MDA No.	1	2	1	0

Title: COVID-19 Experiences of Londoners

Executive Summary

At its meeting on 25 June 2020, the Health Committee resolved:

That authority be delegated to the Chair, in consultation with the Deputy Chair, to agree any output arising from the discussion.

At its meeting on 11 August 2020, the Health Committee resolved:

That authority be delegated to the Chair, in consultation with the Deputy Chair, to agree any output arising from the discussion.

Following consultation with the Deputy Chair, the Chair exercised the above delegations of authority to agree:

- A parliamentary briefing for MPs in advance of a House of Commons debate, which included the Health Committee's data and analysis on healthcare experiences in London and the rate of COVID-19 deaths, as attached at **Appendix 1**; and
- The Committee's report, *Pathways to healthcare: GP experience, COVID-19 and BAME Londoners*, and four supporting policy briefings on supporting Londoners' mental health; the importance of public health; protecting London's health and care workforce; and the importance of a community-led approach (**Appendices 2 and 3**). Appendices 2 and 3 will be published alongside this form following the formal launch of the Committee's report.

The terms of reference for this project were approved by the Chair under delegated authority. Officers confirm that the report and its recommendations fall within these terms of reference. The outputs will be reported to the Committee's next appropriate meeting for formal noting.

Decision

That the Chair, in consultation with the Deputy Chair, agree:

- A parliamentary briefing for MPs on healthcare experiences in London and the rate of COVID-19 deaths, as attached at **Appendix 1**; and
- The Committee's report, *Pathways to healthcare: GP experience, COVID-19 and BAME Londoners*, and the four supporting policy briefings (**Appendices 2 and 3**).

Assembly Member
I confirm that I do not have any disclosable pecuniary interests in the proposed decision and take the decision in compliance with the Code of Conduct for elected Members of the Authority.

The above request has my approval.

Signature  **Date** 10/12/20

Printed Name Dr Onkar Sahota AM, Chair of the Health Committee

Decision by an Assembly Member under Delegated Authority

Notes:

1. *The Lead Officer should prepare this form for signature by relevant Members of the Assembly to record any instance where the Member proposes to take action under a specific delegated authority. The purpose of the form is to record the advice received from officers, and the decision made.*

2. **The 'background' section (below) should be used to include an indication as to whether the information contained in / referred to in this Form should be considered as exempt under the Freedom of Information Act 2000 (FoIA), or the Environmental Information Regulations 2004 (EIR). If so, the specimen Annexe (attached below) should be used. If this form does deal with exempt information, you must submit both parts of this form for approval together.**

Background and proposed next steps:

At its meeting on 25 June 2020, the Health Committee resolved:

That authority be delegated to the Chair, in consultation with the Deputy Chair, to agree any output arising from the discussion.

At its meeting on 11 August 2020, the Health Committee resolved:

That authority be delegated to the Chair, in consultation with the Deputy Chair, to agree any output arising from the discussion.

Following consultation with the Deputy Chair, the Chair exercised the above delegations of authority to agree:

- A parliamentary briefing for MPs in advance of a House of Commons debate, which included the Health Committee's data and analysis on healthcare experiences in London and the rate of COVID-19 deaths, as attached at **Appendix 1**; and
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The outputs will be reported to the Committee's next appropriate meeting for formal noting.

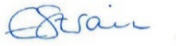
Confirmation that appropriate delegated authority exists for this decision

Signed by Committee Services L J Harvey

Date 30/10/20

Print Name: Lauren Harvey Tel: x4383

Financial implications **NOT REQUIRED**			
Signed by Finance	N/A	Date	.....
Print Name	N/A	Tel:	.....

Legal implications The Chair of the Health Committee has the power to make the decision set out in this report.			
Signed by Legal		Date	30/10/20
Print Name	Emma Strain, Monitoring Officer	Tel:	X 4399

Additional information should be provided supported by background papers. These could include for example the business case, a project report or the results of procurement evaluation.

Supporting detail/List of Consultees:

Andrew Boff AM (Deputy Chair of the Health Committee)

Public Access to Information

Information in this form (Part 1) is subject to the FoIA, or the EIR and will be made available on the GLA Website within one working day of approval.

If immediate publication risks compromising the implementation of the decision (for example, to complete a procurement process), it can be deferred until a specific date. Deferral periods should be kept to the shortest length strictly necessary. **Note:** this form (Part 1) will either be published within one working day after it has been approved or on the defer date.

Part 1 – Deferral
Is the publication of Part 1 of this approval to be deferred? Yes

Until what date: 18 December 2020

Part 2 – Sensitive information

Only the facts or advice that would be exempt from disclosure under FoIA or EIR should be included in the separate Part 2 form, together with the legal rationale for non-publication.

Is there a part 2 form - No

Lead Officer/Author

Signed	Dan Tattersall	Date: 12/11/20
Print Name	**Dan Tattersall**	Tel: x1328
Job Title	**Senior Policy Adviser**	
Countersigned by Director	E. Williams	Date: 20/11/2020
Print Name	**Ed Williams**	Tel: x4399

LONDONASSEMBLY

PARLIAMENTARY BRIEFING

London Assembly Health Committee research on healthcare experiences in London and the rate of COVID-19 deaths.

Satisfaction with GP services appears to be lowest in those areas with the highest rate of COVID-19 deaths

The London Assembly Health Committee has analysed patient healthcare experience data in London to understand in more detail the links between people's experience of healthcare services, population diversity, deprivation and COVID-19 deaths.

The data in this briefing puts quantitative data behind the qualitative findings of Public Health England's report *Beyond the data: Understanding the impact of COVID-19 on BAME groups* in London for the first time.[1] This data has not yet been published.

The Public Health England report found that a lack of trust in healthcare services for many Black and Minority Ethnic people leads to lower engagement with healthcare services, resulting in late diagnosis and worse outcomes from COVID-19. We compared patients' satisfaction with their general practitioner (GP) with COVID-19 deaths, BAME population makeup, and deprivation to understand these findings in the context of London. GPs are a pivotal part of the healthcare system, because they often interact with patients in the first instance and function as a gateway to other NHS services.

About the report

Our report's wider statistics and findings will be published in their entirety in the Health Committee's report *Pathways to healthcare: GP experience, COVID-19 and BAME Londoners*, launching in the first week of November, which focuses on unequal healthcare experiences in London in the context of COVID-19.

Alongside this report, the Committee will publish four policy briefings based on evidence gathered this year, aimed at helping tackle the second wave and supporting Londoners beyond the pandemic. They focus on COVID-19 lessons learned on the following areas:

- Supporting Londoners' mental health
- The importance of public health
- Protecting London's health and care workforce
- The importance of a community-led approach

These will be available to download from the London Assembly Health Committee website.

About the London Assembly

The London Assembly is the 25-member elected body that represents Londoners and holds the Mayor to account. The Health Committee reviews health and wellbeing issues for Londoners,

[1] Public Health England, Beyond the data :Understanding the impact of COVID-19 on BAME groups, 16 June 2020

particularly public health issues. It also keeps a close eye on how well the Mayor's Health Inequalities Strategy is doing.

If you wish to get in contact with us, please contact Dan Tattersall, Senior Policy Adviser, Health Committee (daniel.tattersall@london.gov.uk). For media, please contact Louise Young, External Communications Officer (louise.young@london.gov.uk).

Our findings

The full breakdown of London borough results is contained in the table below.

London has 33 boroughs (we have considered the City of London as a borough for this analysis). We have ordered Clinical Commissioning Groups (CCGs) based on GP satisfaction, and then split the boroughs into three groups: worst, middle and best performing CCGs.[2]

In the eleven boroughs where patients recorded the *worst* level of satisfaction with their GP practice:

- 4 boroughs are within the highest 10 boroughs for COVID-19 death rates;
- Of those, 3 boroughs' (Newham, Brent and Haringey) COVID-19 death rates are statistically higher than the London average; and
- Only 1 borough (Westminster) is statistically lower than the London average for its COVID-19 death rate.

In the middle group of eleven boroughs for satisfaction with their GP practice:

- Again, 4 boroughs are within in the highest 10 boroughs for COVID-19 death rates;
- However, only 2 of these boroughs (Harrow and Lambeth) are statistically higher than the London average, so the number of boroughs with an above-average death rate is lower compared to the 11 worst-rated boroughs; and
- 3 boroughs (Camden, Bexley and Bromley) are in the lowest 10 boroughs for COVID-19 death rates and all 3 of these are statistically lower than the London average.

In the eleven boroughs where patients recorded the *best* level of satisfaction with their GP practice:

- Just 2 boroughs feature within the highest 10 boroughs for COVID-19 death rates;
- Of these, only 1 borough's (Hackney) COVID-19 death rate is statistically higher than the London average, so the number of above-average boroughs for death rates is less than the 22 boroughs with worst and middle level of satisfaction; and

[2] CCGs were ordered based on GP satisfaction, for CCGs covering multiple areas the London boroughs were internally ordered based on Covid-19 death rates. The 33 London boroughs were then split into three equally sized groups, resulting in one CCG being split across groups.

