INSTITUTE of HEALTH EQUITY

THE RISING COST OF LIVING: A REVIEW OF INTERVENTIONS TO REDUCE IMPACTS ON HEALTH INEQUALITIES IN LONDON

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EXECUTIVE SUMMARY

IHE COST OF LIVING RAPID EVIDENCE REVIEW

As of December 2022, headline inflation was running at over 11%, and for many people in London this is the first time in living memory that they have experienced such a rapid decline in their real incomes. People and households on average and low incomes spend a higher share of income on essential goods such as food and home energy, which are rising even faster than headline inflation. The rising cost of living is likely to contribute to widening inequalities in health and life expectancy between the richest and poorest in London.

This report summarises a rapid review of evidence for local interventions to mitigate the impacts on health in London. It has been produced by the UCL Institute of Health Equity (IHE) for the Greater London Authority and system partners across local government, the NHS and the wider voluntary, community, faith and social enterprise (VCFSE) and business sectors.

The report presents the evidence for short to medium term actions that can be delivered at a local level. Many of these will require additional government intervention to be delivered at the scale required to meet the level of need, but most of the interventions cited are already delivered in one or more areas of London, and case studies are presented throughout the report.

This review should be read alongside the accompanying data pack on the impacts of the rising cost of living on London.

Key MESSAGES

- **The rising cost of living may accelerate an existing trend of stalling life expectancy in England, and falling life expectancy in some groups in the poorest communities. A decade of austerity is among the causes of this trend, disproportionately affecting the same groups** who are the most exposed to the impacts of inflation, including children, women, people living with disabilities and long-term conditions, people from minority ethnic groups, lone parents, and people who are socially excluded, such as rough sleepers, undocumented migrants and sex workers.
- **There has been a rapid decline in real incomes, hitting those on low incomes hardest, and this is likely to contribute to widening inequalities in health and life expectancy between the richest and poorest in London.**

LONDON CONTEXT

There are profound health inequalities related to socioeconomic deprivation in London.

- In 2020, London saw the largest increase in all-cause premature mortality of any region in the UK, and this disproportionately impacted the most deprived communities and continues to do so.
- This is related to the fact that, despite being the richest city in the UK, London has the highest rate of poverty of any region, with more than a quarter (27%) of London residents living in poverty in 2021 after taking housing costs into account.
- Inequalities in income in London are wider than the rest of the UK: people in the top income decile earn over ten times more than people in the lowest decile in London.
- The poor in London are poorer than in other regions, with incomes after housing costs in the lowest decile in London 30% below those in the lowest decile in the rest of the UK.
- Income inequality has been further impacted by the pandemic: real wages have declined, and this has impacted lower paid sectors more than higher wage professions in London.

Wealth provides some protection against the rising cost of living as it increases the likelihood of home ownership, and of having a pension and sources of unearned income. Yet in 2020 London had the most unequal wealth of any UK region, with minimal increase in wealth in the lowest income groups over the last decade.

The wide inequalities in wealth and income in London mean that many low-income and 'just about managing' households in London are already cutting back on essentials and turning to credit and savings to afford them. Rising household debt, especially unmanageable debts, are likely to contribute to a major mental health burden as more people are faced with the stress and anxiety of dealing with creditors and debt collection processes.

Compounding this, since 2010 the spending power of local authorities in London has fallen by almost two-fifths, and these cuts combined with increasing demand for social care have resulted in cuts to funding for non-statutory service provision in most boroughs, leaving London entering this period of rising costs with greater unmet need for non-statutory services than a decade ago. Many of these, such as debt and welfare advice and legal aid, are essential to supporting people through the cost-of-living crisis.

The Government have taken several measures to respond to the cost-of-living crisis in the short term, and these forms of support, such as the energy price guarantee and the energy bills support scheme, will reduce the impact of inflation on many households. However, **their role in mitigating inequalities in the impacts of rising living costs is mixed** – whilst some, such as the additional payments of £650 in 2022 and £900 in 2023 for universal credit recipients are targeted at the lowest income households, others, such as the energy price guarantee, will benefit high income households, that consume more energy, more than they benefit low income.

WHAT DOES THE EVIDENCE POINT TO?

The evidence points to a **need for coordinated activity, with organisations playing their role as employers, as local partners in a place, and as service providers and commissioners**.

The report is structured around three factors that contribute to whether a household or individual can cope with high inflation: **(1) income, (2) the cost of essential outgoings, and (3) financial resilience and debt**. As a household's income, essential outgoings, financial resilience and debts are in turn affected by many other factors, the range of interventions to address them is varied. **There is no single mitigating intervention, bespoke combinations at national and local level will be needed to address the different factors** (including health) that contribute to a person or household's financial circumstances and the impacts on health and health inequalities that will result.

INCOME

Nevertheless, logic, social justice and evidence clearly indicate that where a problem is driven by people having insufficient income, then increasing their income will reduce the problem – and this should be the starting point for any response. Doing this requires employers to pay, as a bare minimum, the London Living Wage, and that service commissioners maximise provision of welfare, benefit and legal advisory services to support people to access all entitlements.

ESSENTIAL OUTGOINGS

Even with increased incomes, many households, especially those with dependent children or adults, have higher than average essential outgoings that cannot be covered by the London Living Wage and are unmet in households subject to the benefit cap. **These households are increasingly running 'negative budgets'** - where the cost of essential outgoings exceeds household income. The report discusses more **targeted interventions that can support people to manage the cost of essential outgoings spanning food, childcare, home energy, transport, housing and healthcare.** As a first step, public sector providers across all service areas should identify the need for and promote uptake of the full range of targeted statutory financial assistance that already exists. They should then work with all partners at a place level to commission and deliver additional support to help with essential costs – examples of which are presented in the report.

There are early signs that lower income households in London are taking on more credit and are more likely to default on bill payments as living costs rise. People with problem debts are more likely to suffer from mental health problems, and debt collection processes are heavily implicated in causing significant stress and anxiety and in contributing to a growing mental health crisis. As a growing number of people who default on debt repayments are not choosing to do so, it is essential that organisations in all sectors that have a debt collection function **adjust their processes towards being sensitive to the financial and mental health needs of communities and customers**.

The introduction of Integrated Care Systems (ICSs) across health and social care enables the development of the role of NHS Trusts and local authorities as 'anchor' organisations within their communities, drawing on the range of functions that partners have, as employers, service providers, commissioners, as owners of capital and estates and as partners in a place. **ICS partners should consider how they embed support with rising**

living costs into clinical pathways and the opportunities to extend social prescribing to support people with rising living costs. Their data and intelligence functions have a role in identifying households and communities who are most at risk from the rising cost of living, whilst the workforce itself should be given training and supervision to deliver initial advice and support at an individual level.

FINANCIAL RESILIENCE AND DEBT

Investment in voluntary and community services, in particular advice and support services, offers a high return on investment. Interventions should be developed collaboratively with affected communities in a way that empowers and gives a voice to people most impacted by falling incomes, and does not judge or stigmatise. All commissioners and providers of interventions should maximise use of the power within communities and individuals to advocate for themselves to drive the structural changes needed to reduce income, and health, inequality.

Finally, the private sector are a key partner in mitigating the rising cost of living in London. In addition to the moral case, businesses will benefit from healthy workers and healthy customers. **Businesses can support the cost-of-living response through the pay and benefits they offer, hours worked and job security, and the conditions of work, and can influence the health of individuals in the communities in which they operate through local partnerships, procurement and supply networks.** Large organisations in both the public and private sectors can take the lead and encourage and support smaller organisations to pay the **London Living Wage.**

OVERARCHING RECOMMENDATIONS

For local authorities and health and social care commissioners and providers

Integrated Care System partners, including local authorities and primary, secondary and tertiary care providers, should integrate their response to the rising cost of living with their strategic approach to health inequalities.

As service providers:

1. **Embed financial wellbeing and resilience into clinical pathways, considering how and where to co-locate services to support people.**
2. **Primary Care Networks should consider the opportunities to extend the role of social prescribing link workers and mechanisms to develop the direct and indirect (i.e. signposting) support that they can offer.**
3. **Use data and intelligence functions in real time to identify individuals and communities who are most at risk from the rising cost of living.**
4. **The principles of prevention and early help should underpin any intervention.**
5. **Provide workforce training in how to identify people at risk and support the workforce to contribute to local approaches to address the rising cost of living. Professionals in frontline roles should:**
   - Be aware of how financial insecurity can impact people's health and health behaviours.
   - Understand the impacts of multiple exclusion and discrimination – whether based on ethnicity/racism, disability, stigmatisation of class and poverty, other protected characteristics or being in a group excluded from healthcare, such as people who are homeless or sex workers.
   - Consider the whole person when people present to them, and offer signposting and support as appropriate, ideally with minimal additional effort for the individual, to help address the range of issues a person may need support with.
6. **Embed monitoring and evaluation in the delivery of new initiatives.**
7. **If collecting payment from service users for chargeable services, including council tax and social housing rents by local authorities, review debt collection processes to minimise their impact on mental health, and support people to create a manageable payment plan as opposed to pursuing legal enforcement measures.**

As partners in a place:

8 Interventions should be developed collaboratively with affected communities in a way that empowers and gives a voice to people most impacted by falling incomes, and does not judge or stigmatise, and maximises the use of the power within communities and individuals to advocate for themselves to drive the structural changes needed to reduce inequality.

9 Investment in the VCFSE sector, in particular advice and support services, offers a high return on investment. Funding for the VCFSE must become more sustainable to have a lasting impact.

10 Engage and involve communities, VCSFE sector and community leaders in the assessment of current services and interventions and the development of new ones.

11 When communicating complex information check that communications meet readability and accessibility guidance and ensure that content is relevant to people's lives.

Procurement and commissioning for social value:

12 Use social value levers to require good employment practices throughout supply chains, including paying sufficient wages to meet the London Living Wage.

As employers:

13 Deliver on recommendations for interventions that employers can implement to support their workforce (see section 5.3).

14 Pay the London Living Wage and implement the Mayor of London's Good Work Charter

FOR BUSINESSES

The private sector must be a key partner in mitigating the rising cost of living.

- Businesses affect the health of their employees and suppliers through the pay and benefits they offer, hours worked and job security, and the conditions of work.
- Businesses affect the health of their clients, customers and shareholders through the products and services they provide and how their investments are held.
- The effects on wider society also encompass taxes paid by businesses to local and national government, which support interventions to reduce income inequality. Meanwhile, salaries paid to employees, especially those in lower paid roles, are quickly returned to the local economy and support demand for business products.
- Large organisations in both the public and private sectors can take the lead and encourage and support smaller organisations to, for example, pay the London Living Wage.
- Businesses have a major impact on the mental health of customers when they pursue heavy handed debt collection processes, and this is a particular concern as more people take on debt. As with ICS partners, all businesses, and their regulators, should review debt collection processes to minimise their impact on mental health, and support people to create a manageable payment plan as opposed to pursuing legal enforcement measures.

RECOMMENDATIONS ON MAXIMISING INCOME, SUPPORT TO MANAGE THE COST OF ESSENTIAL OUTGOINGS, AND FINANCIAL RESILIENCE AND DEBT MANAGEMENT

Recommendations – support to manage the cost of essential outgoings

Food

- Food aid providers should adopt a cash-first approach and place trained advisors able to support with financial, housing and any locally identified needs on-site at food aid projects.
- ICS partners should promote uptake of Healthy Start vouchers.
- Local authorities should extend free school meal provision to all year groups in primary schools and widen the eligibility criteria to increase uptake in secondary schools.
- ICS's should consider their role in supporting people with dietary needs who are unable to afford appropriate food.

Childcare

- Employers should offer flexible working as standard, including as applicable: self-rostering, flexible work around core hours, remote working and part-time options.
- Employers should promote childcare support that is available and offer a childcare deposit loan scheme for parents returning to work.
- Build capacity in Children's Centre's, family hubs, and the public health nursing workforce to identify and provide early help to families with young children where childcare costs are leading to financial hardship, either directly or because of barriers to workforce participation.
- Large organisations in all sectors should consider providing subsidised on-site childcare facilities where feasible.

Home energy

- Local authorities, VCFSE and NHS should review the Cold Weather Plan for England and NICE Guideline 6: Excess Winter Deaths, and develop a strategic partnership, seeking to implement all recommendations.
- Primary care, including social prescribing link workers, and adult social care workforce, should be trained to recognise signs of fuel poverty and have conversations about the support available.

Transport

- Employers should implement a range of interventions to reduce people's need to pay for travel at peak times. These include promoting the cycle to work scheme and providing facilities and training to encourage uptake, and providing interest-free season ticket loans and flexible working.
- Local authorities should take a long-term view and integrate making community infrastructure available within a short distance into their local plans to reduce the need to make longer journeys. Together with Transport for London they should invest in cycling and walking infrastructure that connects lower income neighbourhoods with key employment, educational and health infrastructure as well as social and cultural amenities.

Housing

- Integrated Care System partners should consider means of co-locating housing and related support into routine care, with e.g. housing, legal and welfare and benefit advisors available to inpatients and outpatients on-site without need for external referral.
- Local authorities and ICSs should refer to the separate evidence review in this series on Housing and Health Inequalities in London.

Healthcare

- Providers should seek to identify and ensure people are aware of entitlements available to both people who are and are not exempt, e.g. prescription charge exemption certificates for people on low incomes, electricity rebates for home oxygen, and the routine healthcare charge exemptions for certain groups.
- Social prescribing and other advisory roles should be trained to assist with accessing healthcare entitlements.

Recommendations – Maximising income

All employers should	• Pay the London Living Wage and should reinforce this through their procurement processes to influence suppliers and commissioned services. • Support trade union membership in their workforce, in particular encouraging the lowest paid workers to join. • Ensure adequate protections of pay and conditions for all staff when ill, including those not directly employed, and promote a positive culture of taking sick-leave when needed.
Integrated Care System Partners	• All system partners should identify and support people to access all benefits and entitlements for which they are eligible, taking into consideration all barriers to uptake and opportunities to co-locate welfare advice with other services people routinely access. • Should support development of health justice partnerships in their localities, including co-location of services in health and care facilities. They should develop the role of health and care professionals, including social prescribing link workers, in identifying the need for and facilitating access to legal welfare advice.
The Department for Work and Pensions	• Should allocate 5% of the value of unclaimed benefits to services that increase benefit uptake, including health justice partnerships. • Review, nationally, processes for claiming benefits, especially where those often require professional support to complete, to seek to minimise demand for professional support with initial applications.

Recommendations – Financial resilience and debt management

	• All organisations that undertake debt recovery should be sensitive to the mental health needs of clients.
The NHS, local authorities and businesses, should, as appropriate:	• Fund and resource debt advice services sufficiently to meet need. • Where people are in debt to Local authorities, the NHS and businesses, debt advice and support should be offered via outreach at the first sign of financial difficulties to secure the best outcomes. • Commission services that deliver money and debt advice on-site in primary care, hospitals and mental health services. In particular they should ensure people in a mental health crisis are able to access debt advice and a ‘temporary suspension of any enforcement action. • Promote credit unions in their cost-of-living response communications.

