Committee: Health and Wellbeing Board – For decision	**Date:** 12 June 2020
Subject: Addressing Health Inequalities among City Workers	**Public**
Report of: Andrew Carter - Department of Community and Children's Services	**For Decision**
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Summary

According to a report published by Public Health England earlier this month, which provided a descriptive review of data on disparities in the risk and outcomes from COVID-19, "the impact of COVID-19 has replicated existing health inequalities and, in some cases, increased them"[1].

The provision of support by the City of London Corporation to local businesses in their recovery planning and a return to the "new normal" presents an opportunity to address and reduce, and to not further exacerbate, existing health inequalities among the City's 522,000-strong workforce and particularly among the "hidden" workforce. This focus is important, timely and aligned with the City Corporation's Public Health responsibilities.

Recommendations

Members are asked to:

- Note the report.
- Where possible and appropriate, advocate for health inequalities among City workers to be considered in recovery planning across the Square Mile, with a view to contributing to reducing them as a longer-term aim.
- Support measures being taken by other teams and Departments across the Corporation, to proactively address and reduce health inequalities among the City's worker population and especially among "hidden" workers in routine, service and manual roles.

[1] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/889195/disparities_review.pdf

Main Report

Background

1. The COVID-19 pandemic has served to shine a light on health and other associated inequalities in wider public consciousness. The UK's Public Health community has been committed to tackling health inequalities for at least the past decade, since the publication of The Marmot Review report, "Fair Society, Healthy Lives" in 2010.
2. A report published by Public Health England (PHE) in June 2020, which presented findings based on surveillance data available to PHE at the time of its publication, confirmed that "the impact of COVID-19 has replicated existing health inequalities and, in some cases, increased them". Some groups have experienced disproportionately high rates of cases and deaths depending on their ethnicity and/ or socioeconomic background.
3. The PHE report found that "people from Black ethnic groups were most likely to be diagnosed with COVID-19. Death rates from COVID-19 were highest among people of Black and Asian ethnic groups." London has seen the highest rates of COVID-19 diagnoses and deaths.
4. The PHE report also reports that "populations who are socially excluded, such as vulnerable migrants, tend to have the poorest health outcomes, putting them at the extreme end of the gradient of health inequalities. This is a consequence of being exposed to multiple, overlapping risk factors, such as facing barriers in access to services, stigma and discrimination."
5. Data recently published by the Office for National Statistics (ONS), which reviewed information available up to that date[2], shows that the highest rates of deaths involving COVID-19 have been seen among men in "elementary" occupations, which include security guards, low-skilled workers in construction and low-skilled service occupations (including kitchen and catering assistants, waiters and cleaners).
6. It also shows that among the lowest-skilled workers, men working in "elementary" security occupations have had the highest rate of death involving COVID-19. Among women, only one of the nine major occupational groups – caring, leisure and other service occupations - had a statistically significantly higher mortality rate for deaths involving COVID-19 than the rate of death involving COVID-19 among women of the same age in the general population.
7. The link between individuals in occupations that have been hardest hit by COVID-19 may be partly due to the nature of roles in those occupations, as they are usually unable to work remotely, are heavily people-facing or requiring close or frequent contact with other individuals. However, it is likely that wider inequalities – health and otherwise – experienced by individuals working in those occupations are a contributing factor.

[2] https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/coronaviruscovid19relateddeathsbyoccupationenglandandwales/deathsregistereduptoandincluding20april2020#overview-of-coronavirus-related-deaths-by-occupation

Current Position

8. While people who work in the City of London tend to be richer, younger and in a higher social grade than workers elsewhere in the capital, there is a large and mostly "hidden" workforce working behind the scenes in routine, service and manual roles, which helps the Square Mile to operate as a business, visitor and cultural destination. They tend to be less well-off, older and in a lower social grade.
9. In addition, "hidden" workers in the City may be more likely to come from BAME backgrounds and experience poorer health. According to a YouGov study in 2019, those working in the City earning less than £30,000 a year were more likely to be African, Caribbean or Bangladeshi and more likely to have asthma (21% compared with 10% average among the wider City workforce). They may belong to communities that have experienced high numbers of death and severe disease as a result of COVID-19 and the emotional, social and financial impacts of the pandemic may continue to be felt for some time.
10. Across London in 2019 more than one-quarter (26%) of London's workforce was employed in routine, manual or service occupations[3], including security, cleaning, catering, hospitality, taxi driving and low-skilled construction. During the ongoing pandemic, many of these roles have been identified as "essential".
11. Data recently published by the Government shows that within the sectors comprising routine, manual or service occupations across the UK, 18% of Black workers were in "caring, leisure and other services" jobs, the highest percentage out of all ethnic groups; 41% of workers from the combined Pakistani and Bangladeshi ethnic group were in the three least skilled types of occupation ("elementary", "sales and consumer services" and "process, plants and machine operatives" jobs, with the latter including taxi and cab drivers); and the percentage of workers in "elementary" jobs, including security, cleaning, hospital porters, shelf-fillers and waiters and waitresses, was the highest in the Black (16%), White Other (15%) and Other (15%) ethnic groups[4].
12. Prior to lockdown measures being introduced by the UK Government, people working in the City in retail, accommodation and food services made up 6% of the City's workforce[5].
13. The Taylor Review stated that having a job is linked to positive health outcomes and that low quality work can harm worker health, as does unemployment.[6].
14. Many individuals working as part of the "hidden" workforce face inequalities that have direct and indirect consequences for their health. These can include low pay, language barriers or lack of understanding of the health system and how to access it, or working multiple jobs and/ or during nights or weekends, making it difficult to access healthcare support.
15. Pre-COVID-19 data (2017) showed that people working in caring, leisure and service roles already had the highest sickness rates compared with other skilled and unskilled occupations[7]. While PHE reported an overall decline of almost one-