London Assembly Health Committee research on healthcare experiences in London and the rate of COVID-19 deaths.

Satisfaction with GP services appears to be lowest in those areas with the highest rate of COVID-19 deaths

- 6 boroughs are in the lowest 10 boroughs for COVID-19 death rate, and of these 5 (Havering, Sutton, Kingston upon Thames, Richmond upon Thames and Kensington and Chelsea) are statistically lower than the London average.

Diversity, English language and deprivation: In the six boroughs where COVID-19 death rates were statistically higher than the London average:

- 3 are within the top 10 boroughs for ethnic diversity and all 3 (Brent, Newham and Harrow) are statistically higher than the London average for ethnic diversity.
- 5 are within the highest 10 boroughs for lower levels of English language and 3 (Brent, Newham and Haringey) are statistically higher than the London average for lower levels of English language.
- 4 are within the highest 10 boroughs for levels of deprivation and 3 (Newham, Hackney and Haringey) are statistically higher than the London average for deprivation.

More detail

- Patients who described their overall experience of their GP practice as 'very' or 'fairly good' ranged from 71-85 per cent across CCGs in London. CCGs and their corresponding London boroughs have been placed in the table below in ascending order with the lowest level of satisfaction at the top and the greatest level of satisfaction at the bottom.
- In order to visualise any emerging patterns in the dataset, there are orange cells which indicate higher death rates from COVID-19, higher ethnic diversity, lower levels of English language and higher levels of deprivation. These are found towards the top of the table, in those boroughs where patients have a less positive experience of their GP practice.

  Conversely, the green cells – which indicate a lower death rate from COVID-19, lower ethnic diversity, higher levels of English language and lower levels of deprivation – are found towards the bottom of the dataset in those boroughs where patients have a more positive experience of their GP practice.
- Some CCGs cover individual borough areas (e.g. Waltham Forest or Hounslow). However, some CCGs are 'combined CCGs', covering more than one borough. These combined CCGs can cover a diverse range of London boroughs, for example the South East CCG has Lewisham, Southwark and Lambeth which have a range of orange cells, in contrast to Bexley and Bromley which are predominately green. It is important to recognise that this adds complexity to the patterns the dataset presents, but doesn't contradict it overall.

Table 1 – Comparing London boroughs/CCGs with overall GP experience, COVID-19 death rates, BAME residents per centage, language, and Index of Multiple Deprivation

Statistically higher than average
Worst 10 OR highest proportion of BAME/Non-English speaking households/IMD (ranked 1 to 10)
Best 10 OR highest proportion of BAME/Non-English speaking households/IMD (ranked 24 to 33)
Statistically lower than average

Combined CCG	London Borough/CCG	Overall GP experience rated as 'very' or 'fairly' good		Rate of COVID-19 deaths	% BAME Residents	% of residents that do not speak English well or at all	Index of Multiple Deprivation	Rate of COVID-19 deaths	% BAME Residents	% of residents that do not speak English well or at all	Index of Multiple Deprivation
		All patients	BAME patients	ACTUAL VALUES				RANKS			
Not part of a combined CCG	Barking & Dagenham	71%	73%	144.5	41.7	3.6	47.2	15	14	15	1
	Tower Hamlets	73%	73%	168.8	54.8	8	30.6	10	4	3	4
	Redbridge	74%	69%	143.7	57.5	4.5	4.1	16	3	11	28
	Newham	74%	75%	203.4	71	8.7	28.8	2	1	1	6
	Waltham Forest	75%	74%	150.5	47.8	5.8	17.8	14	8	7	15
	Brent	76%	76%	218.3	63.7	8	20.7	1	2	2	10
	Central London (Westminster)	78%	75%	106.1	38.3	4.3	15.9	26	18	12	18
North Central CCG	Haringey	79%	78%	186	39.5	7.2	32.1	4	15	4	3
	Enfield			158.1	39	5.8	29.4	13	17	8	5
	Barnet			141	35.9	4	5.2	18	20	13	26
	Islington			134.9	31.8	3.3	27.1	21	24	17	7
	Camden			93	33.7	3.2	13.8	31	22	18	19
Not part of a combined CCG	Harrow	79%	77%	184.2	57.8	5.2	2.7	5	3	9	30
	Ealing	79%	78%	170.8	51	7.2	16.3	8	6	5	17
	Hammersmith & Fulham	79%	80%	159.7	31.9	2.6	16.4	12	23	23	16
	Hillingdon	79%	78%	138.4	39.4	3.1	6.9	19	16	19	24
South East CCG	Lambeth	80%	80%	179.9	42.9	3.7	19.5	6	13	14	13
	Lewisham			177	46.5	2.9	24.6	7	9	21	8
	Southwark			168.3	45.8	3.0	23.1	11	10	20	9
	Greenwich			135.3	37.5	2.9	20.2	20	19	22	11
	Bromley			107.7	15.7	0.7	7.3	24	31	32	23
	Bexley			103.4	18.1	1.1	7.6	27	30	30	22
Not part of a combined CCG	Havering	80%	80%	106.3	12.3	0.7	8.1	25	33	33	21
	Hounslow	81%	81%	133.2	48.6	4.8	8.9	22	7	10	20
City & Hackney CCG	Hackney	83%	85%	186.8	45.3	6.0	43.2	3	11	6	2
	City of London			NA	21.4	1.4	NA	NA	29	28	NA
South West CCG	Croydon	85%	86%	170	44.9	2.5	19	9	12	24	14
	Merton			141.2	35.1	3.5	3.9	17	21	16	29
	Wandsworth			124.5	28.6	2.4	5	23	26	27	27
	Sutton			102.5	21.4	1.4	5.8	28	28	29	25
	Kingston upon Thames			95.7	25.5	2.4	1.2	30	27	26	31
	Richmond upon Thames			90.3	14	1.0	0.8	32	32	31	32
Not part of a combined CCG	Kensington and Chelsea	85%	86%	97.4	29.4	2.4	19.9	30	25	26	31

LONDONASSEMBLY

PARLIAMENTARY BRIEFING

London Assembly Health Committee research on healthcare experiences in London and the rate of COVID-19 deaths.

Satisfaction with GP services appears to be lowest in those areas with the highest rate of COVID-19 deaths

Discussion:

There are a number of apparent correlations in the data:

- An inverse correlation between GP satisfaction and COVID-19 death rate: the better the GP satisfaction the lower the COVID-19 related death rate
- An inverse correlation between GP satisfaction and the ranking on the index of multiple deprivation: the greater the deprivation, the worse the GP satisfaction score
- An inverse correlation between GP satisfaction and percentage of the population that is BAME: the better the GP satisfaction, the lower the BAME population
- There is an inverse correlation between GP satisfaction and the lack of English language: the better the GP satisfaction, the lower the level of the population with no, or limited, English language.

Dr Tudor Hart, a GP from West Glamorgan, first described the "**Inverse Care Law**" in his seminal essay published in The Lancet 1971, which explains that those who most need medical care are least likely to receive it.[3] It still holds today, and the COVID-19 pandemic has highlighted the inequalities in our society.

The BAME community has been disproportionately affected not because of any genetic susceptibility but because they are more exposed to the adverse social determinants of health. This leads them to have greater incidence of diabetes, cardiovascular disease, renal disease and poor mental health. They are also more likely to live in more overcrowded housing, poorer quality housing, poorer neighbourhoods and work in low-paid, public facing jobs.

GP workload is affected by deprivation of the area in which they work, which leads to poorer retention, recruitment and job satisfaction of the GPs in these areas.[4] This results in resource and workload pressures, leading to a lower level of patient satisfaction in GP services.[5] This is captured in our data by the self-declared experiences of Londoners.

Methodology

Disparities in the risk and outcomes of COVID-19 are well documented. As well as age and gender there are noticeable disparities between those living in more deprived areas, compared to those in

[3] The King's Fund, Inverse Care law, June 2001

[4] The Health Foundation, A worrying cycle of pressure for GPs in deprived areas, May 2019

[5] Pulse, Patient satisfaction in GPs drops to record low levels as 'intense pressures' show, March 2019

London Assembly Health Committee research on healthcare experiences in London and the rate of COVID-19 deaths.

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the least deprived areas and those in Black, Asian and Minority Ethnic (BAME) groups compared to those who are White.[6]

Public Health England's report *Beyond the data: Understanding the impact of COVID-19 on BAME groups,*[7] found that a lack of trust in healthcare services for many BAME groups lead to lower engagement with healthcare services, resulting in late diagnosis and worse outcomes from COVID-19.