1
INTRODUCTION

1.1 BACKGROUND

As of December 2022, headline inflation was running at over 11%, and for many people in London this is the first time in living memory that they have experienced such a rapid decline in their real incomes. The rising cost of living threatens to worsen living standards, increase poverty and widen inequalities in health.

Everyone is affected by rising living costs, but lower income groups spend comparably more of their income on essential goods such as food and home energy, the cost of which is rising much faster than headline inflation. This contributes to a social gradient in the effects of the rising cost of living, and this is likely to mirror the social gradient in health: the finding that people who are more socioeconomically advantaged have better health than people who are less advantaged, a relationship that is continuous from the lowest to the highest income groups . People who are more affluent are likely to be better able to absorb rising living costs, but many people who were previously financially secure will be drawn towards or into poverty and financial hardship by rising inflation and interest rates. This is evident from findings that half of Londoners polled in a representative survey in October 2022 were already either 'financially struggling' or 'just about managing' financially (1). The rising cost of living may accelerate an existing trend of stalling life expectancy in England, and falling life expectancy in some groups in the poorest communities (2).

This report follows a rapid review of evidence for interventions to mitigate the impacts of the rising cost of living on London. It has been produced by the UCL Institute of Health Equity (IHE) for the Greater London Authority and system partners across local government, the NHS and the wider voluntary, community, faith and social enterprise (VCFSE) and business sectors. The report focuses on supporting a coordinated response across these partners and sectors, and provides the following:

- **Section 2** contextualises the rising cost of living in terms of existing inequalities in health and income, and summarises some of the major factors that will determine the resilience of London and its residents to the health impacts of falling real incomes.
- **Section 3** provides an overview of evidence on which population groups are most vulnerable to the rising cost of living and the impacts of this on health and the social determinants of health, to assist with design and implementation of interventions.
- **Section 4** presents a framework for action.

At an individual and household level there are three broad factors that contribute to the capacity to cope with high inflation and rising interest rates: income; the cost of essential outgoings; and the household's financial resilience and debt. Based on these factors, **sections 5 to 8 present evidence for interventions which will mitigate some of the potential health impacts of the cost-of-living crisis.** This begins with an examination of the role of Integrated Care Systems, followed by their partners, including local authorities, the Greater London Authority, the VCFSE sector, and the role of businesses.

The interventions provide a direction of travel and some key information to guide the response of service providers in all sectors. Where possible the review cites the best available evidence regarding a range of areas for intervention.

1.2 SCOPE

The scope of this review includes evidence for short- to medium-term interventions that will help to mitigate the rising cost of living and contribute to preventing the worst health impacts on people and communities that are most at risk. In this review an 'intervention' is an example of a strategy, programme or initiative, taken by a local area, organisation or national government.

The review is focused on prevention and does not cover interventions to respond to the potential health and social consequences of recession, inflation and falling living standards.

The authors recognise that it is essential that income inequalities and levels of poverty are substantially reduced, but this is beyond the scope of this review and requires sustained action form national government, recommendations for which are presented in the Marmot Review: Ten Years On and the Institute of Health Equity's report, Build Back Fairer (2,3).

1.3 METHODS

As a rapid evidence review this report captures evidence gathered via:

1. Literature searches of widely used databases in search of health evidence on topics within scope, including Amed, Embase, Medline and Google Scholar. The searches used relevant terms to capture literature and search results were then sorted for relevance to the review. Given the wide-ranging nature of the review and multiple topics this did not involve pre-planned inclusion or exclusion criteria.
2. Searches for grey literature where the peer-reviewed evidence base was absent or lacking.
3. Forward citation searching from relevant literature.
4. An evidence-gathering exercise from stakeholders involving a call for evidence and review of submissions.

In some sections, this review points to other reviews of evidence and their recommendations rather than seeking to reproduce those here.

Much of the evidence cited in this report was generated in the aftermath of the 2008 financial crash, the macroeconomic conditions that created it and austerity policies which were enacted as a response. Inflation results in real-term declines in funding for public services and in personal incomes that are not dissimilar to the effects of recession and policies of austerity. It can therefore be expected to have comparable consequences unless efforts are made to prevent them.

This review comments on the strength of evidence to mitigate the effect on real-terms incomes. Where the strength of evidence is noted, 'weak' evidence refers to evidence that is at high risk of bias, for example from reports published by a service provider, with limited data or information on methodology. 'Medium-strength' evidence includes studies or published evaluations that include clear descriptions of the methodology and outcome measures, which may include qualitative and/or before and after studies. 'Good-quality' evidence for interventions refers to natural experiments or to controlled studies.

On the criteria above, whilst there is often good evidence for the problems, the solutions are complex and most of the interventions referenced in the review have medium-strength evidence to support them, because most are implemented and evaluated without control groups. There is good evidence that a lack of income and/or high financial outgoings, combined with low savings and/or problem debt, contribute to stress, poor health and inequalities in health. It is logical, therefore, to conclude that interventions that alleviate these conditions will help someone to live a healthy life. However, most interventions are only able to influence one or two factors when there may be several together (such as debt, poor housing and low income) that are contributing to a person's circumstances. This review therefore recommends that a combination of interventions are delivered to address different factors contributing to a person's or household's circumstances.

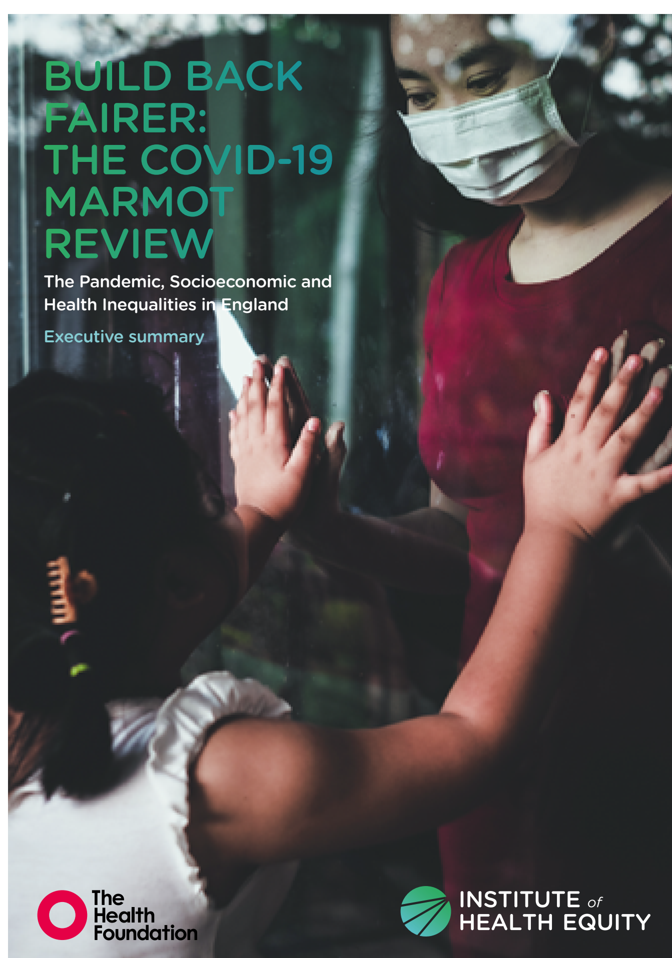
1.4 FURTHER EVIDENCE BEYOND THIS REVIEW

Interventions that place the onus on individuals to change rather than the wider system to change around them are not going to address widespread financial insecurity at scale, or benefit population health.

Poverty causes ill health and drives health inequalities between rich and poor. Whilst the interventions covered in this review are intended to mitigate the effects of inflation and declining living standards, the primary imperative must remain to ensure people have adequate income and access to services to lead a healthy life.

The evidence previously gathered in the IHE report *The Marmot Review: Ten Years On* (2020) restates the case made in the 2010 Marmot Review, *Fair Society, Healthy Lives*, for proportionate universalism: that action should be delivered universally, but with a scale and intensity that is proportionate to need. This remains a valid and important recommendation to service providers considering the cost of living crisis response, and should be considered if commissioning or delivering interventions covered in this report (1, 2).

More recently IHE published *Build Back Fairer*, a national framework for action to reduce inequalities across the life-course in the aftermath of the Covid-19 pandemic (3). That report contained recommendations for central government action to reduce health inequalities through short-, medium- and long-term policy interventions: from giving every child the best start in life, through to creating healthy places, enabling a healthy standard of living for all, and strengthening the role of ill-health prevention. These recommendations are consistent with building resilience across society to financial shocks, such as the current rate of inflation.



2
THE RISING COST OF LIVING IN CONTEXT

2.1 INEQUALITIES IN HEALTH AND FINANCIAL RESILIENCE

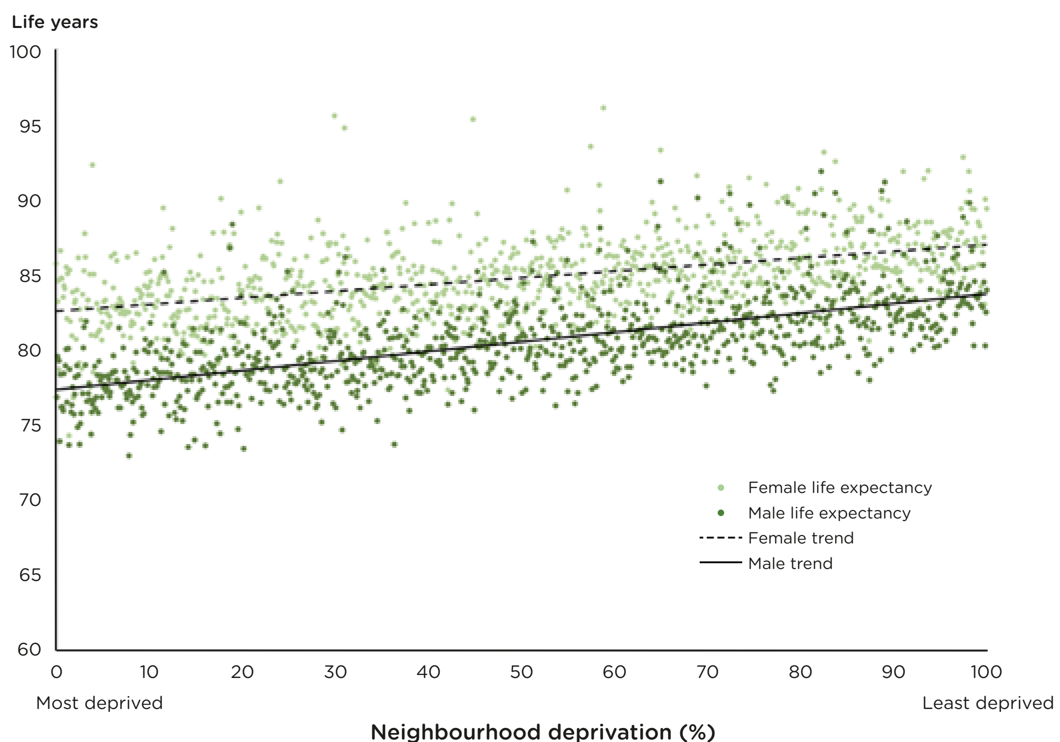
The *Marmot Review: Ten Years On* report highlighted falling life expectancy among women in the lowest income groups in the decade 2010–2020 (2).

There is now evidence indicating how the last decade has been characterised by stalling life expectancy across all income groups, but disproportionately impacting the health of people in the most deprived areas of the UK, which has led to widening health inequalities (5). While the immediate causes of stalling life expectancy are a reduction in the rate of improvement in cardiovascular mortality and an increase in drug-related deaths, austerity is among the causes of the causes (6). Mechanisms for this that are well evidenced include that cuts to local government grants, averaging 23.7% in England, have disproportionately impacted services in more deprived areas that relied more heavily on central government funding (7). Slower increases in NHS funding have similarly affected deprived areas more than the less deprived (8). It has been estimated that life expectancy at birth decreased by 1.3 months for each £100 decline in annual per-person local government funding (9). COVID-19 has exacerbated existing inequalities in health and led to overall reductions in life expectancy in England.(3)

There is a steep gradient in life expectancy by socioeconomic status in London that will likely widen as a result of the cost-of-living crisis.

There are wide and avoidable inequalities in life expectancy related to socioeconomic deprivation in London. Figure 1 shows the inequality in life expectancy by sex and level of deprivation for London boroughs between 2016 and 2020. Each green dot represents neighbourhoods of 5000-7000 people within London, which are ordered by their rank on the Index of Multiple Deprivation (IMD). The graph shows that generally, the greater the level of deprivation, the lower the average life expectancy. The line of best fit shows the socioeconomic gradient in health in London.

Figure 1. Inequality in life expectancy by gender and deprivation for at the local neighbourhood level[1], London, 2016–20



Notes: Percentage distribution derived by ranking neighbourhoods (MSOAs) within London by their IMD 2019 deprivation score. Includes data from Covid-19 in 2020 which may distort patterns.

Sources: (1) ONS. (2) English indices of deprivation 2019: mapping resources.

[1]A mid-layer super output area (MSOA) is a neighourhood of 5000-7200 people that is widely used in the production of population statistical outputs.

MENTAL HEALTH

The relationship between income and mental health is bi-directional - concerns about rising living costs have a negative impact on the mental wellbeing of all people, but this has been found to affect a larger proportion of people with a recent history of mental illness than people without (13). One recent representative UK survey has found that more than half of UK respondents (54%) report having felt either anxious, depressed, filled with dread or unable to cope, or a combination of these, due to concerns about their finances. For some this was particularly acute, with one in six (17%) saying that they had experienced suicidal thoughts or feelings as a result of the rise in the cost of living this year. That share was even higher among people who were in debt, rising to half (49%) of those who were behind on more than one kind of payment like energy bills or rent (13).

There is good evidence that:

- Real-terms cuts to some social security benefits since 2010 worsened mental health outcomes among those affected, and there is some evidence for impact on worsening mortality (6).
- People with problem debt are more likely to have a range of psychological disorders, including psychosis, alcohol dependence and drug dependence (14). As interest rates rise, problem debt is likely to increase.
- The relationship between deprivation and serious mental illness (SMI) is complex – the stresses associated with deprivation have been implicated as contributing to the development of SMI, and SMI frequently worsens socioeconomic circumstances including by reducing workforce participation and earning potential, and contributing to social exclusion (15).
- People in the most deprived areas are more than two times as likely to die by suicide than those in the wealthiest areas, and there is a very real risk that erosion of real incomes will cause increased loss of life from this cause, particularly among those already struggling with their mental health (16).

INCOME INEQUALITIES

London has the highest rate of poverty of any region in the UK, with more than a quarter (27%) of London residents living in poverty in 2021 when measured after taking housing costs into account (17). Inequalities in income in London are wider than the rest of the UK: people in the top decile earned over ten times more than people in the bottom decile in London in 2017/18–2019/20, compared with a multiple of 5.2 between the top and bottom deciles in the rest of the UK. The poor are poorer, with incomes in the lowest decile in London 30% below those in the rest of the UK (18).

