use services on decision-making committees, by holding meetings in public, and publishing meeting documents online (recommendation 63)

4. Implications

4.1. Financial implications

None identified.

Any financial implications arising need to be considered and agreed by the relevant Council departments and any other partners.

Any plans or strategies derived or agreed in relation to this report should use existing available resources and therefore not create a budget pressure for the Council.

4.2. Legal Implications

Section 194 of the Health and Social Care Act 2012 ("the Act") established health and wellbeing boards and required each local authority to establish a board for its area comprising of key leaders from health and social care.

Section 195 of the Act imposes a duty on health and wellbeing boards to encourage persons who arrange for the provision of any health or social care services in that area to work in an integrated manner so as to build strong and effective partnerships, which improve the commissioning and delivery of services across NHS and local government, leading in turn to improved health and wellbeing for local people and reduced health inequalities.

The report of the London Health Commission "Better Health for London" sets out a number of recommendations to support its agenda for improving the health and care of people living in London. In so doing it emphasises the need for greater co-ordination and partnership working to achieve the actions set out in the report and its recommendations. Local authorities and CCGs through health and wellbeing boards are expected to have a lead role in securing significant improvements in the health and care of people living in London and in helping to achieve the recommendations set out in the report.

4.3. Equalities Impact Assessment

None identified.

4.4. Environmental Implications

None identified.

5. Next steps

5.1 Once the bodies named in Better Health for London have set out their responses, the Mayor will convene and chair a group to prepare a unified delivery plan. This group should then continue to oversee progress in the implementation of the recommendations. To prepare our local response, it is recommended that the Board convene a time-limited group whose membership comprises those local organisations named in the recommendations to produce a comprehensive response for Islington.

6. Conclusion and reasons for recommendations

The Health and Wellbeing board is asked to:

- Note the aspirations, ambitions and recommendations set out in the report of the London Health Commission “Better Health for London”.
- Discuss the implications of the report for Islington and potential areas for priority focus and action.
- Agree to convene a time-limited multi-partner working group to consider and respond to the recommendations of the LHC on behalf of Islington’s HWB.

Background papers:

Better Health for London – report of the London Health Commission - <http://www.londonhealthcommission.org.uk/wp-content/uploads/Better-Health-for-London-report-revised-November-2014.pdf>

Attachments:

- Appendix A – Commission members
- Appendix B – Commission’s recommendations

Final Report Clearance

Signed by



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Julie Billett
Director of Public
Health

Date: 5th January
2015

Received by

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Head of Democratic Services

Date

Report author:

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APPENDIX A: COMMISSION MEMBERS

- Professor the Lord Ara Darzi, Chair, London Health Commission
- Lord Victor Adebowale, Chief Executive, Turning Point
- Colin Barrow, Executive Chairman, Alpha Strategic
- Sir Cyril Chantler, Chair, University College London Partners
- Professor Yvonne Doyle, Regional Director, Public Health England (London region)
- Len Duvall, Chair, Greater London Authority Oversight Committee and London Assembly Member
- Peter Ellingworth, Chief Executive, Association of British Healthcare Industries
- Dr Sam Everington OBE, General Practitioner and Chair of Tower Hamlets Clinical Commissioning Group
- Andrew Eyres, Chief Officer, Lambeth Clinical Commissioning Group
- Professor David Fish, Managing Director, University College London Partners
- Professor Chris Ham, Chief Executive, The King's Fund
- Professor Dermot Kelleher, Dean of the Faculty of Medicine, Imperial College London
- Sir Ron Kerr, Chief Executive, Guy's and St Thomas' NHS Foundation Trust
- Professor Sheila Leatherman, Research Professor, The University of North Carolina and Visiting Professor, London School of Economics
- Dr Andy Mitchell, Medical Director, NHS England (London region)
- Crystal Oldman, Chief Executive, The Queen's Nursing Institute
- Cllr Teresa O'Neill, Leader, London Borough of Bexley
- Dr Matthew Patrick, Chief Executive, South London and Maudsley NHS Foundation Trust and Clinical Director for Mental Health, NHS England (London region)
- Dr Anne Rainsberry, Regional Director, NHS England (London region)
- Nick Raynsford, Member of Parliament, Greenwich and Woolwich
- James Reilly, Chief Executive, Central London Community Healthcare NHS Trust
- Andrew Ridley, Managing Director, NHS North and East London Commissioning Support Unit
- Dr Caz Sayer, General Practitioner and Clinical Lead, NHS Camden Clinical Commissioning Group
- Dr Tim Spicer, General Practitioner and Chair of Hammersmith and Fulham Clinical Commissioning Group
- Dr Geraldine Strathdee, National Clinical Director for Mental Health, NHS England
- Dr Chris Streater, Managing Director, South London Academic Health Science Network
- Jeremy Taylor, Chief Executive, National Voices
- Professor Chris Welsh, Director of Education and Quality, Health Education England

APPENDIX B: RECOMMENDATIONS

1. Better health for all

- Recommendation 1: All health and care commissioners and providers should innovatively and energetically engage with Londoners on their health and care, share as much information as possible, and involve people in the future of services.
- Recommendation 2: The Mayor, Royal Parks, City of London and London boroughs should use their respective powers to make more public spaces smoke free, including Trafalgar Square, Parliament Square, and parks and green spaces.
- Recommendation 3: The Mayor should launch a fresh crackdown on the trafficking in and selling of illegal tobacco.
- Recommendation 4: London boroughs should introduce mandatory traffic light labelling and nutritional information on menus in all restaurant and food outlet chains in London, by using their byelaw and licensing powers.
- Recommendation 5: London boroughs afflicted by problem drinking should be supported if they choose to pilot a minimum 50p price/unit for alcohol through their byelaw and licensing powers.