To better understand how access to health services potentially impact COVID-19 outcomes, GP satisfaction data and nationally published statistics were juxtaposed to identify possible relationships. GP satisfaction data, taken from the GP Patient Survey,[8] was used as a proxy for 'experience' of health services. Whilst GPs only represent one part of London health care services, they deal with patients in the first instance and function as a gateway to other NHS services.

The other indicators used were:

- Rate of COVID-19 deaths for the 5-month period of March 2020 to July 2020, ONS[9]
- Percentage of BAME residents, 2011 Census[10]
- Percentage of residents who do not speak English 'well' or 'at all', 2011 Census[11]
- Index of Multiple Deprivation: percentage of population living in the most deprived LSOAs in the country, LG Inform[12]

'Outliers' or values which were statistically above or below the London average were calculated and colour coded according to their value:

- Dark orange: Statistically worse than the London average (e.g. COVID-19 rate) and statistically higher than the London average (e.g. percentage of BAME residents)
- Light orange: Within the worst or highest ten
- White: Are neither statistically different from the average, nor in the top or bottom ten
- Light green: Within the best or lowest ten
- Dark green: Statistically better than the London average and statistically lower than the London average.

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[6] Public Health England, Disparities in the risk and outcomes of COVID-19, August 2020

[7] Public Health England, Beyond the data :Understanding the impact of COVID-10 on BAME groups, June 2020

[8] GP Patient Survey Q31. Overall, how would you describe your experience of your GP practice?

[9] ONS, Deaths involving COVID-19 by local area and socioeconomic deprivation: deaths occurring between 1 March and 31 July 2020, August 2020

[10] Nomis, Census Statistics, 2011

[11] Nomis, Census Statistics, 2011

[12] LG Inform, IMD - Overall - extent (%) in London

LONDONASSEMBLY

PARLIAMENTARY BRIEFING

London Assembly Health Committee research on healthcare experiences in London and the rate of COVID-19 deaths.

Satisfaction with GP services appears to be lowest in those areas with the highest rate of COVID-19 deaths

It should be noted that not all indicators have a 'polarity', i.e. high or low values are not inheritably good or bad. For the purpose of investigating links between ethnicity and language with GP satisfaction orange has been used for high instances but do not infer a negative.

Contact us

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Appendix 2

Pathways to healthcare: GP experience, COVID-19 and BAME Londoners

London Assembly Health Committee

LONDONASSEMBLY

Health Committee

About the London Assembly Health Committee

The London Assembly is the 25-member elected body that represents Londoners and holds the Mayor to account. The Health Committee reviews health and wellbeing issues for Londoners, particularly public health issues. It also keeps a close eye on how well the Mayor's Health Inequalities Strategy is doing.

Contact us

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Foreword

Dr Onkar Sahota AM
Chair of the Health Committee

The COVID-19 pandemic has caused unprecedented damage to Londoners' lives: upending their work, families and travel. Not least, it has cost precious lives and torn holes in the day-to-day of millions of people in our city. Worse still, we do not know when the virus will be under control.

Our city is resilient and innovative – the London Assembly wants to be the foundation that helps citizens to rebuild. We are elected to represent Londoners, and the Health Committee is a cross-party group that helps to deliver this. As society responds with new ways to tackle the virus and help people to maintain some kind of normality - work, school, going to the doctor - the Committee has asked, what can we do better?

This short report, and its sister policy briefings, comprise the work and original analysis undertaken by the Health Committee since the first wave of the pandemic hit London. Because our city is unique, with one of the most complex social makeups in the world, we wanted to investigate how health services have been impacted for the people they serve. It means the Assembly can lead the conversation in improving these services and guide the Mayor to better deliver for the people who elected us.

What we found in this report casts stark local data behind Public Health England's national report on the impact of COVID-19 on Black and Minority Ethnic people (BAME). In London the satisfaction with GPs ranges between 71 to 85 per cent 'very' or 'fairly good' – a 14 per cent gap in rating. General trends show that boroughs with higher levels of deprivation, poorer ratings of GPs satisfaction and higher numbers of BAME residents generally have higher rates of COVID-19 deaths. Broadly, as the boroughs get less diverse and deprived, GP experiences and COVID-19 death rates improve.

Of course, this data does not tell the complete story; there are multiple and complex factors that drive patients' satisfaction with their GP services. Individual experience of healthcare is such a personal measure. GPs, and we suggest the wider healthcare services that they are a

gateway to, need to become more culturally competent to try and bridge the 15 per cent gap in experience for thousands of people.

One step towards this is for the Mayor and the London Health Board to identify and build in measures in their COVID-19 recovery health and wellbeing plans that can create culturally competent services. These must effectively deliver healthcare that meets the social, faith, cultural, and linguistic needs of patients.

The Health Committee is asking the Mayor to report progress on this matter so that we can best represent the interests of our electorate and help improve healthcare access to tackle COVID-19. Now is the time to make our city and its people more resilient to the pandemic.

Executive Summary: What was the impact of COVID-19 in London?

The first wave of the pandemic shone a light on the inequalities faced by Black and Minority Ethnic (BAME) communities. Public Health England's report *Beyond the data: Understanding the impact of COVID-19 on BAME groups* proposed that several underlying factors contributed to these wider inequalities. During our investigation we focused on the impact of the long-standing issues of racism, discrimination, fear, stigma and trust cited by the Public Health England report, drilling our research down to a London level.

As a result, we found that a lack of trust in authorities and healthcare services was reported to lead to poor engagement with healthcare services, leading to late diagnosis and worse health outcomes.

Culturally competent healthcare services are required to address these issues. In London, our statistics show that areas with high diversity and deprivation report worse experiences of care than those with less diversity and deprivation. This is an unacceptable inequality, and one which must be resolved if we are to tackle the disproportionate impacts of COVID-19.

Recommendation

The Mayor should explicitly put equitable healthcare access front and centre in the development of his health and wellbeing COVID-19 recovery plans. He should report on and demonstrably monitor BAME groups' access to, and experience of, healthcare services in London. The Committee asks the Mayor to provide a quarterly report for the next 18 months on the impact of the health equity group's work on this vital issue.

Accountability and Timeliness

Throughout the Health Committee's investigation, we explored in more detail the findings from Public Health England's report *"Beyond the data: Understanding the impact of COVID-19 on BAME groups."*[1] Our investigation heard repeatedly that accountability for the urgent delivery of actions across all aspects of the COVID-19 response is vital to address the disproportionate health impact of COVID-19 on BAME groups, coordinated across levels of governance and with measurable outcomes.

We therefore include the following accountability and timeliness recommendations alongside all other recommendations made by the investigation:

- There need to be clear lines of **accountability** for the delivery of all recommendations in PHE's report *"Beyond the data: Understanding the impact of COVID-19 on BAME groups"*.[2]Adequate resource is also required to ensure delivery.

> *"The report is silent on accountability"*
> *(Professor Gurch Randhawa, Professor of Diversity in Public Health & Director of the Institute for Health Research, University of Bedfordshire)*[3]

- Action on the recommendations needs to be urgently taken forward across **coordinated across all levels**: national, regional and local.

> *"There are some really key messages at an NHS London level to which it may need to at least feel itself to be accountable across the system. From an NHS London perspective, it needs to be speaking to the mental health trust, the acute trusts and GPs and asking them what they are doing in response to the recommendations."*
> *(Dr Somen Banerjee, Director of Public Health, London Borough of Tower Hamlets)*[4]

[1] Public Health England, Beyond the data: Understanding the impact of COVID-19 on BAME groups, 16 June 2020
[2] Public Health England, Beyond the data: Understanding the impact of COVID-19 on BAME groups, 16 June 2020
[3] London Assembly Health Committee, COVID-19: The Experiences of BAME Londoners, Page 15, 11 August 2020
[4] London Assembly Health Committee, COVID-19: The Experiences of BAME Londoners, Page 15, 11 August 2020

- The recommendations presented by PHE's report are not new. They represent known issues related to health inequalities, ethnicity, social class, age and gender. This time **measurable** action, not just words and reports, is required.

"I am quite simplistic around this. If you look at this across London, a very valid question for every key public sector organisation is about what it is doing in response to these recommendations and to have some kind of accountability around that. It would be perfectly reasonable for us as a Council to be asked, "There was this very powerful report in June [2020]. What are you doing around these recommendations?"
(Dr Somen Banerjee, Director of Public Health, London Borough of Tower Hamlets)[5]

[5] London Assembly Health Committee, COVID-19: The Experiences of BAME Londoners, Page 14, 11 August 2020

Access to and, experience of, healthcare services

What are culturally competent healthcare services?

Cultural competency is a crucial factor in ensuring effective engagement with BAME communities. It is defined as the ability of providers and organisations to effectively deliver services that meet the social, faith, cultural, and linguistic needs of service users.

Cultural competency in a health care setting requires healthcare staff to be able to display a set of attitudes, behaviours and perspectives which promote and value positive and effective interactions with diverse cultures. At an organisational level it can be delivered through the development and implementation of organisational policies that support staff to engage positively with diverse communities.