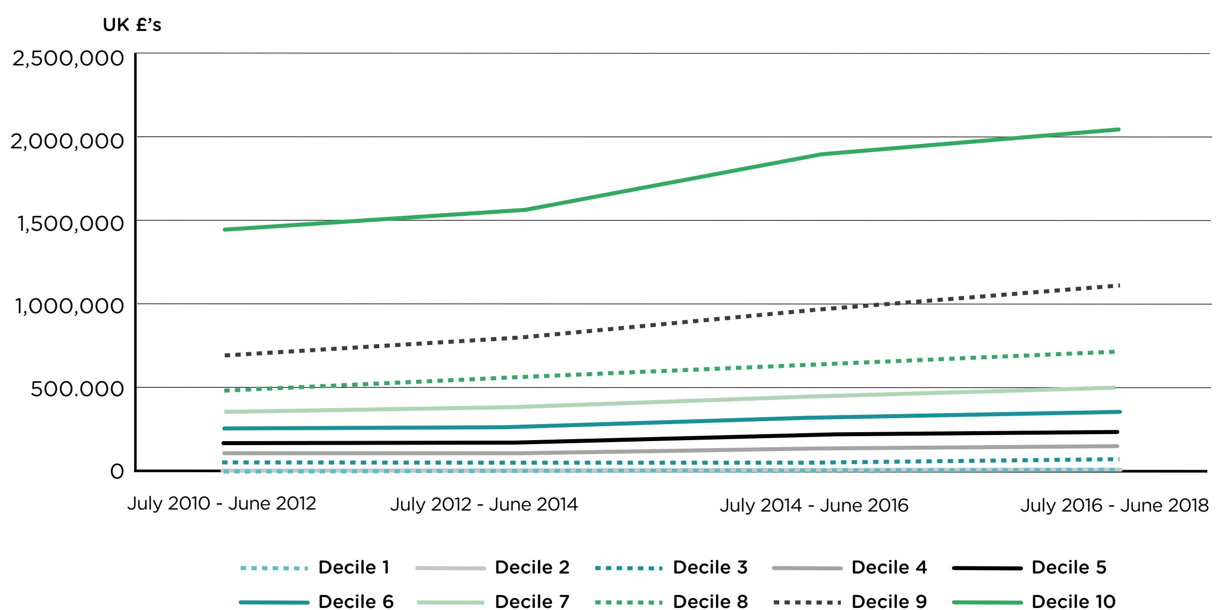
Income inequality has been further impacted by the pandemic: real wages have declined, and this has impacted lower paid sectors more than higher, as their pay has recovered more slowly. Several of the lowest paying sectors in London, including entertainment, retail and hospitality, saw the lowest pay growth of any employment sector in the first year of the pandemic. Meanwhile, the lockdowns enabled many people to save more money than they would normally, and temporarily contributed to increased savings and reduced debt across all income deciles.

WEALTH INEQUALITY

Wealth provides some protection against the rising cost of living. Yet in 2020the UK has high levels of wealth inequality, and it is wider in London and Southeast England than in most of the UK. In 2020 London had the most unequal wealth of any UK region (19).

Between 2010–12 and 2016–18, the median wealth of people in decile 1 grew by £200, while for those in decile 10 it increased by just under £600,000 (see Figure 2).

Figure 2. Median wealth in London by income decile, 2010–2018



Sources: ONS Wealth and Assets Survey

IMPACTS OF RISING LIVING COSTS ON SPENDING PATTERNS

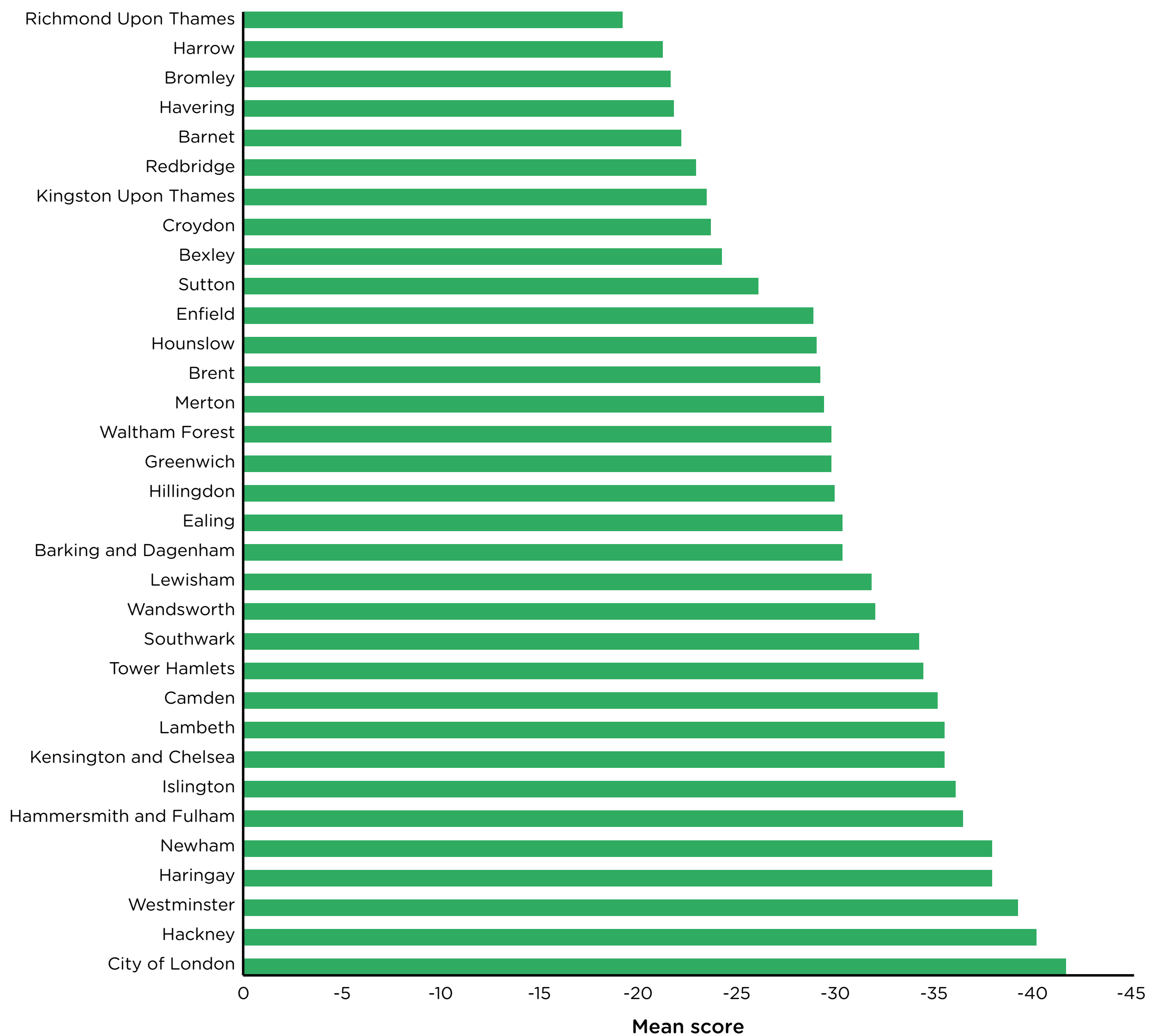
The wide inequalities in wealth and income in London mean that while many people will make different lifestyle choices due to rising living costs, a substantial minority will have reduced access to essential goods and services. In a representative survey of Londoners in summer 2022, over half of people who were 'financially struggling' were buying less food and essentials, and almost a third (31%) were using credit to pay for essentials, compared with only 11% of people who were not struggling financially (20). More evidence of impacts on different population groups are covered in section 3.

2.2 IMPACTS OF AUSTERITY POLICIES

Since 2010 the spending power of local authorities in London has fallen by an average of 38%, and Figure 3 displays how this varies by London borough.

Local authorities are funded in part by council tax and part by government funding. These cuts combined with increasing demand for statutory services have resulted in cuts to funding for non-statutory service provision in most boroughs, which has particularly affected funding for early years and youth services.

Figure 3. Percentage change in London borough council spending power per capita, 2010/11–2020/21



Sources: https://www.nao.org.uk/financial-sustainability-update-raw-data/

This means London is entering this new period of rising costs and spending cuts with less resilience and greater demands on services than a decade ago. The Early Intervention Foundation estimated in 2016 that cuts to benefits and services for children and young people post-2010 would result in £16.6 billion of additional costs to the public purse in England and Wales in the future. These are costs that could have been averted through adequate early help and prevention services for families with young children, which mean some areas of the public sector now face higher demand than they would have in the absence of austerity (21).

Welfare and benefits

Austerity also involved significant changes to working-age welfare and benefits. The UK already had lower than average benefit income compared with other Western European countries: for example, only 48% of median earnings are covered by Job Seeker's Allowance for people who are out of work, compared with an average of 69% in EU countries (22). Job-seeking conditionalities were then introduced for out-of-work claimants, with sanctions for failing these conditionalities. The sanctions – withdrawal of benefit – affected over 130,000 people in London and Essex in the six years to April 2022 (23). The number of Universal Credit (UC) recipients being sanctioned is now at a record high. Despite 10 years of sanctioning policy there is no evidence that conditionalities and sanctions increase uptake of employment in the UK over the long term, as measured by sustained employment (22). Further to this, the transition to UC has been associated with a clinically significant increase in symptoms of psychological distress among UC claimants, which is in part due to a five-week wait for the initial payment once a claim has been approved (24). The health impacts of benefit cuts are presented in the 2020 Marmot Review: Ten Years On report (2).

2.3 EXISTING DIRECT SUPPORT FOR HOUSE-HOLDS FACING RISING LIVING COSTS

The Government's direct support to households with rising living costs includes the Household Support Fund (HSF), the energy price guarantee and the additional flat-rate payments to households on means-tested benefits. (Information about these is readily available elsewhere.)

These are in addition to an inflation-linked uplift in pre-existing benefits and the state pension. While these forms of support will help many households to manage rising living costs, their role in mitigating inequalities in the impacts of rising living costs is mixed:

- The energy price guarantee reduces energy costs at the point of use, but is a regressive structure that does not proportionately target support to the lowest-income households. Many of the lowest-income households will continue to struggle to afford domestic energy bills even with the guarantee (see section 7.23).
- The energy bills support scheme covers £400 of energy bills incurred between October 2022 and March 2023 for people on mains supplies who are billed in arrears; alternative support is or will be available for people on prepayment meters (which includes many of the lowest income customers) or not on mains supply.
- The Treasury have made a commitment that benefits and state pensions will increase in line with inflation in April 2023, which will reach many of the lowest income groups if they are eligible for and able to claim these. However, this report presents evidence that many of these benefits are insufficient to cover essential needs and have declined in real terms over the last decade.
- The HSF has been issued to local authorities primarily to distribute emergency grants to people unable to afford an essential and urgent outgoing. Whilst helpful, it is focused on crisis response, and the guidance on its use does not allow investment in advisory services or infrastructure. Therefore, it does not align with many of the most well-evidenced interventions – which include to offer help early and provide advice and support to people in the right place at the right time.
- Finally, an additional flat-rate payment has been paid to people in receipt of benefits, which varies depending on the benefit claimed. The most widely distributed are payments of £900 for older adults who receive Pension Credit, payments of £650 to people who receive Universal Credit in 2022 and forthcoming payments up to £900 in three instalments in 2023, and an additional £150 for people who receive disability benefit. The Universal Credit payment will reach proportionately more people in London than most areas of England as a higher share of households in London are eligible for means-tested benefits due to high living costs relative to wages (25). Recent modelling by the Resolution Foundation of whether this would help households absorb the rising cost of living found that the value of the flat-rate payments and other support outweighs the increase in spending for many of the very lowest-income households in London (26).

Importantly, many people on low incomes in London do not meet the criteria to claim universal credit or other benefits and will not be reached by the additional support which is contingent on existing benefit claims.

Further to the Government support above, energy suppliers have a winter moratorium in which they commit not to knowingly disconnect consumers in vulnerable circumstances between 1 October and 31 March each year. However, this does not prevent them from switching people to prepayment meters, meaning customers have to pay upfront for energy before using it, and this risks people disconnecting themselves (27).

3

WHO IS MOST AT RISK FROM THE COST-OF-LIVING CRISIS?

IDENTIFYING WHO IS AT RISK

There is a need to identify households and individuals in real-time rather than waiting for lagged statistical reports to emerge of widening health outcomes. There are two broad approaches that system partners can take to identifying individuals and households who are at greater risk – one is data-led, and the other led by professionals and communities.

Integrated Care Systems (ICSs) and public sector partners can evaluate their currently held data sources to assess what data they hold on indicators of financial hardship and markers of vulnerability. For example, local authorities hold data on council tax, rent arrears and some demographic variables; GPs hold health data, and opportunities to use this may arise from the development of population health management; and the Department for Work and Pensions (DWP) holds benefit claimant data. Partners should examine whether they are actively using this data and the barriers to doing this and how they can be broken down rapidly, as was done in the Covid pandemic. Case studies 7 and 8 in section 8.2 provide examples of how data-sharing can support people with cost-of-living issues.

With professional and VCFSE-led identification, paid employees and volunteers are best placed to identify where someone may be in financial hardship, yet they need to be able to access support in a way that is effective and efficient. Making every contact count and the development of social prescribing provide pathways to support, and in the case of the latter there are examples of the role being expanded to support people in financial hardship (see Case study 7 in section 8.2).

RISK FACTORS FOR THE COST-OF-LIVING CRISIS

Low-income households

The cost-of-living crisis will have the greatest negative impact on the financial security of low-income households and those 'just about managing'. People with less money to begin with will have less ability to absorb rising living costs. Low income also interacts with other sources of financial stress. For example, people who are earning only the threshold amount for the statutory living wage (previously the minimum wage) are more likely to be on precarious contracts and face greater job insecurity (26).

Within that cohort, some population groups are at a greater disadvantage when faced with rising living costs, including as a result of age, disability, ethnicity, sex, mental health and/or being in an inclusion health group. These multiple disadvantages are likely to be a major factor in increasing the risk that a person or household will be unable to absorb rising living costs. Examining how and where these multiple disadvantages are clustered at an individual and area level in real time should influence how organisations identify and prioritise support for people who are at risk.

Age

Inflation and the erosion of real income make it likely that more children will grow up in poverty. It is already the case that 29% of all London's children are classed as in persistent poverty (28). When housing costs are taken into account, 38% of children in London were living in poverty in 2019/20, compared with 29% in the rest of the UK (17). Having children typically increases essential outgoings while reducing household income.

Low-income families with children have already absorbed real-terms reductions in income over the last decade. Housing and childcare costs have risen, and their effects are compounded by welfare reforms since 2010, such as the benefit cap and the two-child limit on payments of Housing Benefit, which have reduced incomes for many of the lowest income families. The benefit cap for households with children is £1916.67 per month for households in Greater London. This does not affect all benefits, but affects those most likely to be claimed, including universal credit, child benefit, and housing benefit. The Equality and Human Rights Commission's analysis of tax and welfare reforms found that households with children were the largest average losers from the reforms from 2010 to 2018. In particular, lone parents had lost on average almost one-fifth of their total net income (29). Cuts to Children's Centres have compounded the negative impacts by withdrawing availability of early years help and support.