[3] https://www.nomisweb.co.uk/reports/lmp/la/1946157247/report.aspx#tabempocc
[4] https://www.ethnicity-facts-figures.service.gov.uk/work-pay-and-benefits/employment/employment-by-occupation/latest
[5] https://www.cityoflondon.gov.uk/business/economic-research-and-information/Documents/city-statistics-briefing.pdf
[6] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/627671/good-work-taylor-review-modern-working-practices-rg.pdf
[7] https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/datasets/sicknessabsenceinthelabourmarket

quarter in smoking rates across England between 2014 and 2019, they remain high among those in routine and manual occupations[8].

16. Regarding work, they may experience poor working conditions and precarious employment, which means they are not able to challenge bad working practices. In addition, as they may work remotely on clients' sites, this makes it difficult for their actual employers to provide workplace health initiatives to support them and also to communicate with them to signpost to support services. While the client organisations they may provide cleaning or security services to, for example, may offer on-site health and wellbeing interventions for their direct employees, it is not common practice that these are extended to employees of contractors. This leads to further inequalities when compared with City workers in desk-based, "white collar" roles.
17. There is a growing body of evidence highlighting inequalities faced by people working in routine, service and manual roles.
18. Recent publications from Samaritans[9] and The Chartered Institute of Building (CIOB)[10] have highlighted the increased risks of poor mental health and suicide among middle-aged men on low incomes and men working in manual roles in the construction industry respectively. A report published in July 2019 by the Latin American Women's Rights Service (LAWRS), called "The Unheard Workforce", presented the experiences of Latin American migrant women residing in London and working in low-paid occupations – cleaning, hospitality and domestic work[11]. The Royal Society for Public Health produced a policy paper focusing on the mental health of the hospitality workforce in 2019[12] - a sector that has particularly suffered as a result of COVID-19.
19. Tackling health and wider inequalities faced by certain groups within the City's 522,000-strong workforce has been a focus within the City Corporation and has been undertaken in a cross-organisational manner. For example, in 2019 the Public Health team's Business Healthy, with support from Environmental Health, collaborated with the Greater London Authority to host a session focusing on this issue and engaging with employers in the routine, service and manual sectors to explore best practice and showcase the business case[13]. The Community Safety team conducted a focus group with the services users of the LAWRS to hear about their experiences and to develop culturally- and language-appropriate materials for employers to signpost to support for domestic abuse. The City Advice service, commissioned the City Corporation and delivered by Toynbee Hall, has worked to establish relationships with specific groups within the "hidden" workforce. Innovation and Growth and the Town Clerk's department have worked to encourage businesses to pay the London Living Wage and champion social mobility.
20. The spotlight that the impacts of COVID-19 has shone on health, and other inequalities linked to the wider determinants of health, provides an important opportunity to engage key stakeholders and address health inequalities among the City's "hidden" workforce in recovery-planning going forward.

[8] https://publichealthmatters.blog.gov.uk/2018/07/03/turning-the-tide-on-tobacco-smoking-in-england-hits-a-new-low/
[9] https://media.samaritans.org/documents/Lived_experience_report_FINAL.pdf
[10] https://policy.ciob.org/wp-content/uploads/2020/05/Understanding-Mental-Health-in-the-Built-Environment-May-2020-1.pdf
[11] http://www.lawrs.org.uk/wp-content/uploads/2018/12/unheard-workforce-research.pdf
[12] https://www.rsph.org.uk/our-work/policy/wellbeing/service-with-out-a-smile.html
[13] https://www.businesshealthy.org/resource/supporting-the-health-and-wellbeing-of-londons-hidden-workforce-full-slidedeck/

Conclusion

21. The COVID-19 pandemic has shone a light on existing health and wider inequalities, which are reflected within the City's 522,000-strong workforce.
22. Recovery planning presents an opportunity to proactively tackle these inequalities experienced by the City's "hidden" workforce, and it is important that planning for a return to "the new normal" does not further exacerbate these inequalities.

Proposals

23. Where possible and appropriate, members of the Health and Wellbeing Board should themselves advocate - and support colleagues involved in relevant conversations to advocate - for health inequalities among City workers to be considered in recovery planning across the Square Mile, with a view to contributing to reducing them as a longer-term aim. Wherever possible, the views of individuals working in "hidden" occupations should be sought and serve to influence action. The Public Health team is able to support these efforts by providing data, sharing evidence and insights and collaborating with colleagues in the advocacy.

24. Where possible and appropriate, members of the Health and Wellbeing Board should support measures being taken by other teams and Departments across the Corporation, to proactively address and reduce health inequalities among the City's worker population and especially among "hidden" workers in routine, service and manual roles.

Corporate & Strategic Implications

25. Corporate Plan: Contribute to a flourishing society; Support a thriving economy
26. Joint Health and Wellbeing Strategy: Good mental health for all; a healthy urban environment; promoting healthy behaviours
27. Responsible Business Strategy: Individuals and communities flourish
28. DCCS Business Plan: Safe; Potential; Independence, Involvement and Choice; Health and Wellbeing; Community

Appendices

Appendix A - Marmot 10-Year Review Summary

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