Figure 1: PHE: Beyond the data: Understanding the impact of COVID-19 on BAME groups [6]

Access to, and experience of, healthcare services for marginalised groups

Longstanding issues of racism, discrimination, trust, stigma and fear experienced by BAME communities have all been cited as contributory factors in the poor outcomes arising from COVID-19.[7] The Public Health England report *Beyond the data: Understanding the impact of COVID-19 on BAME groups* has pointed directly to the role that a lack of culturally competent healthcare services, as defined in figure 1, has played in individuals trust or faith in healthcare providers:[8]

"Fear and anxiety have increased not only with NHS staff but also in communities, with people nervous to use primary and secondary services. In my opinion this must be a priority of this review – this must not be a one size fits all solution – investing in this long-standing issue will need time and effort"[9]
Public Health England Beyond the data: Understanding the impact of COVID-19 on BAME groups

[6] Public Health England, Beyond the data: Understanding the impact of COVID-19 on BAME groups, 16 June 2020
[7] Public Health England, Beyond the data: Understanding the impact of COVID-19 on BAME groups, 16 June 2020
[8] Public Health England, Beyond the data: Understanding the impact of COVID-19 on BAME groups, 16 June 2020
[9] Public Health England, Beyond the data: Understanding the impact of COVID-19 on BAME groups, 16 June 2020

Overall, it was reported that factors such as these have resulted in BAME groups not seeking health advice in a timely fashion:

- Low health literacy (the ability to obtain and understand health information and make health-related decisions);
- Loss of trust;
- Fear of discrimination.

It has also reduced uptake of COVID-19 testing and fear of reporting COVID-19 symptoms. This has serious implications resulting in more acute symptoms and severity of condition.

As a result of these discrepancies, Public Health England's report recommended the following:

> **Public Health England Recommendation 3**: Improve access, experiences and outcomes of NHS, local government and integrated care systems commissioned services by BAME communities including: regular equity audits; use of health impact assessments; integration of equality into quality systems; good representation of black and minority ethnic communities among staff at all levels; sustained workforce development and employment practices; trust-building dialogue with service users.[10]

The London Assembly Health Committee has analysed patient healthcare experience data in London to understand in more detail the links between people's experience of healthcare services, population diversity, deprivation and COVID-19 deaths.

The data in this briefing puts quantitative data behind the qualitative findings of Public Health England's report *Beyond the data: Understanding the impact of COVID-19 on BAME groups* in London for the first time.[11]

The Public Health England report found that a lack of trust in healthcare services for many Black and Minority Ethnic people leads to lower engagement with healthcare services, resulting in late diagnosis and worse outcomes from COVID-19. We compared patients' satisfaction with their general practitioner (GP) with COVID-19 deaths, BAME population makeup, and deprivation to understand these findings in the context of London. GPs are a pivotal part of the healthcare system, because they often interact with patients in the first instance and function as a gateway to other NHS services.

[10] Public Health England, Beyond the data: Understanding the impact of COVID-19 on BAME groups, 16 June 2020
[11] Public Health England, Beyond the data: Understanding the impact of COVID-19 on BAME groups, 16 June 2020

Statistically higher than average
Worst 10 OR highest proportion of BAME/Non-English speaking households/IMD (ranked 1 to 10)
Best 10 OR highest proportion of BAME/Non-English speaking households/IMD (ranked 24 to 33)
Statistically lower than average

Table 1 – Comparing London boroughs/CCGs with overall GP experience, COVID-19 death rates, BAME residents per centage, language, and Index of Multiple Deprivation

Combined CCG	London Borough / CCG	Overall GP experience rated as 'very' or 'fairly' good		Rate of COVID-19 deaths	% BAME Residents	% of residents that do not speak English well or at all	Index of Multiple Deprivation	Rate of COVID-19 deaths	% BAME Residents	% of residents that do not speak English well or at all	Index of Multiple Deprivation
		All patients	BAME patients	ACTUAL VALUES				RANKS			
Not part of a combined CCG	Barking & Dagenham	71%	73%	144.5	41.7	3.6	47.2	15	14	15	16
	Tower Hamlets	73%	73%	168.8	54.8	8	30.6	10	4	3	45
	Redbridge	74%	69%	143.7	57.5	4.5	4.1	16	3	11	13
	Newham	74%	75%	203.4	71	8.7	28.8	2	1	1	33
	Waltham Forest	75%	74%	150.5	47.8	5.8	17.8	14	8	7	17
	Brent	76%	76%	218.3	63.7	8	20.7	1	2	2	49
	Central London (Westminster)	78%	75%	106.1	38.3	4.3	15.9	26	18	12	15
North Central CCG	Haringey	79%	78%	186	39.5	7.2	32.1	4	15	4	26
	Enfield			158.1	39	5.8	29.4	13	17	8	52
	Barnet			141	35.9	4	5.2	18	20	13	36
	Islington			134.9	31.8	3.3	27.1	21	24	17	58
	Camden			93	33.7	3.2	13.8	31	22	18	42
Not part of a combined CCG	Harrow	79%	77%	184.2	57.8	5.2	2.7	5	3	9	33
	Ealing	79%	78%	170.8	51	7.2	16.3	8	6	5	43
	Hammersmith & Fulham	79%	80%	159.7	31.9	2.6	16.4	12	23	23	51
	Hillingdon	79%	78%	138.4	39.4	3.1	6.9	19	16	19	34
South East CCG	Lambeth	80%	80%	179.9	42.9	3.7	19.5	6	13	14	30
	Lewisham			177	46.5	2.9	24.6	7	9	21	35
	Southwark			168.3	45.8	3.0	23.1	11	10	20	46
	Greenwich			135.3	37.5	2.9	20.2	20	19	22	62
	Bromley			107.7	15.7	0.7	7.3	24	31	32	64
	Bexley			103.4	18.1	1.1	7.6	27	30	30	61
Not part of a combined CCG	Havering	80%	80%	106.3	12.3	0.7	8.1	25	33	33	65
	Hounslow	81%	81%	133.2	48.6	4.8	8.9	22	7	10	29
City & Hackney CCG	Hackney	83%	85%	186.8	45.3	6.0	43.2	3	11	6	
	City of London			NA	21.4	1.4	NA	NA	29	28	49
South West CCG	Croydon	85%	86%	170	44.9	2.5	19	9	12	24	72
	Merton			141.2	35.1	3.5	3.9	17	21	16	76
	Wandsworth			124.5	28.6	2.4	5	23	26	27	79
	Sutton			102.5	21.4	1.4	5.8	28	28	29	87
	Kingston upon Thames			95.7	25.5	2.4	1.2	30	27	26	90
	Richmond upon Thames			90.3	14	1.0	0.8	32	32	31	87
Not part of a combined CCG	Kensington and Chelsea	85%	86%	97.4	29.4	2.4	19.9	30	25	26	31

Our key findings

The full breakdown of London borough results is contained in the table above.
London has 33 boroughs (we have considered the City of London as a borough for this analysis). We have ordered Clinical Commissioning Groups (CCGs) based on GP satisfaction, and then split the boroughs into three groups: worst, middle and best performing.[12]

In the eleven boroughs where patients recorded the worst level of satisfaction with their GP practice:

- 4 boroughs are within the highest 10 boroughs for COVID-19 death rates;
- Of those, 3 boroughs' (Newham, Brent and Haringey) COVID-19 death rates are statistically higher than the London average; and
- Only 1 borough (Westminster) is statistically lower than the London average for its COVID-19 death rate.

In the middle group of eleven boroughs for satisfaction with their GP practice:

- Again, 4 boroughs are within in the highest 10 boroughs for COVID-19 death rates;
- However, only 2 of these boroughs (Harrow and Lambeth) are statistically higher than the London average, so the number of boroughs with an above-average death rate is lower compared to the 11 worst-rated boroughs; and
- 3 boroughs (Camden, Bexley and Bromley) are in the lowest 10 boroughs for COVID-19 death rates and all 3 of these are statistically lower than the London average.

In the eleven boroughs where patients recorded the best level of satisfaction with their GP practice:

- Just 2 boroughs feature within the highest 10 boroughs for COVID-19 death rates;
- Of these, only 1 borough's (Hackney) COVID-19 death rate is statistically higher than the London average, so the number of above-average boroughs for death rates is less than the 22 boroughs with worst and middle level of satisfaction; and
- 6 boroughs are in the lowest 10 boroughs for COVID-19 death rate, and of these 5 (Havering, Sutton, Kingston upon Thames, Richmond upon Thames and Kensington and Chelsea) are statistically lower than the London average.

[12] CCGs were ordered based on GP satisfaction, for CCGs covering multiple areas the London boroughs were internally ordered based on Covid-19 death rates. The 33 London boroughs were then split into three equally sized groups, resulting in one CCG being split across groups.