- Recommendation 6: The GLA and London boroughs should include 'sin taxes' in their review of how London might manage devolved taxation powers, and if appropriate, make a case to central Government.
- Recommendation 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.
- Recommendation 8: The NHS, Public Health England, and TfL should work together to create a platform to enable employers to incentivise their employees to walk to work through the Oyster or a contactless scheme.
- Recommendation 9: The Mayor should encourage all employers to promote the health of Londoners through workplace health initiatives. The NHS should lead the way by introducing wellbeing programmes, including having a mental health first aider for every NHS organisation.
- Recommendation 10: London boroughs, the GLA and the NHS should work together to organise an annual Mayor's 'Imagine Healthy London' Day in London's parks, centred on an 'All-Borough Sports Festival' with health professionals offering health checks, and exercise and healthy eating workshops.
- Recommendation 11: London's professional football clubs should promote health in stadiums and local communities through club incentives and competition.
- Recommendation 12: The Mayor should accelerate planned initiatives on air quality in London to help save lives and improve the quality of life for all Londoners.

2. Better health for London's children

- Recommendation 13: Health and care commissioners should jointly develop a new model to improve support for parents of vulnerable children under three.
- Recommendation 14: The Mayor should use the 'London Plan' planning guidance to support local authorities in protecting London's children from junk food through tighter controls within 400 metres of schools and to promote access to healthier alternatives.
- Recommendation 15: Local authorities, the GLA and Public Health England should work with Ofsted to ensure more data is published on school health and wellbeing.
- Recommendation 16: Health commissioners and providers should launch a process to address the variation in quality of care for children and to propose actions to improve outcomes.

3. Better care

- Recommendation 17: Health and care commissioners should commission holistic, integrated physical, mental and social care services for population groups with similar needs, with clearly defined outcomes developed by listening to people who use services.
- Recommendation 18: Health and social care professionals should partner with people who use services to ensure that their voice is heard in designing and implementing improvements to care.
- Recommendation 19: Health and care commissioners and the voluntary sector should promote the implementation of shared decision making, care and support planning, education for self-management, personal health budgets, and access to health records so that London becomes an exemplar in improving people's participation in their own care and treatment.
- Recommendation 20: Health Education England, NHS England, and professional regulators should work together with the voluntary sector to develop education programmes for self-management of long-term conditions, which would enable more peer support and empower programme graduates to self-prescribe their own medication for their own condition.
- Recommendation 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.

- Recommendation 22: Health commissioners should increase the proportion of total London NHS spending dedicated to GPs and primary and community services and facilities.
- Recommendation 23: Commissioners should set ambitious new service and quality standards for GPs in London, tailored to the different population groups of patients they serve.
- Recommendation 24: NHS England and CCGs should promote and support GPs working in networks to reduce professional isolation, to provide a wider range of services and to provide more appointments at more convenient times.
- Recommendation 25: NHS England and CCGs should allow patients to move freely within GP networks, so those registered with one GP practice are able to access services from other practices within the same network.
- Recommendation 26: NHS England and CCGs should put in place arrangements to allow existing or new providers to set up new GP services in areas of persistent poor provision in London.
- Recommendation 27: Health commissioners should improve specialist care by accelerating efforts to create centres of excellence for cancer and cardiovascular services, launching a new programme to review elective orthopaedic services, and ensuring London Quality Standards are implemented.
- Recommendation 28: Health and care commissioners should ensure that all Londoners have access to digital mental health support, in the languages that they speak, and using the latest technology.
- Recommendation 29: NHS England should strengthen the role of mental health in primary care, with a particular focus on timely access to psychological therapies and early intervention services, and on improving the capacity and capability of GPs to care for people with mental illnesses.
- Recommendation 30: Health and care commissioners should develop a pan-London multi-agency (including the police and ambulance service) case for change and model of care for child and adult mental health patients in crisis.
- Recommendation 31: Health and care commissioners should develop a pan-London, multi-agency approach to healthcare for the homeless and rough sleepers, with dedicated integrated care teams, and commissioned across the capital by single lead commissioner.