Both the 2010 and 2020 IHE Marmot reports showed how inequalities in development and experiences during the early years have lifelong impacts. Having a good start in life is closely associated with a range of beneficial long-term outcomes: better social and emotional development and performance at school, improved work outcomes, higher income, better lifelong health and longer life expectancy (4). Having a poor start early in life relates closely to many negative long-term outcomes: poverty, unemployment, homelessness, unhealthy behaviours and poor mental and physical health (2).

Low income in older age can also be a major risk to health given it is a potentially vulnerable time of life, when support needs and costs are likely to be higher. Despite the triple lock guaranteeing that the state pension rises with inflation, people aged over 50 in London are more likely to be in poverty than average for the UK, with one in four over 50s in London living in poverty (defined as a household income below 60% of the median) before the pandemic in 2019/20 (30). This particularly affects people aged over 50 who are living in the private (39%) or social (44%) rented sectors, compared with owner occupiers, of whom 17% are in poverty. (30) For people on very low pension income, Pension Credit benefit is important in both increasing income and providing access to wider support, but it is widely underclaimed by older people not aware they are entitled or not comfortable with claiming support.

Disability

London residents who are living with a disability or long-term health condition are increasingly being found to be running a negative budget, meaning their essential outgoings are greater than their income (31). Recent data from Citizens Advice has demonstrated the way in which the cost-of-living crisis emerged over a year earlier for those with disabilities and long-term health conditions than it did for the general population. More than two in five Londoners whose activities are limited significantly by their disability or health condition were struggling financially in August 2022, almost three times the rate of people with no limitations (43% compared with 15%) (1). More than two in five reported using less water, energy and fuel as a consequence (in the same survey). The majority of people who are disabled or living with a long-term condition who approach Citizens Advice are now accessing their support for cost-of-living-related issues, which was not the case before 2020 (31).

Living costs are rising at a time when incomes for people living with disabilities have already been declining in real terms over the last decade. The Equality and Human Rights Commission found that changes to the tax and benefit system since 2010 have disproportionately reduced the incomes of households with more disabled members, and individuals with more severe disabilities, with most of this explained by reduced benefits and tax credits (29). For households that have a disabled adult and a disabled child, the average loss was £6,500 per year between 2010 and 2018. The same study found lone parents with at least one seriously disabled child lost almost 30%, of their net income. As people in receipt of disability benefit only receive a one-off flat rate additional payment of £150 in 2022/23 (see section 2.3) they are less protected by additional Government support than other low income groups, unless also claiming UC.

Ethnicity

People from some minority ethnic backgrounds have lower incomes on average and are less likely than other groups to have any financial savings. The 2019–20 Family Resources Survey found 70% of Bangladeshi, Pakistani and Black households in London had no savings at all, compared with 40% of White and 46% of Indian households.(32) In a survey of London residents in August 2022, Black people were more likely than White people to say they were financially struggling or having to go without meeting basic needs, or were reliant on debt (29% compared with 17% of White residents) (1). These differences also manifest in some indicators of hardship where ethnicity data are known. For example, in response to the Family Resources survey Black people were over three times more likely than White people to have recently experienced food insecurity.(32) Further to this, data published in the 2019–2020 annual London Poverty Profile found that 39% of people from minority ethnic backgrounds live in poverty, compared with 21% of White London residents..

Sex

In the decade to 2020 female life expectancy decreased in the most deprived 10 percent of neighbourhoods in every English region except London, the West Midlands and the North West, whilst female healthy life expectancy decreased across England over that period (1).

Women enter this period of high inflation with less financial resilience than men, as the average income of women is lower than that of men, and women have shouldered more of the impacts of austerity from cuts to benefits and services in the decade to 2022 (33). On the latter, women typically have greater demands on their time for unpaid caring responsibilities, meaning that cuts to local authority services that would otherwise support with care for children and older adults, and cuts to social security benefits that are more likely to be claimed by women, have disproportionately fallen on women, who have had to make up the difference (33). The lower financial resilience of women is in part due to the cost of raising children in London, which is a factor in lower than average workforce participation of mothers compared with the rest of England (see section 6.2).

Women with significant financial responsibilities and low income are also more likely to turn to sources of income that increase their risk of social exclusion (see Inclusion Health Groups below). In 2020, evidence submitted to the House of Commons Work and Pensions Committee found that the difficulties women face when applying for Universal Credit were a significant driver of women turning to sex work (34). A professional network of sex workers claim that about 70% of their members are mothers (35). These patterns reflect that falling real incomes and the rising cost of essential outgoings affect females on the lowest incomes more than males due to the baseline reality that women have lower average incomes and more unpaid responsibilities than men.

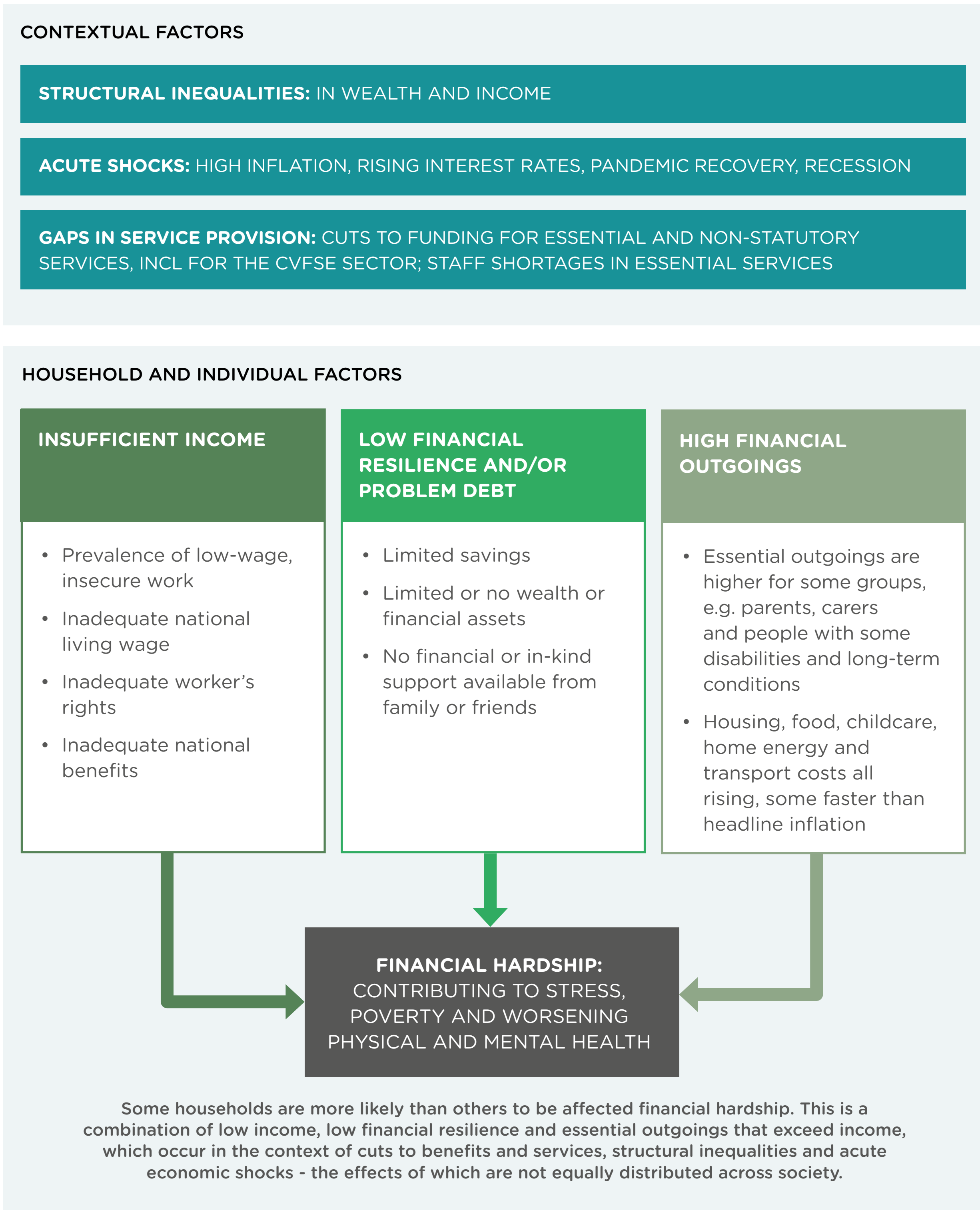
Inclusion health groups

Inclusion health is a term used to describe people who are socially excluded or marginalised, which includes people who experience homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system and victims of modern slavery. These groups typically have much lower incomes and worse health outcomes than average for the population and are therefore at higher risk from rising living costs. There is good evidence that the relative effect of social exclusion on health is greater on females than males (36). Some of these groups are likely to increase in size as a result of high inflation, for example there are early signs that statutory homelessness and the number of sex workers in England are increasing (32, 33).

4
A FRAMEWORK FOR ACTION

Figure 4 depicts the factors that contribute to a person's risk of financial hardship, and illustrates why some groups are at greater risk than others (38).

Figure 4. Factors that increase the risk or severe financial hardship



This framework informs the themes of this evidence review, in which interventions are grouped under those that (1) address high financial outgoings with support to manage the cost of essential outgoings; (2) address insufficient income; and (3) increase financial resilience and manage problem debt.

5
CROSS-CUTTING RECOMMENDATIONS

This section describes overarching recommendations for each sector, and for the public, private and VCFSE sectors working together.

5.1 FOR LOCAL AUTHORITIES AND HEALTH AND SOCIAL CARE COMMISSIONERS AND PROVIDERS

The introduction of Integrated Care Systems (ICSs) across health and social care provides an opportunity for action to mitigate the effects of the rising cost of living, and the likely impacts on health inequalities create a clear ethical, demand-based and financial case for doing so.

The size and scope of an ICS enables longer-term planning and partnerships with key stakeholders to support better population health. It also facilitates development of the role of Trusts and local authorities as 'anchor' organisations within their communities, drawing on the range of functions that partners have, as employers, service providers, commissioners, as owners of capital and estates and as partners in a place (39). An ICS can also hope to have a stronger voice for national advocacy on health equity and the impact of falling real incomes than any individual council, NHS Trust or GP practice. Critical to this is leadership and strong accountability at ICS board level and working in partnership with the local authority, the VCFSE and businesses to support, and sometimes lead, action to address the rising cost of living and its impacts on the determinants of health.

Integrated Care System partners, including local authorities and primary, secondary and tertiary care providers, should integrate their response to the rising cost of living with their strategic approach to health inequalities. Cross-cutting recommendations based on the findings presented in sections 6–8 below, that apply to all cost-of-living interventions, include:

As service providers:

1. **Embed financial wellbeing and resilience into clinical pathways, considering how and where to co-locate services to support people.**
2. **Primary Care Networks should consider the opportunities to extend the role of social prescribing link workers and mechanisms to develop the direct and indirect (i.e. signposting) support that they can offer.**
3. **Use data and intelligence functions in real time to identify individuals and communities who are most at risk from the rising cost of living.**
4. **The principles of prevention and early help should underpin any intervention, meaning that all services supporting people try to intervene before a person's problem becomes a crisis – rather than focussing resources on crisis response functions.**
5. **Provide workforce training in how to identify people at risk and support the workforce to contribute to local approaches to address the rising cost of living. Professionals in frontline roles across local and regional governments, the health and social care system, public services, business, VCFSE and wider partners should:**
    - Be aware of how financial insecurity can impact people's health and health behaviours.
    - Understand the impacts of multiple exclusion and discrimination – whether based on ethnicity/racism, disability, stigmatisation of class and poverty, other protected characteristics or being in a group excluded from healthcare, such as people who are homeless or sex workers.
    - Consider the whole person when people present to them, and offer signposting and support as appropriate, ideally with minimal additional effort for the individual, to help address the range of issues a person may need support with.
6. **Embed monitoring and evaluation in the delivery of new initiatives, considering both qualitative and quantitative measures of impact.**
7. **If collecting payment from service users for chargeable services, including council tax and social housing rents by local authorities, review debt collection processes to minimise their impact on mental health, and support people to create a manageable payment plan as opposed to pursuing legal enforcement measures.**

As partners in a place:

8 Interventions should be developed collaboratively with affected communities in a way that empowers and gives a voice to people most impacted by falling incomes, and does not judge or stigmatise. All commissioners and providers of interventions should maximise use of the power within communities and individuals to advocate for themselves to drive the structural changes needed to reduce inequality.

9 ICS partners should extend partnership working to other services such as Criminal justice system, VCFSE and employers, local authorities and health care as part of a health equity system.

10 ICS partners should use their position to advocate on behalf of those most affected by the rising cost of living to influence policy and hold decision makers accountable for the impacts on health (and by extension their services).

11 Investment in the VCFSE sector, in particular advice and support services, offers a high return on investment. Funding for the VCFSE must become more sustainable and not small 'one-off' pots of money that severely limit the capacity of the sector to have a sustainable and lasting impact.

12 Engage and involve communities, VCSFE sector and community leaders in the assessment of current services and interventions and the development of new ones. Communities should be involved in identifying needs and assets, addressing barriers to engagement with statutory and non-statutory provision, and decisions around commissioning and funding of the VCFSE sector.

13 When communicating complex information check that communications meet readability and accessibility guidance and ensure that content is relevant to people's lives (40).

Procurement and commissioning for social value:

14 Use social value levers to require good employment practices throughout supply chains, including paying sufficient wages to meet the London Living Wage.

As employers:

15 Deliver on recommendations for interventions that employers can implement to support their workforce (see section 5.3).

16 Pay the London Living Wage and implement the Mayor of London's Good Work Charter

5.2 FOR BUSINESSES

The private sector must be a key partner in mitigating the rising cost of living. In addition to the moral case, businesses will benefit from a healthier and more productive workforce, and increased attractiveness to potential employees, customers and investors.

The Covid-19 pandemic made clear the close interdependency of health and wealth, and that neither could thrive without the other. The economy requires healthy workers and healthy customers, and a failing economy damages health. Involvement of business in taking action on health inequalities is a recent development, but one that is gaining momentum. IHE recently published The Business of Health Equity: The Marmot Review for Industry, examining the ways in which businesses shape the conditions in which people live and work and, through these, their health (41). It found that:

- Businesses affect the health of their employees and suppliers through the pay and benefits they offer, hours worked and job security, and the conditions of work.
- Businesses affect the health of their clients, customers and shareholders through the products and services they provide and how their investments are held.
- The effects on wider society also encompass taxes paid by businesses to local and national government, which support interventions to reduce income inequality. Meanwhile, salaries paid to employees, especially those in lower paid roles, are quickly returned to the local economy and support demand for business products.
- Large organisations in both the public and private sectors can take the lead and encourage and support smaller organisations to, for example, pay the London Living Wage.