Diversity, English language and deprivation: In the six boroughs where COVID-19 death rates were statistically higher than the London average:

- 3 are within the top 10 boroughs for ethnic diversity and all 3 (Brent, Newham and Harrow) are statistically higher than the London average for ethnic diversity.
- 5 are within the highest 10 boroughs for lower levels of English language and 3 (Brent, Newham and Haringey) are statistically higher than the London average for lower levels of English language.
- 4 are within the highest 10 boroughs for levels of deprivation and 3 (Newham, Hackney and Haringey) are statistically higher than the London average for deprivation.

Further discussion of the results

- Patients who described their overall experience of their GP practice as 'very' or 'fairly good' ranged from 71-85 per cent across CCGs in London. CCGs and their corresponding London boroughs have been placed in the table below in ascending order with the lowest level of satisfaction at the top and the greatest level of satisfaction at the bottom.
- In order to visualise any emerging patterns in the dataset, there are orange cells which indicate higher death rates from COVID-19, higher ethnic diversity, lower levels of English language and higher levels of deprivation. These are found towards the top of the table, in those boroughs where patients have a less positive experience of their GP practice.

  Conversely, the green cells – which indicate a lower death rate from COVID-19, lower ethnic diversity, higher levels of English language and lower levels of deprivation – are found towards the bottom of the dataset in those boroughs where patients have a more positive experience of their GP practice.
- Some CCGs cover individual borough areas (e.g. Waltham Forest or Hounslow). However, some CCGs are 'combined CCGs', covering more than one borough. These combined CCGs can cover a diverse range of London boroughs, for example the South East CCG has Lewisham, Southwark and Lambeth which have a range of orange cells, in contrast to Bexley and Bromley which are predominately green. It is important to recognise that this adds complexity to the patterns the dataset presents, but doesn't contradict it overall.

There are a number of apparent correlations in the data:

- An inverse correlation between GP satisfaction and COVID-19 death rate: the better the GP satisfaction the lower the COVID-19 related death rate.
- An inverse correlation between GP satisfaction and the ranking on the index of multiple deprivation: the greater the deprivation, the worse the GP satisfaction score.
- An inverse correlation between GP satisfaction and percentage of the population that is BAME: the better the GP satisfaction, the lower the BAME population.
- There is an inverse correlation between GP satisfaction and the lack of English language: the better the GP satisfaction, the lower the level of the population with no, or limited, English language.

Dr Tudor Hart, a GP from West Glamorgan, first described the "Inverse Care Law" in his seminal essay published in The Lancet 1971, which explains that those who most need medical care are least likely to receive it.[13] It still holds today, and the COVID-19 pandemic has highlighted the inequalities in our society.

The BAME community has been disproportionately affected because they are more exposed to the adverse social determinants of health. This leads them to have greater incidence of diabetes, cardiovascular disease, renal disease and poor mental health. They are also more likely to live in more overcrowded housing, poorer quality housing, poorer neighbourhoods and work in low-paid, public facing jobs.

GP workload is affected by deprivation of the area in which they work, which leads to poorer retention, recruitment and job satisfaction of the GPs in these areas.[14] This results in resource and workload pressures, leading to a lower level of patient satisfaction in GP services.[15] This is captured in our data by the self-declared experiences of Londoners.

Differences in GP satisfaction between ethnic groups

Additionally, further analysis demonstrates that across different ethnic groups there are significant discrepancies in reported patient satisfaction emerging from the results of the GP patient experience survey. Table 2 shows that across London BAME communities are consistently reporting a negative experience of care compared to their white counterparts. Those from a non-BAME background are consistently reporting a more positive experience of care.

[13] The King's Fund, Inverse Care law, June 2001
[14] The Health Foundation, A worrying cycle of pressure for GPs in deprived areas, May 2019
[15] Pulse, Patient satisfaction in GPs drops to record low levels as 'intense pressures' show, March 2019

	Percentage of total CCGs where the group were generally less satisfied	Number of CCG's where the group has above average experience of GPs	Number of CCG's where the group has below average experience of GPs
English / Welsh / Scottish / Northern Irish / British	11%	6	2
Irish	17%	13	3
Gypsy or Irish Traveller	NA	0	1
Any other White background	72%	0	13
White and Black Caribbean	41%	7	7
White and Black African	44%	7	7
White and Asian	39%	7	7
Any other Mixed / multiple ethnic background	50%	8	9
Indian	56%	1	10
Pakistani	61%	2	11
Bangladeshi	56%	4	10
Chinese	56%	2	10
Any other Asian background	61%	2	11
African	0%	13	0
Caribbean	17%	11	3
Any other Black / African / Caribbean background	24%	7	4
Arab	44%	2	7
Any other ethnic group	17%	3	3

Table 2: Breakdown by ethnicity of the proportion of CCG's reporting a statistically high or low value for overall GP experience compared with the London average.

Conclusion

Inequality of access to, and experience of, healthcare by BAME communities across London must be addressed and those responsible should be held accountable for driving action. It is widely acknowledged access to health and care for a diverse population is more than simply providing a service; it is about high quality and culturally competent services that enable people from all backgrounds to feel confident in accessing the care they need.[16]
It is vital that the Mayor drives further action, reports on and monitors issues of BAME groups' access to, and experience of healthcare services in London.

[16] The BMJ, Access to healthcare for ethnic minority populations, 2004

Methodology and Contributions

Data methodology and sources

Disparities in the risk and outcomes of COVID-19 are well documented. As well as age and gender there are noticeable disparities between those living in more deprived areas, compared to those in the least deprived areas and those in Black, Asian and Minority Ethnic (BAME) groups compared to those who are White.[17]

Public Health England's report *Beyond the data: Understanding the impact of COVID-19 on BAME groups,*[18] found that a lack of trust in healthcare services for many BAME groups lead to lower engagement with healthcare services, resulting in late diagnosis and worse outcomes from COVID-19.

To better understand how access to health services potentially impact COVID-19 outcomes, GP satisfaction data and nationally published statistics were juxtaposed to identify possible relationships. In October, GP satisfaction data, taken from the NHS GP Patient Survey,[19] was used as a proxy for 'experience' of health services. Whilst GPs only represent one part of London health care services, they deal with patients in the first instance and function as a gateway to other NHS services.

The other indicators used were:

- Rate of COVID-19 deaths for the 5-month period of March 2020 to July 2020, ONS[20]
- Percentage of BAME residents, 2011 Census[21]
- Percentage of residents who do not speak English 'well' or 'at all', 2011 Census[22]
- Index of Multiple Deprivation: percentage of population living in the most deprived LSOAs in the country, LG Inform[23]

[17] Public Health England, Disparities in the risk and outcomes of COVID-19, August 2020
[18] Public Health England, Beyond the data: Understanding the impact of COVID-19 on BAME groups, June 2020
[19] GP Patient Survey Q31. Overall, how would you describe your experience of your GP practice?
[20] ONS, Deaths involving COVID-19 by local area and socioeconomic deprivation: deaths occurring between 1 March and 31 July 2020, August 2020
[21] Nomis, Census Statistics, 2011
[22] Nomis, Census Statistics, 2011
[23] LG Inform, IMD - Overall - extent (%) in London

'Outliers' or values which were statistically above or below the London average were calculated and colour coded according to their value:

- Dark orange: Statistically worse than the London average (e.g. COVID-19 rate) and statistically higher than the London average (e.g. percentage of BAME residents)
- Light orange: Within the worst or highest ten
- White: Are neither statistically different from the average, nor in the top or bottom ten
- Light green: Within the best or lowest ten
- Dark green: Statistically better than the London average and statistically lower than the London average.

It should be noted that not all indicators have a 'polarity', i.e. high or low values are not inheritably good or bad. For the purpose of investigating links between ethnicity and language with GP satisfaction orange has been used for high instances but do not infer a negative.

The Health Committee's investigation

Over the course of the summer of 2020 the Health Committee investigated the impacts of COVID-19 on the lives of Londoners during the first wave of the pandemic. The investigation comprised of two Committee meetings and a call for evidence.

The first Committee meeting, held in June, heard from an expert panel of guests and examined the immediate impact of COVID-19 on London's population and health and care workforce.