4. Maximising science, discovery and innovation to enhance economic growth

- Recommendation 32: The Department of Health, the Department of Business, Innovation and Skills, and the National Institute for Health Research should invest in an Institute for Digital Health and Accelerator for London, coordinated by MedCity and the AHSNs.
- Recommendation 33: London's AHSCs should support and help expand the Health Informatics Collaborative funded by NIHR to improve knowledge sharing for research purposes.
- Recommendation 34: The Department of Health, the Department of Business, Innovation and Skills, and the National Institute for Health Research should invest in an Institute for Dementia Research to bring together expertise in basic sciences, technology and social policy to address the dementia crisis.
- Recommendation 35: London's providers should work with the Health Research Agency and Clinical Research Networks to create a simple and unified gateway for clinical trials in London.
- Recommendation 36: Clinical Research Networks should establish a strategic clinical research office to increase late phase research/novel real world studies in smaller NHS Trusts and GP practices.
- Recommendation 37: NHS England should strengthen London's AHSNs by further consolidating and channeling all innovation and improvement programmes through them.
- Recommendation 38: AHSC/Ns should forge greater links with Commissioners to advise on the use of latest innovations for patient benefit and to support delivery by providers.
- Recommendation 39: AHSNs in the South East should continue to collaborate – specifically on systematic knowledge sharing to improve adoption of innovation – to make South East England a leading region internationally for the adoption of the latest healthcare technologies and innovations.

5. Making it happen

- Recommendation 40: NHS England should develop a single London-wide online platform to encourage and inform people about how they can actively participate in discussions and decisions about health, care and services, building on the NHS Citizen initiative and the Imagine Healthy London brand.
- Recommendation 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.
- Recommendation 42: AHSNs, CCGs and NHS England should work together to create matched patient-level data sets and real-time information sharing to improve both care delivery and service planning, with robust safeguards for privacy and confidentiality.
- Recommendation 43: The National Information Board should designate London as an incubator for innovative health information, providing investment and support.
- Recommendation 44: Health and care commissioners should embrace advanced data analytics to better understand care needs and to commission higher quality care.
- Recommendation 45: NHS England should fund and trial patient-reported outcomes measures linked to payments to London providers.
- Recommendation 46: London CCGs and Strategic Planning Groups should consider developing local initiatives to promote greater equity in financing the health and care system.
- Recommendation 47: NHS England should make clear the budget for the London Region of NHS England and for London CCGs for the duration of future spending review periods.
- Recommendation 48: NHS England and CCGs should establish a shared transformation budget for investment in strategic change, jointly managed by NHS England (London) and CCGs with investments agreed with sub-regional health economies.
- Recommendation 49: NHS England should work with CCGs and local authorities to trial capitated budgets for specific population groups, such as elderly people with long-term conditions.
- Recommendation 50: NHS England should lead the trial and development of Personally Controlled Payments in London, starting with a pilot with 12.5% of payments for maternity care controlled directly by individual mothers.
- Recommendation 51: NHS England should reform the rent reimbursement system for GP premises, offer modern facilities for all practices, and require practices to comply with disabled access requirements or accept new facilities.
- Recommendation 52: The Department of Health should end the public subsidy for hospital assets that are no longer used for the public good by raising capital charges from 3% (public dividend capital rate) to 8% (the market cost of capital) from 2016/17.
- Recommendation 53: The Department of Health should agree with HM Treasury that NHS Trusts in London routinely retain 50% of any capital receipts, with the remaining 50% agreed with the TDA and local commissioners, so that trusts have an incentive to dispose of surplus assets.
- Recommendation 54: The Trust Development Authority and Monitor should work with the GLA to establish an unused NHS buildings programme in London so that trusts are encouraged to transfer assets for redevelopment and disposal receipts would revert back to the trusts).
- Recommendation 55: Transformation programmes should be able to apply to a joint HM Treasury, Department of Health, and Department for Communities and Local Government committee for permission to transfer assets from the NHS to other parts of the public sector at District Valuer figures.
- Recommendation 56: NHS commissioners and providers and local authorities should create Strategic Planning and Capital Boards to ensure that estates planning and a comprehensive asset database are part of wider service planning.
- Recommendation 57: Health Education England should ensure that education and training funding continues to support choice, foster excellence, and secure higher quality care.
- Recommendation 58: NHS Trusts should be permitted to include affordable housing as part of wider site redevelopment plans, working in partnership with local authorities.
- Recommendation 59: Local Education and Training Boards, Health Education England and employers should shift more training to general practice, community and integrated care settings, and explore the creation of new hybrid health and social care roles.

- Recommendation 60: The London Leadership Academy and London LETBs should recruit a wider range of NHS and social care professionals to the Darzi Fellowship programme.
- Recommendation 61: The Mayor should appoint a London Health Commissioner to champion health in the capital, supported by combining the London region of Public Health England and the GLA health teams; the Mayor should request the Department of Health for the Commissioner to receive a significant budget from Public Health England.
- Recommendation 62: NHS England should further empower CCGs to work together – with their local authority partners – to improve care across multiple boroughs, by devolving further decision-making powers to strategic planning groups.
- Recommendation 63: London should be the most transparent region of England's health and care system by including representation of people who use services on decision-making committees, by holding meetings in public, and publishing meeting documents online.
- Recommendation 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 in the implementation of the recommendations in this report.