Source: *Institute of Health Equity (41)*

Further to this, businesses have a major impact on the mental health of customers when they pursue heavy handed debt collection processes, and this is a particular concern as more people take on debt. As with ICS partners, all businesses, and their regulators, should review debt collection processes to minimise their impact on mental health, and support people to create a manageable payment plan as opposed to pursuing legal enforcement measures (13).

6
SUPPORT TO MANAGE THE COST OF ESSENTIAL OUTGOINGS

Logic, social justice and evidence clearly indicate that where a problem is driven by people having insufficient income, then increasing their income will reduce the problem – and this is always the preferred option in providing people with the greatest dignity and choice and the least stigma. However, this is not always immediately possible, and this section discusses interventions that subsidise or support people to manage the cost of six main categories of essential outgoings: food, childcare, home energy, transport, housing and healthcare.

6.1 FOOD

FOOD INSECURITY IN LONDON

Household food insecurity is an established concept, with a widely used definition being 'a household-level economic and social condition of limited or uncertain access to adequate food' (42). Severe food insecurity indicates an inability to access any or enough food, while moderate insecurity indicates that the quality of diet is compromised even if food volume is adequate. In GLA polling, around a quarter (26%) of respondents said they were buying less in food and essentials in August 2022. This rises to around two-thirds (65%) among London residents who are struggling financially.

Rising food insecurity risks widening income-related health inequalities because insufficient income leads to food insecurity, which in turn leads to a higher risk of diet-related disease. Food insecurity Food insecurity is associated with poor diet by definition, and many and with poor diet by definition, and many of the leading causes of chronic illness and premature mortality are related to poor diet, including obesity, type-2 diabetes, cardiovascular disease, some types of cancer, and osteoporosis. Poor diet is associated with low birthweight, preterm birth, anaemia, birth defects and slower development (43, 44). Food insecurity also impacts mental health in children and adults, and there is evidence that the psychological stress affects parenting, including reduced sensitivity to distress in infants and increasing frustration towards children (45).

PROVIDE PEOPLE WITH SUFFICIENT INCOME TO AFFORD FOOD

Severe food insecurity is driven by insufficient income to afford food (45). This is reflected in the finding that in England, the percentage of the population affected by welfare reforms, including the roll-out of Universal Credit (UC), benefit sanctions, reductions in the main out-of-work benefit and the 'bedroom tax', has been closely associated with increasing demand for food banks (44). The reversal of the £20 UC uplift which was put in place during the Covid-19 pandemic but later removed, has been heavily implicated in driving people to turn to food banks for support (46). In the United States, a strong inverse relationship was found between the value of child benefit and rates of household food insecurity over a 10-year period (47), and other studies have found similar associations (45). Therefore, while this section covers interventions to help people manage the cost of food, the most effective intervention to reduce food insecurity is to provide people with sufficient income to afford food, which includes ensuring welfare benefits are adequate to prevent food insecurity.

CASE STUDY 1: CASH FIRST

The Independent Food Aid Network (IFAN) seeks to address the drivers as well as symptoms of food insecurity by promoting the principle of 'cash first' – the idea that giving people cash to pay for food is the best way to address the problem of being unable to afford food. The step-by-step cash first guides identify which local agencies are best placed to help people maximise income and access any existing financial entitlements. IFAN publishes leaflets online, helps to disseminate printed copies as widely as possible, and produces poster, translated and interactive versions of its advice.

PROMOTE HEALTHY START VOUCHERS

The main form of direct subsidy for food in England is Healthy Start vouchers. These are worth up to £8.50 per week (or £442 per year) and are available to pregnant women and young children under 4 years old in low-income households to subsidise the purchase of fruit and vegetables and infant formula. Although a small amount of money, Healthy Start vouchers can stretch available food budgets slightly further for those eligible. However, fewer than half of eligible households in London participate in the programme, resulting in over £10 million per year in unclaimed vouchers (48).

To increase uptake, the NHS and the food charity Sustain have produced resources to promote Healthy Start in relevant settings. No evidence for their effectiveness accompanies these resources but they address some of the potential barriers to uptake, such as awareness, language and concerns about stigma. There is medium-strength evidence from Scotland that raising awareness and understanding of the scheme among key professionals, including health visitors and midwives, can also increase uptake (49).

As an alternative and less targeted approach, there is medium-strength evidence from an uncontrolled study in Scotland that providing vouchers for fruit and vegetables to all households within a low-income community can reduce the stigma of food vouchers and lead to increased consumption of fruit and vegetables (50).

EXTEND UNIVERSAL FREE SCHOOL MEALS AND WIDEN ELIGIBILITY CRITERIA

Currently, free school meals (FSM) are universally available to all children in key stage 1 (Reception class to Year 2), and beyond that they are means-tested. The income threshold for entitlement has been static at £7,400 a year after taxes and before benefits since 2018. Despite higher rates of after-housing-cost child poverty, children in low-income households in London are therefore less likely to receive free school meals (FSM) than in other parts of the country as their household income is more likely to be above the entitlement threshold (51). Further to this, an estimated 11% of school children who are eligible do not claim FSM in England, and there is an ongoing campaign to call for automatic enrolment of eligible children into the scheme (52).

Extending the eligibility of FSM would address the issue of affordability, and has been found to bring health and attainment benefits. In Islington, Newham, Tower Hamlets and Southwark the local authorities have implemented universal FSM provision to children in Years 3–6. Sustain and a coalition of children's and food charities found good evidence from evaluation of these areas that universal FSM boosts attainment and attendance, improves food security and helps families save on food costs, and reduces rates of childhood obesity (53).

REACH PEOPLE WITH SERVICES THAT INCREASE FOOD RESILIENCE VIA FOOD AID PROVIDERS

Some people who are food-insecure in the UK turn to food aid providers. Food aid in the UK is primarily provided by food banks, of which the main provider is the Trussell Trust, with many of the independent food banks registered with the Independent Food Aid Network (IFAN). Other models of food aid provision include community larders and fridges, pantries and social supermarkets, which all vary in the services they deliver – these are collectively referred to as food aid providers in this report.

The Trussell Trust estimated that 2.5% of all UK households had accessed a food bank at some point in 2019/20, with use increasing significantly during 2022 (42). Therefore, food banks do not function as a 'safety net' on the scale required to address food insecurity in the UK. This is also the conclusion of a synthesis of published research into the effectiveness of food banks at reducing food insecurity, and there is general consensus in published research that there is no evidence that food banks reduce food insecurity at a population level (38, 48, 49).

There is good evidence that typical food parcels are not nutritionally balanced, usually being above the fat, sugar and salt guidelines and below the fruit and vegetable content guidelines. There is medium-strength evidence from the United States that interventions to improve food quality in food banks and provide medically tailored food support can bring health benefits to recipients, as measured by reductions in emergency department visits, inpatient admissions and medical spending (43) (56). This may help people with some long-term conditions with the cost of managing their condition. UK studies of food bank-based diabetes-specific interventions also indicate there are health benefits from tailoring food parcels for food bank users that have diabetes (54).

However, a major challenge for food aid providers is funding, and this has implications for how some providers source food and funding. There are established links between food charities in the UK and the food industry, with the strongest being with supermarkets that donate surplus produce, and food manufacturers that develop sponsorship arrangements. Food manufacturers that sponsor food banks are often those that produce food that is high in fat, sugar and salt, with examples in the UK including McDonalds, Coca Cola, Pepsi, Deliveroo

and Cadbury (55). These relationships create a conflict of interest for food charities, which in accepting their food are providing a 'halo effect' to the companies involved (55). For example, FareShare, the largest food distributor to food banks in the UK, has publicly endorsed McDonalds for funding 1 million meals for UK families (57). In the United States this link has been called the *hunger industrial complex*, with an accusation that food banks facilitate and enable cuts to welfare and the social safety net (58). There is good evidence that UK food aid providers that rely on food redistribution networks play a role in enabling wastage in supply chains, and those that rely on food donations direct attention towards the notion of food as charity rather than a right (55).

There is therefore a tension in the UK food aid system between building links with industry that enable both sponsorship arrangements and the redistribution of fresh food from supply chains, and the opposing desire to avoid entrenching food aid provision and the notion of food aid as a means to avoid wastage. The latter requires food aid providers to cut ties with industry and distribute locally donated (or funded), more easily stored, processed foods that are cheaper and less likely to be sourced from waste. This conflict between the nutritional quality of food and the long-term sustainability of how it is sourced underline the need to reverse the increasing dependence on food aid and prioritise ensuring people have sufficient income to afford food.

The Trussell Trust and IFAN both explicitly call for benefit uplifts and for upstream drivers to be addressed (46). Alongside other food aid providers, some food banks now co-locate advice services to help people access housing and employment support and claim benefit entitlements. There is good evidence that food aid providers that offer one-to-one advice, greater food choice, and membership-based models have greater impact in reducing food insecurity over time than traditional food banks that only provide food (59). The Lewisham social supermarket (see Case study 2) is a good example of this.

On the demand side, in recent work in the London Borough of Waltham Forest people eligible for financial benefits said that barriers to claiming benefits meant it was easier to visit a food bank than to go through the benefit application process.(60) As such it is important to provide advisory and support services at the point people need them, as early as possible. People need to feel and believe they will receive help when they seek it, rather than face a list of administrative demands or tasks and a long waiting period (see also sections 7 and 8).

CASE STUDY 2: SOCIAL SUPERMARKETS IN LEWISHAM

In Lewisham, Southeast London, food aid providers for people who are food-insecure are transitioning from offering a food bank to offering a 'social supermarket'. Six food projects are in the process of becoming a place where residents can shop for their weekly basket of food for a small membership fee only. It gives people choice over the food they purchase, enables ongoing access to food rather than a three-day food parcel, and has less stigma attached to it.

The first of these social supermarkets was the Evelyn Community Store, which is used by around 70 households a week. Members sign up to the store and pay £3.50 per week for food that they choose themselves, typically worth five to ten times this amount. The shop is staffed by volunteers who get to know the residents coming in (61).

Other food banks and food projects are helping by extending the support they provide, including financial assistance and support schemes to help people move away from dependence on emergency food aid. This includes debt advice, emotional support and employment advice.

The project has also involved the sourcing of culturally appropriate foods, including fresh fruit and vegetables for food projects supporting these residents. Culturally appropriate foods are now provided to 11 groups, supporting over 300 households per week.

ENSURE FOOD AID MEETS CULTURAL, DIETARY AND PRACTICAL NEEDS

Food aid providers of all types can better meet the needs of people facing food insecurity by examining what barriers to access, uptake and usage exist in their provision. These may include the need, in some cases, for a professional referral; practical barriers to accessing food support, such as transport and communication; and feelings of shame and stigma in asking for charity. Further to this are issues such as the suitability of the food provided to meet people's cultural and dietary preferences and needs, and whether people know how to prepare the food, and have the tools, equipment and time to transport, store and prepare it (62). The rising cost of energy has added an extra variable in that increasingly, people cannot afford as much power for their home cooking appliances.

6.2 CHILDCARE

Children are among the most vulnerable population groups to the rising cost of living, and it is therefore important that measures to reduce childhood inequalities are prioritised. Among these, one of the most significant is access to good quality childcare. There is good evidence that high quality services in the early years have enduring effects on health and other outcomes, and in the context of this review, support families to earn a living wage, and these outcomes are particularly strong for those from disadvantaged backgrounds (4).

AFFORDABLE CHILDCARE INCREASES HOUSEHOLD INCOME AND REDUCES INEQUALITIES IN CHILDREN'S DEVELOPMENTAL OUTCOMES

Affordable childcare enables greater workforce participation, especially of mothers. The UK performs poorly compared with Northern European neighbours in providing adequate childcare that enables women to return to work after having a child, especially full-time, and progress their careers (63). In 2019, 69% of London mothers with dependent children were in employment, compared with an England average of 75%.(64) Good quality childcare is also important to early years development and reducing differences in attainment between socioeconomic groups: this was a repeated message of the Marmot Reviews in 2010 and 2020, with the observation that inequalities in attainment outcomes during the early years set trajectories for inequalities throughout the rest of life (2). Good quality early years education benefits personal, social and emotional development; communication skills; and physical development, and has a higher return on investment than interventions in later life (65).

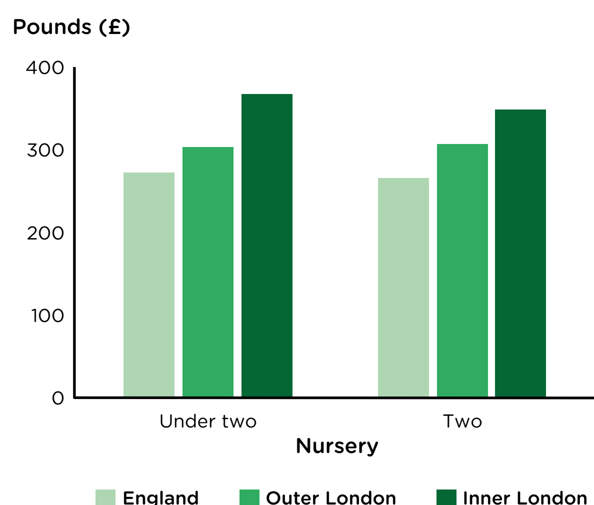
Being unable to access childcare has dual impacts on children via adverse impacts on both children's development and on women's employment options after maternity leave. Partly as a result of this, children from more deprived areas of London typically start school having met fewer developmental milestones than those from less deprived areas, and the pandemic is likely to have further widened these inequalities (66).

LONDON HAS THE HIGHEST CHILDCARE COSTS IN THE UK

Childcare costs are among the biggest outgoings for working parents of young children, and as incomes are eroded by inflation, the cost of childcare is likely to be a major influence on the financial resilience of families with children. Figure 6 displays data showing that in early 2022, average childcare costs for a 2-year-old in a full-time nursery place were over 30% higher in Inner London than the average for England, at £347.25 per week, and 16% higher in Outer London, at £308.79 per week.

There is a major gap in childcare funding support for children aged under 3 with working parents. Even after claiming tax relief, to return to work full time for 44 weeks per year with a 1-year-old costs on average over £13,000 for a full-time nursery place in Inner London, (equivalent to just over 30% of gross median full-time pay in London), and over £10,000 in Outer London, based on the Family and Childcare Trust's survey findings (66).

Figure 6. Price of 50 hours a week of nursery based childcare for children aged under three, Inner and Outer London and England, 2022



Sources: Coram Family and Childcare Annual Survey 2022

The childcare system in the UK is considered complex and expensive, with prohibitive childcare costs that are among the most expensive in OECD countries (67). Compounding the weekly cost is that many childcare providers demand substantial deposits upfront to pay for childcare in advance, often between £1,000 and £2,000. This is particularly a barrier at the point when mothers are deciding when and how to return to work.

Taken together with rising living and housing costs, the cost of childcare is likely to strain the financial resilience of many families in London. This is further likely to affect many parents' ability to parent well, which is typically easier when stress and anxiety are low and social and material circumstances are not a source of anxiety (4).