- Professor Kevin Fenton, PHE London Regional Director and Statutory Health Advisor to the Mayor
- Dr Vin Diwakar, NHS Regional Medical Director for London
- Dr Chaand Nagpaul, Chair of the Council of the British Medical Association
- Lisa Elliott, London Regional Director, Royal College of Nursing
- Gavin Edwards, Senior National Officer – Social Care, UNISON

To build our understanding of the effect of COVID-19 on London's health and social care workforce, we also received written submissions from the following medical organisations:

- London Regional Council, British Medical Association
- The Faculty of Intensive Care Medicine
- The Royal College of Obstetricians and Gynaecologists
- Royal College of Physicians
- Royal College of Pathologists

The second Committee meeting was split into two parts. In the first, we focused in more depth on the experiences of BAME Londoners, with particular attention on the issues of racism, stigma, discrimination, fear and trust. Evidence was provided by:

- Dr Somen Banerjee, Director of Public Health, London Borough of Tower Hamlets
- Professor Gurch Randhawa, Professor of Diversity in Public Health & Director of the Institute for Health Research, University of Bedfordshire

In the second part we looked at the effects of lockdown on Londoner's mental health, supplemented by additional evidence and views from Talk London Respondents. We heard from:

- Vicki Nash, Head of Policy and Campaigns, Mind
- Lynette Charles, the CEO of Mind in Haringey
- Nikki Morris, Chief Executive Officer of Age UK Camden
- Sarah MacFadyen, Head of Policy and External Affairs, British Lung Foundation and Asthma UK

Other formats and languages

If you, or someone you know needs this report in large print or braille, or a copy of the summary and main findings in another language, then please call us on: 020 7983 4100 or email assembly.translations@london.gov.uk

Chinese

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Email 与我们联系。

Hindi

यदि आपको इस दस्तावेज का सारांश अपनी भाषा में
चाहिए तो उपर दिये हुए नंबर पर फोन करें या उपर दिये
गये डाक पते या ई मेल पते पर हम से संपर्क करें।

Vietnamese

Nếu ông (bà) muốn nội dung văn bản này được dịch sang tiếng Việt, xin vui lòng liên hệ với chúng tôi bằng điện thoại, thư hoặc thư điện tử theo địa chỉ ở trên.

Bengali

আপনি যদি এই দলিলের একটা সারাংশ নিজের ভাষায় পেতে চান, তাহলে দয়া করে ফো করবেন অথবা উল্লেখিত ডাক ঠিকানায় বা ই-মেইল ঠিকানায় আমাদের সাথে যোগাযোগ করবেন।

Greek

Εάν επιθυμείτε περίληψη αυτού του κειμένου στην γλώσσα σας, παρακαλώ καλέστε τον αριθμό ή επικοινωνήστε μαζί μας στην ανωτέρω ταχυδρομική ή την ηλεκτρονική διεύθυνση.

Urdu

اگر آپ کو اس دستاویز کا خلاصہ اپنی زبان میں
درکار ہو تو، براہ کرم نمبر پر فون کریں
یا مذکورہ بالا ڈاک کے پتے یا ای میل
پتے پر ہم سے رابطہ کریں۔

Turkish

Bu belgenin kendi dilinize çevrilmiş bir özetini okumak isterseniz, lütfen yukarıdaki telefon numarasını arayın, veya posta ya da e-posta adresi aracılığıyla bizimle temasa geçin.

Arabic

الحصول على ملخص لهذا المستند بلغتك،
فرجاء الاتصال برقم الهاتف أو الاتصال على
العنوان البريدي العادي أو عنوان البريد
الإلكتروني أعلاه.

Punjabi

ਜੇ ਤੁਸੀਂ ਇਸ ਦਸਤਾਵੇਜ਼ ਦਾ ਸੰਖੇਪ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਲੈਣਾ ਚਾਹੋ, ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਇਸ ਨੰਬਰ 'ਤੇ ਫ਼ੋਨ ਕਰੋ ਜਾਂ ਉਪਰ ਦਿੱਤੇ ਡਾਕ ਜਾਂ ਈਮੇਲ ਪਤੇ 'ਤੇ ਸਾਨੂੰ ਸੰਪਰਕ ਕਰੋ।

Gujarati

જો તમારે આ દસ્તાવેજનો સાર તમારી ભાષામાં
જોઈતો હોય તો ઉપર આપેલ નંબર પર ફોન કરો
અથવા ઉપર આપેલ ટપાલ અથવા ઈ-મેઈલ સરનામા
પર અમારો સંપર્ક કરો.

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HEALTH COMMITTEE BRIEFING

Lessons learned from the first wave of COVID-19: The importance of a community-led approach

Executive summary

Local areas know their communities best and know how to reach them most effectively. To minimise the impacts on the most vulnerable and worst affected communities, London needs culturally competent messaging, delivered by trusted figures who best represent and understand the diversity of their locality. Culturally competent messaging will help increase awareness of, and engagement with, COVID-19 measures and the test and trace system.

Appropriately delivered messaging will also help businesses to adopt the necessary safety measures and minimise the risk of local outbreaks, but local authorities also require adequate capacity to take enforcement action when these safety measures are not adhered to. Effective community action requires local authorities to be well resourced.

The London Assembly Health Committee has investigated what lessons must be learned from the first wave of COVID-19 by consulting experts, calling for evidence, and undertaking research, to understand how to best support London through the ongoing pandemic.

Key findings

- Local infrastructure, such as links into communities, and adequate financial and personnel resource are required to most effectively deliver culturally competent public health messaging to communities across London, and coordinate efforts on test, trace and isolate.
- Local authorities in London have varying capacity to deliver public health enforcement measures, with implications for the management of community outbreaks.

Recommendation

- The Mayor to advocate on behalf of London boroughs to ensure that local authorities are adequately financially resourced and have equal ability to implement necessary local measures across London, including:

  a. To deliver culturally competent messaging to communities and businesses;
  b. To implement local enforcement measures where necessary.

Lessons learned from the first wave of COVID-19: The importance of a community-led approach

Accountability and timeliness

Throughout the Health Committee's investigation, we explored in more detail the findings from Public Health England's report *"Beyond the data: Understanding the impact of COVID-19 on BAME groups."*[1] Our investigation heard repeatedly that accountability for the urgent delivery of actions across all aspects of the COVID-19 response is vital to address the disproportionate health impact of COVID-19 on BAME groups, coordinated across levels of governance and with measurable outcomes.

We therefore include the following accountability and timeliness recommendations alongside all other recommendations made by the investigation:

- There need to be clear lines of **accountability** for the delivery of all recommendations in PHE's report *"Beyond the data: Understanding the impact of COVID-19 on BAME groups"*.[2] Adequate resource is also required to ensure delivery.

"The report is silent on accountability"

(Professor Gurch Randhawa, Professor of Diversity in Public Health & Director of the Institute for Health Research, University of Bedfordshire)[3]

- Action on the recommendations needs to be urgently taken forward across **coordinated across all levels**: national, regional and local.

"There are some really key messages at an NHS London level to which it may need to at least feel itself to be accountable across the system. From an NHS London perspective, it needs to be speaking to the mental health trust, the acute trusts and GPs and asking them what they are doing in response to the recommendations."

(Dr Somen Banerjee, Director of Public Health, London Borough of Tower Hamlets)[4]

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[1] Public Health England, Beyond the data: Understanding the impact of COVID-10 on BAME groups, 16 June 2020

[2] Public Health England, Beyond the data: Understanding the impact of COVID-10 on BAME groups, 16 June 2020

[3] London Assembly Health Committee, COVID-19: The Experiences of BAME Londoners, Page 15, 11 August 2020

[4] London Assembly Health Committee, COVID-19: The Experiences of BAME Londoners, Page 15, 11 August 2020

- The recommendations presented by PHE's report are not new. They represent known issues related to health inequalities, ethnicity, social class, age and gender. This time **measurable** action, not just words and reports, is required.

"I am quite simplistic around this. If you look at this across London, a very valid question for every key public sector organisation is about what it is doing in response to these recommendations and to have some kind of accountability around that. It would be perfectly reasonable for us as a Council to be asked, "There was this very powerful report in June [2020]. What are you doing around these recommendations?"

(Dr Somen Banerjee, Director of Public Health, London Borough of Tower Hamlets)[5]

[5] London Assembly Health Committee, COVID-19: The Experiences of BAME Londoners, Page 14, 11 August 2020

The importance of a community-led approach

A community-led response is critical to effectively responding to the pandemic. There is a very clear and important role for local authorities to play in ensuring the delivery of tailored and effective public health messaging, coordination of the test and trace system, and engagement with local businesses and premises to ensure compliance with COVID-19 measures and regulations. Throughout the investigation the Committee heard that a prevention-led approach is key in order to most effectively minimise the transmission of the virus. In order to ensure prevention of transmission, action needs to be taken quickly. The Committee heard from Professor Kevin Fenton, Regional Director of Public Health England (PHE), that local intelligence and insight enables areas to respond quickly to the virus, and in areas with low incidence it can help to prevent an increase in cases.

"There is definitely a case for localised action plans. If you look at all the World Health Organization pandemic guidance, it always talks about localised action plans." (**Professor Gurch Randhawa Professor of Diversity in Public Health; and Director of the Institute for Health Research, University of Bedfordshire)**[6]

Cultural competence

London has one of the most ethnically diverse populations in the UK. London is home to 60 per cent of Black residents of England and Wales and 50 per cent of the Bangladeshi population.[7] According to the 2011 census, there are over 80 different languages spoken as a first language in the capital.[8] The city has the highest proportion of non-UK born residents, at 37 per cent. In 2018 in one local authority – Brent - over half (52 per cent) of the population was born outside of the UK. Kensington and Chelsea, Westminster, and Harrow all had just under half (49 per cent) of the population not born in the UK.[9]

During the investigation, we heard that public health messaging must be culturally competent if it is to be successful at reaching London's diverse communities. Cultural competency is a widely acknowledged aspect of successful public health messaging, and refers to the idea that messaging must reflect the wider communities it serves. However, despite its importance, a lack of culturally competent and targeted messaging was cited as a core issue during the first wave of the COVID-19 pandemic. Professor Kevin Fenton, Regional Director of Public Health England, pointed out that many communities felt left behind during the pandemic as messaging had not been adequately tailored to meet their needs. We heard that, in part, this was due to the speed at which areas

[6] London Assembly Health Committee, COVID-19: The Experiences of BAME Londoners, Page 3, 11 August 2020

[7] Public Health England, Beyond the data: Understanding the impact of COVID-10 on BAME groups, 16 June 2020

[8] London Datastore, Main Language Spoken at Home (Census) Borough, 2011

[9] ONS, Population of the UK by country of birth and nationality: 2019, 2019

needed to respond in the first wave.[10] Professor Gurch Randhawa, Professor of Diversity in Public Health; and Director of the Institute for Health Research, University of Bedfordshire, also reflected that culturally competent messaging plays a vital role in improving health outcomes.[11]

Community groups and Black and Minority Ethnic (BAME) individuals, engaged by PHE, highlighted that people receive and process national messages differently and that not all have the same means to apply these messages in the same way. For example, PHE's research cited that digital communication is efficient and easy to use but does not reach all vulnerable groups. Certain groups, such as the elderly, those with mental health issues, and certain cultural or faith-based communities, including Orthodox Jews, may be excluded.[12] A survey conducted by the Runnymede trust demonstrates the effect of this between the BAME and white population. The findings show that while just under nine in ten white people (87 per cent) had heard of the request for people to 'Stay Home, Protect the NHS, Save Lives', the proportion among BAME people was seven in ten (69 per cent).[13] The same is true for the request to 'Stay Alert, Control the Virus, Save Lives' (84 per cent vs 66 per cent).[14] Culturally competent messaging, therefore, will be particularly important going forward in London's cultural context, as engagement with testing and contact tracing will be key to controlling the virus.

Recommendations put forward by the Public Health England report, *"Beyond the data, Understanding the impact of COVID-19 on BAME groups"*, highlight important aspects of culturally competent communications. These include:

- Including culturally specific imagery and content in all communication and marketing;
- Using voices of communities with lived experiences to shape public messaging;
- Working with community and faith leaders to develop a communication plan to mitigate the fears and stigma in communities arising from media headlines around BAME and COVID-19.[15]

During our investigation, the Committee heard examples of the work undertaken to ensure communications were accessible to all Londoners:

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[10] London Assembly Health Committee, COVID-19: London's Response, Inequalities, and the Health and Care Workforce, Page 7, 25 June 2020

[11] London Assembly Health Committee, COVID-19: The Experiences of BAME Londoners, Page 9 ,11 August 2020

[12]PHE: Beyond the data: Understanding the impact of COVID-19 on BAME groups. 16 June 2020

[13] The Runnymede trust, Over-Exposed and Under-Protected, The Devastating Impact of COVID-19 on Black and Minority Ethnic Communities in Great Britain, August 2020

[14] Ibid

[15] Public Health England, Beyond the data: Understanding the impact of COVID-10 on BAME groups, 16 June 2020

"In Tower Hamlets we use Channel S to transmit the messages in Sylheti. Also, we work with the Somali community and other communities. The experience that I have had is that the sorts of mechanisms that really work are very simple."
(Dr Somen Banerjee Director of Public Health, London Borough of Tower Hamlets)[16]

As highlighted by the experience of Dr Somen Banerjee, Director of Public Health in Tower Hamlets, cultural and religious customs can also influence how messaging is received and understood:
"I guess, from my perspective as a Director of Public Health, I worry a lot about the groups that I am not engaging with. We do a lot of work with faith leaders and we do a lot of work with workplaces, but I worry about small mosques that may be struggling to implement social distancing and for whom the messaging may not be getting across."
(Dr Somen Banerjee Director of Public Health, London Borough of Tower Hamlets)[17]

As Table 1 shows, in London there are a significant number of people who practice a religion. Targeted messaging, and utilising faith leaders, can therefore be a critical way to help ensure that guidance can be understood and applied to protect certain communities.

Religion	Approximate number of London residents
Christian	3.4 million
Buddhist	76,000
Hindu	457,000
Jewish	198,000
Muslim	1.25 million
Sikh	126,000
Any other religion	200,000

Table 1: ONS data, Breakdown of London population by religion in 2018[18]

Overall the right approach needs to be taken to understand how people receive messages, ensure accessibility of the message in multiple languages, and identify how cultural customs and individual faiths interact with people's ability to understand and apply public health messaging. Local authorities are vital in ensuring messages are culturally competent; they know and understand their communities, and can work with community leaders to disseminate culturally competent messaging.
"All our engagement work essentially says that people trust people from their own communities. What that means is that we need to work with those communities, and we need to educate and train people and have very simple messages that can be disseminated through the communities. It

[16] London Assembly Health Committee, COVID-19: The Experiences of BAME Londoners, Page 3, 11 August 2020
[17] London Assembly Health Committee, COVID-19: The Experiences of BAME Londoners, Page 3, 11 August 2020
[18] ONS, Population by Religion, Borough, 2018

is not necessarily us in the council, although through this process we have had a role around very direct communication with faith leaders and all sorts of groups across the community, but what we really need to do is build that capacity within the communities so that there are trusted people who can disseminate clear messages."
(Dr Somen Banerjee Director of Public Health, London Borough of Tower Hamlets)[19]

"They know their local communities. They would know how to mobilise the local communities. They would know how to develop tailored messaging. They would be able to put that infrastructure in place."
(Professor Gurch Randhawa, Professor of Diversity in Public Health; and Director of the Institute for Health Research, University of Bedfordshire)[20]

Local authorities also play a fundamental role in ensuring that national messages are aligned across London, which is particularly important given the speed at which national messages continually evolve. We heard that new information must be communicated in multiple languages with community disseminators and be best tailored to individual communities. Messages always need to be localised, so that they can be most effectively applied within diverse communities.

Furthermore, we heard the importance of building trust within communities to ensure messages can be taken forward. It is vital that local communities feel they are being listened to for the messages to be heard.

"Listening to communities is absolutely fundamental. Over the past few months we have had a lot of sessions with a whole range of diverse groups across Tower Hamlets and we hear things that indicate that the messages have not been taken forward or not been understood and also that people do not feel listened to. Therefore, that whole process of sitting down and listening and shaping your response in response to what you are hearing develops trust."
(Dr Somen Banerjee, Director of Public Health, London Borough of Tower Hamlets)[21]

It is imperative moving forward that messages must be targeted, and sensitive, to the local realities in which certain vulnerable and at-risk communities face. As such, the Committee believes that local authorities must have the resources and ability to effectively deliver culturally competent messaging to London's diverse communities in order to increase engagement with, and awareness of, COVID-19 national guidance.

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[19] London Assembly Health Committee, COVID-19: The Experiences of BAME Londoners, Page 5 , 11 August 2020
[20] London Assembly Health Committee, COVID-19: The Experiences of BAME Londoners, Page 4, 11 August 2020
[21] London Assembly Health Committee, COVID-19: The Experiences of BAME Londoners, Page 9 , 11 August 2020

Enforcement

Local authorities can shut down events and premises if they deem that they pose a threat to public health.[22] However, we heard that whilst enforcement is an important measure, it should not be utilised immediately. Firstly, it is important to give culturally competent and tailored information and then offer tailored support. Local environmental health and trading standards officers are required to assess and support local businesses to implement COVID-19 guidance. If guidance is still not adhered to, then enforcement to close premises may be the safest option to protect public health. However, currently boroughs do not all have equal capacity to deliver these measures:

"The capacity for enforcement across London varies a lot. Different boroughs have different levels of environmental health officers and trading standards officers. One of the issues that may manifest if there is a second wave is the varying ability of councils to respond to local outbreaks. If there is a need for quite an intensive local response alongside PHE and there is a need to go out into community settings to implement enforcement, what you are likely to find is that that capacity is going to be different in different boroughs and so the ability to respond may vary."
(Dr Somen Banerjee Director of Public Health, London Borough of Tower Hamlets)[23]

It is therefore vital that the Mayor should advocate on behalf of London boroughs to ensure that local authorities have equal and necessary financial resource to implement local enforcement measures where necessary, to ensure the protection of local communities.