LONDON PARENTS ARE MORE LIKELY TO REQUIRE PAID CHILDCARE THAN PARENTS IN OTHER REGIONS

London families are also more exposed to higher childcare costs than other regions due to typically longer work commutes and the fact that more families are not within reach of extended family for childcare support (68). Single parents are further impacted by high childcare costs as they are more likely than coupled parents to occupy jobs that do not allow home or flexible working, are less likely to be employed in roles that match their qualification level, and due to a shortage of part-time jobs (69). Even when able to claim subsidised childcare, single parents are less likely to be able to afford the cost of childcare deposits than coupled parents.

CURRENT SUPPORT FOR CHILDCARE COSTS

Financial support for childcare costs is currently complex and dependent on household income and benefit entitlements. In brief, the current main forms of statutory support are available on the Government's Childcare Choices website and include:

- All parents, regardless of income, are entitled to 15 hours a week free childcare for 38 weeks a year for 3- and 4-year-olds, rising to 30 hours for working parents.
- Parents who are in receipt of benefits are entitled to 15 hours a week for 38 weeks a year for children aged 2, and 85% of up to £300-worth of childcare per week for children of any age if they are on a low income.
- Parents who are working and not claiming other forms of support (aside from universal entitlements) can claim lower rate tax relief on childcare for up to £10,000-worth per year of care for children under age 11.

EMPLOYER SUPPORTED CHILDCARE

One of the main ways an employer can directly support with childcare is by establishing a subsidised on-site childcare facility. Some private sector employers and several NHS Trusts provide on-site childcare and nurseries. On-site nurseries are exempt from PAYE tax and national insurance, though these tax breaks have not stopped the decline in the number of such facilities over recent years. Providing childcare at workplaces can make returning to the workplace more feasible after parental leave, and there is medium-strength evidence from the United States (where more businesses and hospitals offer childcare than in the UK) that it reduces absenteeism and staff turnover and improves employee relations, all of which are likely to help people cope with the rising cost of living (70).

FLEXIBLE WORKING CAN SUPPORT WORKFORCE PARTICIPATION AND THEREFORE INCREASED INCOMES, AND MAY REDUCE EXTERNAL CHILDCARE REQUIREMENTS

The pandemic has significantly increased the amount of people working flexibly, with key flexibilities that employers can use to support parents being: working from home at least part of the time; flexible hours; and enabling on-site employees to self-roster their shift patterns or work flexibly around core hours.

Outcomes that are frequently studied in relation to flexible working include employee productivity, employee health and wellbeing, and female workforce participation. This review did not find direct evidence of impacts on childcare requirements or living costs, though if flexible working enables greater workforce participation and productivity it can be inferred that it also increases income. A Cochrane review on the health effects of flexible working conditions found that self-scheduling shift patterns significantly improved health, including reduced blood pressure, heart rate and tiredness, and improved mental health, sleep quality and self-rated health (62). These are all likely to contribute to improved parenting, although no evidence has been found of the health, wellbeing or income effects of flexible working on parents specifically.

CHILDCARE DEPOSIT LOANS

The Mayor of London's 'Employer toolkit: helping your employees to understand childcare offers' is a guide to employer-provided support with childcare costs and flexible working to accommodate parents with young children (71). Beyond signposting to information about childcare entitlements and availability, employers are encouraged to extend the offer of a loan to parents required to pay a deposit for childcare. These may be existing employees who are returning to the workplace after maternity or paternity leave. In an example of this, in 2017 the GLA Group introduced an interest-free Childcare Deposit Loan Scheme to cover the initial cost of a place with an Ofsted-registered childcare provider. Other employers, including some local authorities, have since initiated a loan scheme as well.

SUPPORTING PARENTS VIA CHILDREN'S CENTRES AND FAMILY HUBS

Children's centres are designed to improve outcomes for young children and their families, and family hub models are a more recent iteration of a similar principle, though directed towards a wider age range.

They do not routinely provide on-site childcare (although some do). They are nevertheless an essential service in reducing inequalities in the early years: before widespread closures of children's centres from 2010 onwards there was good emerging evidence for their impact on reducing inequalities in early years health outcomes and educational attainment (2). With the range of impacts on families with children that are highlighted throughout this report – in particular on housing costs, food and childcare – children's centres, and the more recent family hubs, provide a vital setting in which to identify the support needs of families with young children and to offer early help to prevent problems escalating.

6.3 HOME ENERGY

Cold weather can affect or exacerbate a range of health problems, including respiratory and circulatory conditions, cardiovascular disease, mental health and accidental injury, and also contributes to excess winter deaths.(70)

Despite the energy price guarantee, people who switched energy contract in 2022 were likely to be paying twice as much per unit of home energy as the same time in 2021. A 2022 survey found almost half of London residents (45%) said they will definitely or probably struggle with their energy bills this winter (i.e. 2022/23) (1). The 2022 Survey of London found people in more deprived communities are more likely to struggle to afford energy bills and keep their homes warm than in the least deprived (20). Citizens Advice predicts that over 450,000 people in England in 2022 alone, and over 225,000 people between October 2022 and March 2023, could be forced to move to a prepayment meter due to struggling with debts, putting them at risk of self-disconnection and a cold, dark home. These customers who pay as they go for their energy could spend £258 more on their energy this winter than someone paying by direct debit (27). Concerningly, between January and October 2022, nearly two-thirds of the people Citizens Advice helped who were forced onto a prepayment meter due to debt had a disability or long-term health condition.

Cold weather can affect or exacerbate a range of health problems, including respiratory and circulatory conditions, cardiovascular disease, mental health and accidental injury, and also contributes to excess winter deaths (72).

National policies to reduce fuel poverty this winter include the energy price guarantee, which caps the unit price of mains source home energy, and the energy bill support scheme, which are both universal and time-limited measures to limit the rise in fuel poverty in winter 2022-23. In addition, there is the ongoing Energy Company Obligation, which requires energy suppliers to provide measures which improve the ability of low income households to heat their homes; the means-tested warm homes discount and cold weather payments, which are designed to alleviate the impacts on people on low incomes during cold weather; and winter fuel payments for pensioners.

At a local level, Integrated Care System partners, including local authorities, are well-placed to understand the needs of their population and how best to identify and reach people who are most vulnerable to the health effects of fuel poverty and cold homes.

Evidence for interventions to address fuel poverty and reduce the number of people living in cold homes are summarised in NICE Guideline 6: Excess Winter Deaths, in the Cold Weather Plan for England, and in 'Making the case: why long-term strategic planning for cold weather is essential to health and wellbeing' (72–74). The Cold Weather Plan for England cites good evidence for the need for a strategic approach (year-round planning) across health and social care commissioners and local authorities to the reduction of Excess Winter Deaths (EWDs) and fuel poverty. This should consider how people and households who are most at risk can be identified, and ensure a local, joined-up programme is in place to support improved housing, heating and insulation.

Once established, strategic partnerships can develop interventions to:

- Improve the energy efficiency of homes
- Improve access to support mechanisms to tackle fuel poverty, low household incomes and protect against cold weather
- Help residents reduce fuel bills
- Support residents who are vulnerable to cold weather.

To support this, there is good evidence that people in more energy efficient and warmer homes, provided there is adequate ventilation, make lower demands on health services (73,75–77). There is qualitative evidence that simply subsidising home energy bills of patients with long-term conditions can improve their physical and mental health during winter months (78). However, whilst the idea is appealing, there is good evidence that workload pressures mean that GP prescribing interventions, such as heating or boilers on prescription, are not an effective mechanism to identify and reach the most vulnerable (78–80). Other health and care professionals, including social prescribing link workers, are likely to be better placed to identify and support the most vulnerable households to access the range of support listed above that should be made available at a local level.

6.4 TRANSPORT

In London, there are already generous schemes of discounted or subsidised travel for certain groups, e.g. children under the age of 11 can travel for free on the bus, tram, DLR, overground and tube when accompanied by an adult, fares for older children and students are also discounted, and over-65s receive free off-peak travel on public transport.

Since the expansion of remote office working, key workers in roles that require them to be on-site at work are likely to face higher commuting costs than office workers whose employers operate flexible working polices. For example, in 2016 7% of the average London nurse's pay was spent on transport, and this is only likely to have risen as wages have not kept up with fare increases (81). Public transport fares are linked to inflation, meaning Transport for London fares may rise by 10% in January 2023, which would raise the price of a monthly travelcard from zones 1–6 to almost £300.

Key workers are also more likely to work antisocial hours, at times when transport options are more limited: in 2017, the Trades Union Congress (TUC) estimated that one in eight (12%) employees in London regularly works at night (82). The majority of night-time bus journeys in London are made by people working in health and social care services, transport and logistics, and in 2015 the majority of night bus passengers (57%) earned below £20,000 per annum (83).

Although the following mechanisms have not been evaluated in relation to the rising cost of living, those available to employers and local authorities include:

- Season ticket loans paid back interest-free.
- Free car parking for hospital staff – although few hospital staff drive to work in London, there are days and shifts where it may be the only option.
- Where possible, flexible working to enable people to travel at off-peak, lower fare times of day or not at all.
- Longer-term – make community infrastructure available within a short distance to reduce the need to make longer journeys. The 15-minute neighbourhood model is one example of this (see Case study 3).

CASE STUDY 3: 15-MINUTE NEIGHBOURHOODS IN WALTHAM FOREST

Following the height of the Covid-19 pandemic, Waltham Forest Council named the introduction of 15-minute neighbourhoods as one of its key priorities in its Public Service Strategy and it hopes to implement the vision of the 15-minute city at a neighbourhood level across the borough. The plan is designed to make all necessary support services accessible to residents at a hyper-local level. Urban design would be shaped to create people-friendly streets, the importance of green spaces and climate friendly planning would be emphasised, and there would be investment in spaces for cultural activities to celebrate local communities. The borough has consulted widely with communities, focussing on how they experience their neighbourhoods and what they need locally so that communities are at the centre of the plans. Whereas most 15-minute plans have checklists of places and space that should be available within neighbourhoods for residents to meet their daily needs, the Waltham Forest plan has also placed social and cultural capital as part of the model.

If implemented, the development of these 15-minute neighbourhoods will be an opportunity for Waltham Forest to work differently with its communities, ensuring that all neighbourhoods across the borough are healthy and sustainable communities, suited to the real needs of those who live there (197).

6.5 HOUSING

Based on 2021 census findings, London had the lowest level of overall home ownership (46.8%) of any English region. London also had the highest proportion of households that rented privately (30%) or in the social rented sector (23.1%) (84).

Housing costs for many owner-occupiers and private sector rental tenants are rising faster than general inflation. While homeowners with a mortgage will be increasingly impacted by rising interest rates, private sector rents typically affect more low-income households than do rising mortgage rates. Both are likely to lead to reduced housing security, and rising demand for homelessness prevention services.

In a survey of London residents in August 2022, renters of social and private rental homes were three times as likely as homeowners to report financial struggles (31% of all renters, including local authority and housing association, compared with 10% of home owners) (1). This affects the most vulnerable in society more: the majority (53%) of people that Citizens Advice has supported with actual or threatened homelessness in the UK during 2022 are people living with a disability or long-term health condition (31). This issue also has major implications for essential services. As one example, in a 2016 survey only 35% of nurses in London were owner-occupiers, compared with almost 50% of London households, making this professional group more exposed to rising private sector rents (81).

Housing affordability is one theme of the first evidence review in this series, published in October 2022, based on which the following headline recommendations were made to improve housing affordability in London (76):

1. The Government should increase local housing allowance in line with local rents and inflation, at a minimum returning it to pre-April 2011 levels, when housing allowance was set at 50% of average rents.
2. The definition of 'affordable housing' used to determine prices for sale and rent should be universally agreed to become a function of local incomes rather than of average local house values and rents.

These recommendations should be considered in the context of the housing evidence review and aligned with efforts to improve housing quality, services and security of tenure.

6.6 HEALTHCARE

Most healthcare in the UK is free at the point of use, but chargeable healthcare items include NHS and private dental fees, opticians, prescription charges and transport, unless a person is otherwise exempt.

Current prescription charges in England are £9.36 per item dispensed. However, about 90% of prescriptions dispensed in England are already free due to the number of health and individual factors that exempt someone from paying (85). Most pharmacies now digitally check if a patient is eligible for free prescriptions, making accessing this entitlement more automatic than before (86).

However, some long-term conditions do not lead to a medical exemption certificate, including asthma, and prescription charges remain a barrier to some people accessing medications (87). There is mixed evidence regarding how many more medications would be dispensed if prescription charges were abolished (88). However, there is good evidence that people on low incomes who are not exempt from paying find it difficult to choose between spending money on medicine or on eating and other essentials for health (89).

HEALTHCARE PROVIDERS SHOULD ENSURE PATIENTS ARE AWARE OF ALL POTENTIAL ENTITLEMENTS, TO REDUCE COSTS

As with the above interventions, healthcare providers should enquire about a patient's ability to afford healthcare costs and should first signpost them to advice and support to access all benefit entitlements. This is particularly in view of the fact that claiming some benefits, including Universal Credit, entitles people to other benefits, which include being exempt from most healthcare costs.

For patients who are not entitled to UC or other welfare support, there are alternatives that do not rely on being eligible for health cost exemptions which can reduce costs, although they will not be a solution for everyone:

- A prepayment certificate (PPC) can be purchased by people who pay for their NHS prescriptions: the certificate covers all NHS prescriptions for a set price and essentially means all prescriptions in a month are covered for the price of one prescription in a month, at £108.10 for 12 months (90).
- People on low incomes with no more than £16,000 in savings, investments and property (excluding their home) can apply for a certificate to exempt or partially exempt them from certain health costs, including prescription charges, healthcare travel, dental, eyecare and wig costs. The threshold for eligibility is lower than for most means-tested benefits as council tax and housing costs are factored into the assessment alongside income, so people may be eligible even if their income is too high for routine exemptions.
- People requiring home oxygen can reclaim electricity costs through a rebate scheme via their oxygen supplier.

NHS providers should seek to identify patients who would benefit from the above entitlements based on patient records and consider how they can be supported to pay for it (see also section 3).

Recommendations – support to manage the cost of essential outgoings

Food	• Food aid providers should adopt a cash-first approach and place trained advisors able to support with financial, housing and any locally identified needs on-site at food aid projects. • ICS partners should promote uptake of Healthy Start vouchers. • Local authorities should extend free school meal provision to all year groups in primary schools and widen the eligibility criteria to increase uptake in secondary schools. • ICS's should consider their role in supporting people with dietary needs who are unable to afford appropriate food.
Childcare	• Employers should offer flexible working as standard, including as applicable: self-rostering, flexible work around core hours, remote working and part-time options. • Employers should promote childcare support that is available and offer a childcare deposit loan scheme for parents returning to work. • Build capacity in Children's Centre's, family hubs, and the public health nursing workforce to identify and provide early help to families with young children where childcare costs are leading to financial hardship, either directly or because of barriers to workforce participation. • Large organisations in all sectors should consider providing subsidised on-site childcare facilities where feasible.
Home energy	• Local authorities, VCFSE and NHS should review the Cold Weather Plan for England and NICE Guideline 6: Excess Winter Deaths, and develop a strategic partnership, seeking to implement all recommendations. • Primary care, including social prescribing link workers, and adult social care workforce, should be trained to recognise signs of fuel poverty and have conversations about the support available.
Transport	• Employers should implement a range of interventions to reduce people's need to pay for travel at peak times. These include promoting the cycle to work scheme and providing facilities and training to encourage uptake, and providing interest-free season ticket loans and flexible working. • Local authorities should take a long-term view and integrate making community infrastructure available within a short distance into their local plans to reduce the need to make longer journeys. Together with Transport for London they should invest in cycling and walking infrastructure that connects lower income neighbourhoods with key employment, educational and health infrastructure as well as social and cultural amenities.
Housing	• Integrated Care System partners should consider means of co-locating housing and related support into routine care, with e.g. housing, legal and welfare and benefit advisors available to inpatients and outpatients on-site without need for external referral. • Local authorities and ICSs should refer to the separate evidence review in this series on Housing and Health Inequalities in London.
Healthcare	• Providers should seek to identify and ensure people are aware of entitlements available to both people who are and are not exempt, e.g. prescription charge exemption certificates for people on low incomes, electricity rebates for home oxygen, and the routine healthcare charge exemptions for certain groups. • Social prescribing and other advisory roles should be trained to assist with accessing healthcare entitlements.

7 MAXIMISING INCOMES

There is a long history in the UK, dating back to the early twentieth century, of trying to establish the minimum income required for essential needs. A minimum income for healthy living allows people to pursue healthy and dignified lives that they have reason to value. This includes nutritious food, good quality housing and the ability to heat it, the resources to allow a health-supportive lifestyle, and also full engagement with society, which is necessary for good mental health and wellbeing. The case for this was explained in the 2010 Marmot Review, *Fair Society, Healthy Lives* (4).

Having a reasonable income cannot guarantee good health but what is certain is that having an income insufficient for one's needs will contribute to worse health. Inadequate incomes lead to poor health by making it harder to: avoid stress and feel in control of one's life; access resources and services including housing, food and heating; and adopt and maintain healthy behaviours. It also removes the sense of having a supportive financial safety net. The relationship also works in the other direction: lower income can lead to poorer health, and poor health can reduce earning capacity (2).

7.1 THE LONDON LIVING WAGE

The London Living Wage (LLW) is based on the Joseph Rowntree Foundation's methodology to calculate a minimum income required and is endorsed as equivalent to a minimum income for healthy living. The costs covered by the LLW are regularly reviewed through public engagement (26).

In London is £11.95 per hour for 2022/23, which is approximately 70% of median wages and over 25% higher than the Government's Living Wage (formerly the Minimum Wage) of £9.50 per hour for adults aged 23 and over. People in part-time work are about four times more likely than full-time workers to be paid less than the London Living Wage as an hourly rate (42.8% of part-time workers earned less than the LLW in 2021, vs. 10.4% of full-time), and the LLW therefore disproportionately benefits people who work part-time, with women being significantly more likely than men to be part-time (91).

The campaign for a London Living Wage (LLW) was launched in 2001 and it has been successful in increasing the wages of employees in more than 100 workplaces in London. In a study of 173 employees in workplaces signed up to the LLW comparing them with 127 who were not, those in the LLW workplaces had higher psychological wellbeing even after adjustment for factors such as gender, education, place of birth, working hours and ethnicity. However, the effects of the Living Wage cannot be isolated, and it is possible that LLW employers also promote worker wellbeing through other measures (4). Nevertheless, the study findings endorse academic work advocating a minimum income for healthy living, and paying all direct and indirect employees the London Living Wage is a recommended measure to protect the lowest earners from the rising cost of living.

Whilst this report endorses the LLW as a bare minimum hourly rate, the high cost of many essential outgoings affects families with children more than those without, including housing, home energy and childcare. Many people with childcare or other caring responsibilities will therefore still be reliant on benefits to cover the cost of essentials even if paid the LLW as an hourly rate. Whilst the LLW is a starting point, working towards more affordable housing, childcare and home energy remains critical if pay is to enable full workforce participation and a healthy standard of living for all households.

CASE STUDY 4: THE ROLE OF COMMUNITY-LED ACTION TO INCREASE THE NUMBER OF EMPLOYERS COMMITTED TO THE LONDON LIVING WAGE

The most effective advocates for change are those who are directly affected by low wages, meaning community organising plays a critical role in achieving wage rises for the lowest-paid.

In Newham, a highly effective campaign led by a group of cleaners, teachers, a nun and a local priest resulted in two of the biggest employers, London City Airport and Tate & Lyle, committing to pay all staff and contractors the London Living Wage. Working with St Antony's Catholic Primary School, the campaign team researched how many households were affected by earnings below the London Living Wage, and mapped which local employers were implicated in this. They then planned creative actions involving the school children to take place outside the workplaces, including the airport, and involved media in drawing attention to the cause. In the case of the airport, executives invited the school children to meet them in the boardroom, and following the meeting decided to become an accredited Living Wage Employer. In a similar effort Tate & Lyle also committed to paying the London Living Wage, and the community are now working on pushing for the LLW in the Royal Docks neighbourhood.

More information about the campaign is available here: **https://www.citizensuk.org/campaigns/our-wins/newhams-biggest-employers-commit-to-the-real-living-wage/**

Large organisations in both the public and private sectors can take the lead and encourage and support smaller organisations to pay the LLW. The Social Value Act supports public sector procurement that builds in social as well as economic value as a criterion for awarding contracts and spending public money. The Good Work Charter (see Case study 5) and extensions to social value contracting are important mechanisms to achieve leverage over suppliers and contractors.

CASE STUDY 5: GOOD WORK CHARTERS AND STANDARDS

Being a good employer involves paying the minimum income for a healthy standard of living. The Mayor of London's London Good Work Standard is based on evidence for good employment practice and links to resources and support to help employers meet the standard. It has been developed in collaboration with London's employers, trade unions, professional bodies and experts. It includes four pillars: pay and contracts - with London Living Wage accreditation being a compulsory pre-requisite - workplace wellbeing, skills and progression, and diversity and recruitment (92).

Employers and organisations that meet the criteria apply for accreditation and recognition as leading employers.

More information about the Mayor's Good Work Standard is available here: **https://www.london.gov.uk/programmes-strategies/business-and-economy/supporting-business/good-work-standard-gws**

7.2 SUPPORT PEOPLE TO ACCESS ALL BENEFITS AND ENTITLEMENTS

Benefits provide a safety net for people facing financial hardship and are a central pillar of the welfare state. There is qualitative evidence that increasing older people's financial security through raised benefits has secondary impacts on health, social networks, housing, levels of independence and emotional and psychological wellbeing (93) and medium-strength evidence that good welfare advice and support to people claiming benefits results in reduced stress and anxiety, improved sleep, increased rates of smoking cessation and improved diet and physical activity (2, 78).

MANY PEOPLE WHO ARE ELIGIBLE FOR FINANCIAL BENEFITS DO NOT CLAIM THEM

Non-uptake of financial benefits leads to entrenched poverty and is remediable. According to the Department for Work and Pensions, in 2018/19 up to £3.4 billion of available Housing Benefit went unclaimed. If claimed, on average this would have led to those households receiving an additional £3,100 per year. Of the unclaimed benefit, it is estimated that up to 1.1 million families who were entitled were among those not claiming it. Uptake of Housing Benefit varies by type of rental sector and has done so consistently since 2013. Households in the private rented sector have a much lower uptake rate, 69%, compared with 88% in the social rented sector (95). Policy in Practice estimates that one in five people who need discretionary support are not always aware that it exists or do not understand if they are eligible, or how to access this support (96).

Further indicators of the scale of unclaimed benefits include estimates that nationally in 2019/20 three in 10 older people entitled to pension credit (averaging £1,900 per household per year) did not claim it, and 23% of total pension credit was unclaimed, while two in 10 older people who are entitled to Housing Benefit also do not claim (97). However, for many benefits, there are no uptake estimates, including for Universal Credit, Disability Living Allowance and Personal Independence Payments, Attendance Allowance and Carer's Allowance. Jobseeker's Allowance statistics are no longer published and there have been no estimates for Council Tax Benefit uptake (formerly the Council Tax Support scheme) since 2009–10 (98).

Recent intelligence-gathering in Waltham Forest (not yet published) by the Institute for Health Equity found that not claiming financial benefits was often due to feelings of shame, anxiety and hopelessness and the stigma of being poor. Staff and organisations that work with local communities to identify barriers find accessibility to be a significant problem. For example, the impact of disabilities, lack of digital access, and the effects of previous traumas experienced all affect uptake of financial benefits.

BENEFIT ADVISORY SERVICES GENERATE A RETURN THAT COVERS THEIR OPERATING COSTS

Some benefits also open up 'passport benefits': as mentioned above, these are further benefits for which a person becomes eligible or entitled to receive if in receipt of Universal Credit or another qualifying benefit. Passport benefits include free school meals, housing grants, energy efficiency grants and the Warm Home Discount; and help with health costs, such as free prescriptions, dental costs, eye tests, and costs of travel to appointments (99).

There is good evidence that the average financial gain from services to increase uptake generates a high return on investment. A review of interventions by Adams et al. found them achieving a mean financial gain among all clients that was equivalent to around 9% of average individual gross income in the UK (94). Returns on investment are frequently greater than £10 in annual gained income for every £1 invested (23), and therefore it would be cost-effective for the DWP to allocate 5% of the value of unclaimed benefits to services to increase uptake (100).

INCOME MAXIMISATION INTERVENTIONS

Various terms are used to describe interventions to increase benefit uptake, including benefit maximisation checks, benefit entitlement checks and welfare rights assessments – these are all designed to assess whether someone is eligible for any welfare benefits and support them to claim those benefits. Most of the evidence for their effectiveness dates to pre-2010, with few recent studies of interventions.

There are three key stages required for benefit maximisation to translate into higher incomes: the first is to recruit people to undergo an assessment or check, the second is to assess their eligibility for benefits, and the third is for them to apply for and receive those benefits (100).

Older people, especially those aged over 80, are less likely than younger age groups to apply and therefore receive benefits (100). Older people are more likely to consider themselves too old, ill or frail to apply for benefits, even when likely to be eligible (101). Interventions to reduce fuel poverty often have higher rates of conversion into receipt of benefits than non-specific welfare rights assessments (102) (103).

DATA- AND INTELLIGENCE-LED TARGETING CAN INCREASE THE RETURN ON INVESTMENT

There is medium-strength evidence that the interventions to increase benefit uptake that have higher success rates are those with a narrower scope than general welfare entitlement assessment, for example focussing on home heating support, or entitlements for older adults, as well as targeting low-income communities (101). There is also good evidence that using GP data to identify people who are not claiming health-based benefits will increase the success rate (101).

CASE STUDY 6: HEALTH JUSTICE PARTNERSHIPS

Health Justice Partnerships (HJPs) tackle poverty-related issues that affect the health of populations. HJPs involve the integration of free community legal services with patient care, in hospitals, mental health trusts and in primary care. These services provide advice and assistance relating to matters of social welfare law, such as welfare benefits, debt, housing and employment. Ensuring access to legal advice is not only a matter of social justice but also addresses the root causes of poverty, poor health and health inequalities.

Social welfare legal issues predominantly affect low-income groups. People experiencing social welfare legal problems commonly suffer mental and physical health consequences, due to chronic anxiety about the issue or its effects on living and working conditions (64). Community legal services such as HJP help individuals to gain access to the support they are entitled to by law, and are a key partner for the NHS in the fight against health inequality.

HJPs exist in many healthcare settings across England, including GP practices, hospital clinics, mental health services, hospices, maternity services and others. There are different ways in which legal advice services can be linked with healthcare, for example by integrating welfare rights advisors directly within multidisciplinary care teams, or using referral systems to coordinate service delivery.

HJPs can achieve a range of positive impacts. Providing advice in healthcare settings facilitates timely access to assistance and reaches people who would otherwise not seek help. There is good evidence that HJPs *'improve access to legal assistance for people at risk of social and health disadvantage; positively influence material and social circumstances through resolution of legal problems; and improve mental wellbeing'* (104,105).

In terms of delivery, free community legal services are diverse, and can include local authority welfare rights units, law centres, and local and national charities. Advice networks operate in some regions, bringing together local providers to coordinate activity. An example is the Liverpool Access to Advice Network, which operates a local referral network.

TAILORING COMMUNICATIONS CAN INCREASE UPTAKE

Advice services also need to cater to the range of language and communication needs of those who are more likely to be disadvantaged in accessing welfare rights. To illustrate the potential problem, one study inviting patients to receive a benefit entitlement assessment had no uptake from people of South Asian origin in an area of Newcastle Upon Tyne that has a sizeable South Asian community, and the fact that materials were written in English only was thought likely to have contributed to this (101).

'GET IT RIGHT FIRST TIME' AND TAKE A PERSON-CENTRED APPROACH TO ASSESSING ENTITLEMENTS AND ADVISING CLIENTS

In 2019, the UN Special Rapporteur on extreme poverty and human rights recommended that DWP staff be trained to use 'more constructive and less punitive approaches to encouraging compliance' (33). People's reluctance to ask for help may be partly driven by some people's experiences of trying to claim benefit entitlements, including experiences of sanctioning.

The Low Commission on the Future of Advice and Legal Support found that in 2011/12, over one-third of benefit applicants who were refused a benefit and then appealed were successful in their appeal, and that this may have been even higher had more people received Legal Aid support (106). While more recent data are not available, if the poor quality of benefit assessments a decade ago remains a current issue, then many welfare advisors will waste valuable resources submitting applications at a time when these professionals and volunteers are in short supply.

In London, difficulties in accessing the Personal Independence Payment for people with disability and limited conditions has become the most common benefits issue that Citizens Advice are supporting people with (19). This is because the application is extremely challenging to complete without professional support. It is not an efficient use of the time of professional advisors to complete applications that many people could manage themselves if the process were simpler. Given rising living costs and potential further waves of cuts to public sector spending, it is essential that the DWP seek to ensure it 'gets it right first time' and that rights and entitlements are upheld and barriers to claiming minimised.

OFFER HELP EARLY AND WORK WITH PARTNERS TO CO-LOCATE SUPPORT WITHIN COMMUNITIES

The Low Commission in 2014 examined the impact of austerity on the provision of advice services in the UK, and recommended that early intervention be an underpinning principle to prevent problems escalating (106). Embedding services in settings where people go routinely, such as primary care and early years settings, is likely to increase uptake at an earlier stage in the course of people facing financial challenges. The Commission also found good evidence that when local authorities, in particular housing departments, worked directly with advice services, they were able to significantly reduce the time taken to process housing applications. It recommended that advice services work with local authority housing departments and Jobcentre Plus on ways to reduce preventable demand for advice by helping improve or redesign their processes.

A 2015 evidence review of the role of welfare advice services in improving health outcomes found good evidence that welfare advice provided in healthcare settings results in better individual health and wellbeing outcomes and lower demand for health services (14). Historically, many welfare advisors worked through primary care, which studies have found to relieve demands on GPs while reducing the need for repeat appointments and prescriptions.

Providing welfare advice within healthcare settings aligns with wider efforts to integrate services at a place level. The Fuller Stocktake and Early Help System Guide found the following benefits of primary care adopting a psychosocial model of care that takes a holistic view of health and supports the health and wellbeing of a community (107):

- Reducing demand on acute services in health and care.
- Building lasting relationships among the professionals working together, thus increasing capacity and productivity.
- Helping to build resilient communities with services available where and when people need them.
- Enabling investment at a local level though shared resources, shared funding applications, and better use of local assets through effectively steering community development.
- Creating a platform for place-based joint commissioning.
- Better ability to share intelligence to target areas of need/neighbourhood issues. This can help to monitor pressure points and, where action may be needed quickly, help to alleviate the cost-of-living crisis.

7.3 TRADE UNION MEMBERSHIP

Many UK trade unions are currently calling for wage increases that are indexed to inflation. The prominent role of unions in demanding pay keep pace with inflation could indicate that joining a union is a way to protect against the rising cost of living (108).

Historically, trade union members earned more than non-members: in 1995 members of trade unions earned on average 25.9% more than people who were not in a union (109). Since then, the wage premium has declined (109). Wage premiums may also not be directly attributable to the union: union members are typically older than non-union members and are likely to have been in their jobs for longer, which may mean being higher-paid (110), and the relationship between pay and unionisation fluctuates over time (111). However, the most recent analysis of the wage premium for union members in the UK found females earn more when unionised, even after controlling for the factors above. The authors concluded this was attributable to the fact that unions typically raise wages for people on lower incomes, and females are more likely to occupy those roles (112).

The above evidence indicates that there is a value in low-paid members of the workforce being unionised. This is in the context that in London fewer workers are unionised than in any other UK region and numbers have declined since the 1980s: fewer than one in five (17.7%) workers were unionised in London in 2019, compared with the highest rate of 28% in the Northeast, where unions' ongoing relative strength has been linked to the legacy of miners' unions (16, 21). Less than 3% of private sector workplaces in the UK had any union representation in 2011, although those that did tended to be larger workplaces and therefore represented a larger share of the total private sector workforce (111). The weakening of union powers in various Employment Acts in the 1980s, combined with the changing nature of work, are significant factors in reduced union membership (112).

TRADE UNIONS ALSO CONTRIBUTE TO MAINTAINING AND IMPROVING WORKPLACE STANDARDS

There is good evidence that unions have a role in protecting the health and wellbeing of their members. Current regulations mean that health and safety at work largely relies on self-regulation by employers in the UK, with minimal enforcement of standards. Enforcement is made even less likely since central government funding for enforcement by the Health and Safety Executive reduced by almost three-fifths in real terms between 2009–10 and 2019–20 (114).

The low standards of health and safety at work in the UK are significant in the context of high inflation as they may lead to longer working hours and declining working conditions (115). There is good evidence that workers who were not unionised in the past were at higher risk of workplace injury and illness (116). This is considered linked to the fact that unionised workers are more likely to appoint members to health and safety committees or be represented on them. Although a trade union presence does not always guarantee effective employee representation, it makes it more likely, and there is good evidence that it is worker representation that is important in reducing rates of workplace injury and illness (116).

Nevertheless, some workers with the poorest working conditions are the least likely to be unionised. For example, the number of unionised people in administrative and support services, and hospitality sectors are so low in London the data cannot be reported (113). The Health and Safety (Consultation with Employees) Regulations 1996 cover non-unionised employees and demand consultation with and representation of all workers on health and safety matters, regardless of trade union membership.

There is also good historic evidence that the protection offered by being a member of a trade union in the UK enables members to take sickness absence when needed (117). These functions of a trade union have an essential role in maintaining and improving working conditions at a time when some employees may be more vulnerable to exploitation due to financial pressures.

Recommendations – Maximising income

All employers should	• Pay the London Living Wage and should reinforce this through their procurement processes to influence suppliers and commissioned services. • Support trade union membership in their workforce, in particular encouraging the lowest paid workers to join. • Ensure adequate protections of pay and conditions for all staff when ill, including those not directly employed, and promote a positive culture of taking sick-leave when needed.
Integrated Care System Partners	• All system partners should identify and support people to access all benefits and entitlements for which they are eligible, taking into consideration all barriers to uptake and opportunities to co-locate welfare advice with other services people routinely access. • Should support development of health justice partnerships in their localities, including co-location of services in health and care facilities. They should develop the role of health and care professionals, including social prescribing link workers, in identifying the need for and facilitating access to legal welfare advice.
The Department for Work and Pensions	• Should allocate 5% of the value of unclaimed benefits to services that increase benefit uptake, including health justice partnerships. • Review, nationally, processes for claiming benefits, especially where those often require professional support to complete, to seek to minimise demand for professional support with initial applications.

8 FINANCIAL RESILIENCE AND DEBT MANANGEMENT SUPPORT

Low financial resilience is indicated by a lack of savings or sources of financial support, including state benefits, to fall back on if and when needed due to a loss of income or high outgoings. People with low financial resilience are more likely to go into debt if they do not have savings or other financial support they can draw on. This increases their vulnerability to unregulated creditors, including loan sharks, and makes it more likely they will not pay routine bills and will develop problem debt.

In the last decade welfare reforms have contributed to more people developing problem debt. For example, local housing allowance is now paid in arrears and directly to the tenant, rather than to landlords. This makes budgeting difficult and can mean continually falling into arrears, threatening security of tenure. The health implications of problem debt are serious, and there is good evidence for a significant relationship, which may be in both directions, between debt and: serious mental illness, suicide, problem drinking and drug dependence. (118)

The 2022 Survey of London found that people in more deprived communities are more likely than those in better-off neighbourhoods to have unsecured loans and credit agreements. They are also more likely to feel debt is a heavy burden and rely on cash, indicating reduced access to banking and regulated financial services.

Household debt in the UK has been increasing since 2012 and worsened during the pandemic. IHE's *Build Back Fairer* report showed low-income households had taken on additional debt whereas high-income households increased their savings during the first few months of the pandemic (3). In 2021 a study of 1,252 people who had been forced to use loan sharks in the UK found 62% had an income below £20,000 and 65% had a long-term health condition (119). Levels of debt continued to increase and recent GLA/YouGov polling has found that Londoners who are struggling financially are increasingly likely to use credit or go into debt to tackle rising costs.

The first Marmot Review, *Fair Society, Healthy Lives* (2010), found that debt is closely associated with mental illness (4). There is established evidence for the negative mental health impacts of indebtedness, including that people with problem debt are over three times more likely to have mental health problems than the general population, though the direction of association – whether debt contributes to poor mental health or vice versa - is not established (14).

There is good evidence that debt collection processes, often involving repeated phone calls, emails, texts and letters, are threatening, time-consuming and extremely stressful for people who are unable to afford repayments, and this is likely to be a significant factor in driving the relationship between debt and mental health (13).

With increasing interest rates and household debt, urgent action is needed at all levels to reduce the mental health burden associated with problem debt, and this section summarises some of the local interventions that can support this.

8.1 DEBT ADVICE SERVICES

Similar to benefit checks, debt advice services may involve a combination of legal and financial advice. For this reason, cuts to legal aid and the non-statutory nature of advice services have significantly reduced the scale of support available to people in 2022 compared with 10 years ago.

It is methodologically difficult to evidence the health impacts of debt advice because the outcomes tend to be diffuse and over long timescales, and recipients tend not to be followed up. Nevertheless, there is medium strength evidence from in-house evaluations that positive mental health outcomes are seen quickly having talked about debt problems with friends, family or professional advisors, and that people whose mental health and wellbeing improves after an initial debt advice intervention are less likely to request further debt management support (120).

8.2 SUSPENDING DEBT COLLECTION PROCESSES

Further to debt advice, creditors, including businesses, local authorities and the NHS (where they are charging for services) have a role in not enforcing debt collection measures. Mechanisms for this are already being piloted in South London by creating a new Joint Debt Protocol between two local authorities and four housing associations (see Case study 7). A similar approach has been adopted in Barking and Dagenham (see Case study 8).

In 2020, the government introduced The Debt Respite Scheme (Breathing Space Moratorium and Mental Health Crisis Moratorium) Regulations (121). A breathing space involves pausing most enforcement action and contact from creditors and freezing most interest and charges on debts to anyone with problem debt. It gives people with problem debts legal protections from creditor action for up to 60 days, or for as long as a mental health crisis lasts plus 30 days if the person is receiving mental health crisis treatment. This gives people who meet the criteria a window of time in which to develop a payment plan if that is feasible for them. A breathing space can only be accessed via a debt adviser that is regulated by the Financial Conduct Authority, and therefore the scheme relies on adequate funding and uptake of debt advice services. Breathing spaces have strict eligibility criteria and are not a solution for everyone with problem debt. In London in 2021 only 9.8 per 10,000 people registered for a breathing space, compared with an England average of 13.6 per 10,000, and nationally, three-quarters were adults aged between 25 and 54, despite this group being only half of the adult population (122).

Given the relationship between debt and mental health, and the protection these regulations offer people eligible for the mental health crisis moratorium, Citizens Advice have advocated that advisers able to refer people for this scheme are co-located in mental health inpatient and community services (123).

Whilst a formal breathing space can benefit some people with problem debt, it is not essential as a mechanism for pausing enforcement action, and the case studies presented below contain examples of creditors, debt advice and health services working together to provide debt support. In both cases, they show creditors initiating a pause on enforcement action even where someone has not been formally offered a breathing space.

CASE STUDY 7: FINANCIAL SHIELD PROGRAMME

The Centre for Responsible Credit (CfRC) has been leading delivery of the innovative Financial Shield pilot project in parts of the London Boroughs of Lambeth and Southwark. The project is designed to provide improved financial support to working-age people with, or at risk of developing, long-term health conditions and who have money worries.

Funded by Impact on Urban Health, the project forms part of CfRC's wider programme to improve outcomes for people with multiple long-term health conditions.

Financial Shield is being tested with up to 2,000 people in Peckham, South Bermondsey, Stockwell and Clapham Park through to March 2023. The pilot brings GP practices, Primary Care Networks, social prescribing teams, and local authority and housing association creditors together with advice and community-based support agencies to provide a holistic response to people's financial and health support needs.

Financial Shield has been designed to drive improvements in people's health trajectories, financial situation and debt repayment, and to bring cost savings to the NHS through reduced use of NHS appointments and admissions.

The pilot began in September 2020 and has continued into the cost-of-living crisis. Among other outputs, the Financial Shield has:

- Created new pathways to support. Local GPs, community groups and creditors proactively identify and target people for support. In the main, this has been through GP practices messaging their patients to alert them to the availability of advice concerning their financial issues. However, it is also working with Southwark and Lambeth Councils and four large Housing Associations (Southern, Optivo, Hyde Housing and MTVH) to promote the service to their residents.

- Embedded new Financial Support Link Worker roles within social prescribing teams. These roles receive referrals and provide advice on benefit entitlements, grants and discretionary payments, and debt problems alongside health support.

- Provided residents with more time and space, without the threat of debt enforcement, to address their financial and health problems.

This has seen an Information Sharing Agreement put in place between all parties. On entering the project, the resident consents for data to be shared across all project partners. Creditor partners then check their systems to identify any outstanding rent or council tax arrears, and, if present, place an immediate stop on debt collection and enforcement activity while the Financial Support Link Workers seek to maximise the resident's income. On completion of this work, the creditors are then provided with a Standard Financial Statement, showing how much is available for the repayment of debt, and the Joint Debt Protocol requires that these then liaise regarding repayment plans to avoid competition for any surplus income.

The pilot is being independently evaluated by Cordis Bright Ltd, with the evaluation expected in April 2023 (124).

CASE STUDY 8: TARGETED DEBT SUPPORT AND PREVENTION FOR VULNERABLE RESIDENTS PILOT

Over half of Barking and Dagenham residents live in poverty, and the borough is the fifth most deprived area in the country; putting many residents at major risk from the rising cost of living. The challenge of insufficient income in Barking and Dagenham is not new, however.

A review of the borough's Support and Collections services revealed a rushed arrears ladder, with the council being too quick to begin legal proceedings against residents. The council considered whether legal proceedings could be avoided if debt advice and financial support were offered to residents that need it earlier in the process.

They developed a preventative approach to support people in debt. The aim was to encourage people to set up a payment plan to repay council tax and make social housing rent payments as required, support residents that cannot pay, avoid costly recovery processes with residents, and improve engagement with residents. Using a database holding the relevant information, they identified a cohort of residents with multiple debts and more than one form of vulnerability, and sent them personalised texts offering support. The Homes and Money Hub then undertook outreach by calling those residents and working with them to resolve their issues.

Measuring outcomes of this cohort against a comparison or control group the intervention achieved 26% engagement and delivered 127 support interventions to residents who engaged, such as setting up payment plans and other benefits support. In comparison, the control group received only five interventions as part of the 'business as usual' approach. Despite a focus on support, the approach brought in an additional £75,000 over the four months of the pilot and reduced legal costs to the council as the people worked with had greater improvements in collections status and lower rates of legal and bailiff action.

For more information see: **https://www.homelessnessimpact.org/post/proactive-debt-outreach**

8.3 CREDIT UNIONS

Local credit unions are cooperative societies and an alternative to high street banks and can provide services to tackle financial exclusion and offer affordable loans, reducing the reliance on high interest loans from loan sharks.

Each credit union has a 'common bond' which determines who can join it, which may be people living or working in the same area, people working for the same employer or people who belong to the same association, such as a church or trade union. Only members can save into a credit union, and for legal reasons most unions require members to demonstrate their ability to save before offering loans. While this means they are not an option for people in severe financial hardship, they can be an important player in building people's financial resilience as they often provide savings and loan facilities to those with limited or no access to mainstream financial services, and at significantly lower interest rates.

There are over 30 credit unions in London, which are easily searchable using the **'Find your credit union'** website. However, polling shows that most people in Britain do not know what a credit union is and 44% of loan shark victims were unaware of credit unions when surveyed by England's Illegal Money Lending team (119).

Substantial legislative barriers prevent credit unions from expanding significantly in size and from reaching very financially excluded customers, and local organisations are not able to resolve these barriers (119). This means that although credit unions should be one tool that is promoted as appropriate by advisory services, and awareness of them should be created through communications about the cost of living, it is unlikely that in the short term they will be able to meet all the demands for low-cost and accessible financial services.

Recommendations – Financial resilience and debt management

- All organisations that undertake debt recovery should be sensitive to the mental health needs of clients.

The NHS, local authorities and businesses, should, as appropriate:

- Fund and resource debt advice services sufficiently to meet need.
- Where people are in debt to Local authorities, the NHS and businesses, debt advice and support should be offered via outreach at the first sign of financial difficulties to secure the best outcomes.
- Commission services that deliver money and debt advice on-site in primary care, hospitals and mental health services. In particular they should ensure people in a mental health crisis are able to access debt advice and a 'temporary suspension of any enforcement action.
- Promote credit unions in their cost-of-living response communications.

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