[22]Department for Health and Social Care (DHSC), Local authority powers to impose restrictions: Health Protection (Coronavirus, Restrictions) (England) (No.3) Regulations 2020, 12 October 2020

[23] London Assembly Health Committee, COVID-19: The Experiences of BAME Londoners, Page 7, 11 August 2020

Methodology and contributions

Over the course of the summer of 2020 the Health Committee investigated the impacts of COVID-19 on the lives of Londoners during the first wave of the pandemic. The investigation comprised of two Committee meetings and a call for evidence.

The first Committee meeting, held in June, heard from an expert panel of guests and examined the immediate impact of COVID-19 on London's population and health and care workforce.

- Professor Kevin Fenton, PHE London Regional Director and Statutory Health Advisor to the Mayor
- Dr Vin Diwakar, NHS Regional Medical Director for London
- Dr Chaand Nagpaul, Chair of the Council of the British Medical Association
- Lisa Elliott, London Regional Director, Royal College of Nursing
- Gavin Edwards, Senior National Officer – Social Care, UNISON

To build our understanding of the effect of COVID-19 on London's health and social care workforce, we also received written submissions from the following medical organisations:

- London Regional Council, British Medical Association
- The Faculty of Intensive Care Medicine
- The Royal College of Obstetricians and Gynaecologists
- Royal College of Physicians
- Royal College of Pathologists

The second Committee meeting was split into two parts. In the first, we focused in more depth on the experiences of BAME Londoners, with particular attention on the issues of racism, stigma, discrimination, fear and trust. Evidence was provided by:

- Dr Somen Banerjee, Director of Public Health, London Borough of Tower Hamlets
- Professor Gurch Randhawa, Professor of Diversity in Public Health & Director of the Institute for Health Research, University of Bedfordshire

In the second part we looked at the effects of lockdown on Londoner's mental health, supplemented by additional evidence and views from Talk London Respondents. We heard from:

- Vicki Nash, Head of Policy and Campaigns, Mind
- Lynette Charles, the CEO of Mind in Haringey
- Nikki Morris, Chief Executive Officer of Age UK Camden
- Sarah MacFadyen, Head of Policy and External Affairs, British Lung Foundation and Asthma UK

Lessons learned from the first wave of COVID-19: The importance of a community-led approach

Health Committee

About the London Assembly Health Committee

The London Assembly is the 25-member elected body that represents Londoners and holds the Mayor to account. The Health Committee reviews health and wellbeing issues for Londoners, particularly public health issues. It also keeps a close eye on how well the Mayor's Health Inequalities Strategy is doing.

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LONDONASSEMBLY

HEALTH COMMITTEE BRIEFING

Lessons learned from the first wave of COVID-19: Supporting Londoners' mental health

Executive summary

The first wave of the pandemic had a significant impact on Londoners' mental health. In addition to pre-existing mental health issues worsening, many people reported experiencing new mental health issues for the first time as a direct result of the pandemic. As the pandemic evolves, experts have warned that Londoners must build mental and physical resilience to the pandemic if the overall impacts of the virus on individual health are to be mitigated. In the first wave, mental health service provision was affected by measures put in place to control the spread of the virus. Given the profound impacts on individuals' mental health during the first wave, there is a need for increased mental health support moving forward. The challenges for Londoners will continue in the months ahead. It must be an urgent priority of the Mayor's recovery plans to ensure that Londoners' mental health is a point of focus.

The London Assembly Health Committee has investigated what lessons must be learned from the first wave of COVID-19 by consulting experts, calling for evidence, and undertaking research, to understand how to best support London through the ongoing pandemic.

Key findings

- The COVID-19 pandemic, and the lockdown, has had significant and widespread mental health effects for Londoners.
- Many of those who continue to shield are facing economic hardship, and as a result their mental health is suffering.
- As the pandemic continues, there needs to be adequate community resource for people to access mental health support locally.

Recommendations

- The Mayor must advocate for those who will be unable to return to work due to their pre-existing health and mental health conditions, to ensure they are financially supported.
- The Mayor should ensure that that mental health is at the heart of London's recovery. This includes working with mental health charities and organisations in the ongoing pandemic response and future recovery work, and working with partners to ensure improved access to mental health pathways for both digital and face-to-face services.

Accountability and timeliness

Throughout the Health Committee's investigation, we explored in more detail the findings from Public Health England's report *"Beyond the data: Understanding the impact of COVID-19 on BAME groups."*[1] Our investigation heard repeatedly that accountability for the urgent delivery of actions across all aspects of the COVID-19 response is vital to address the disproportionate health impact of COVID-19 on BAME groups, coordinated across levels of governance and with measurable outcomes.

We therefore include the following accountability and timeliness recommendations alongside all other recommendations made by the investigation:

- There need to be clear lines of **accountability** for the delivery of all recommendations in PHE's report *"Beyond the data: Understanding the impact of COVID-19 on BAME groups"*.[2] Adequate resource is also required to ensure delivery.

"The report is silent on accountability"

(Professor Gurch Randhawa, Professor of Diversity in Public Health & Director of the Institute for Health Research, University of Bedfordshire)[3]

- Action on the recommendations needs to be urgently taken forward across **coordinated across all levels**: national, regional and local.

"There are some really key messages at an NHS London level to which it may need to at least feel itself to be accountable across the system. From an NHS London perspective, it needs to be speaking to the mental health trust, the acute trusts and GPs and asking them what they are doing in response to the recommendations."

(Dr Somen Banerjee, Director of Public Health, London Borough of Tower Hamlets)[4]

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[1] Public Health England, Beyond the data: Understanding the impact of COVID-10 on BAME groups, 16 June 2020

[2] Public Health England, Beyond the data: Understanding the impact of COVID-10 on BAME groups, 16 June 2020

[3] London Assembly Health Committee, COVID-19: The Experiences of BAME Londoners, Page 15, 11 August 2020

[4] London Assembly Health Committee, COVID-19: The Experiences of BAME Londoners, Page 15, 11 August 2020

- The recommendations presented by PHE's report are not new. They represent known issues related to health inequalities, ethnicity, social class, age and gender. This time **measurable** action, not just words and reports, is required.

"I am quite simplistic around this. If you look at this across London, a very valid question for every key public sector organisation is about what it is doing in response to these recommendations and to have some kind of accountability around that. It would be perfectly reasonable for us as a Council to be asked, "There was this very powerful report in June [2020]. What are you doing around these recommendations?"

(Dr Somen Banerjee, Director of Public Health, London Borough of Tower Hamlets)[5]

[5] London Assembly Health Committee, COVID-19: The Experiences of BAME Londoners, Page 14, 11 August 2020

How has COVID-19 affected people's mental health?

The disruption to daily life, caused both by the pandemic itself and the subsequent lockdown restrictions, has caused many Londoners to develop mental ill-health for the first time, and for others with existing conditions their mental ill-health has worsened.[6]

Recent research on the impact of COVID-19 and lockdown has identified a disproportionate impact on particular groups of people. Mental health effects have been particularly pronounced for:[7]

- People living with mental health problems, whose access to services has been interrupted;
- People who live with both mental health problems and long-term physical conditions that put them at greater risk of the virus;
- Older adults who are both susceptible to the virus themselves and much more likely than others to lose partners and peers;
- Women and children exposed to trauma and violence at home during lockdown;
- People from ethnic groups where the prevalence of COVID-19 has been highest and outcomes have been the worst, notably people from Black British, Black African, Bangladeshi and Pakistani backgrounds.

According to Londoners' contributions to TalkLondon, an online community for Londoners to share their views on key issues, and experts that the Health Committee heard evidence from, there were several factors that have exacerbated mental ill-health throughout the lockdown period.

Living arrangements and outside space

Londoners who live in shared accommodation have felt isolated as, in some arrangements, they are living with strangers. Others don't have enough inside or outside space, which heightened anxieties during the lockdown.

One TalkLondon respondent said: *"I've been finding it a real struggle. I'm in a flatshare but not close to my flatmates. One of them is a key worker - although I'm proud of her and she's doing vital work, this has meant that my anxiety has increased dramatically and I feel like shared areas are no longer safe."* (Talk London Member, Female, 25-34, White British from Lewisham)

Londoners living alone in small flats have found it particularly difficult during lockdown. This has included both elderly and young Londoners, who may live alone in small flats for different reasons.

One TalkLondon respondent said: *"What has actually been taking a toll on my mental health is living alone in a studio flat with vacancies on both sides of me and no garden. Phone calls to my girlfriend and mates have been good but since they're all on the other side of the city it's been pretty isolating."* (Talk London Member, Male, 25-34, Any other white background from Haringey)

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[6] British Medical Association, The impact of covid-19 on mental health in England: Supporting services to go beyond parity of esteem, July 2020

[7] Centre for Mental Health: Covid-19: understanding inequalities in mental health during the pandemic. June 2020

This issue has also been identified by the National Housing Federation, which has recently published analysis suggesting that "nearly one third (31 per cent) of adults in Britain had mental or physical health problems because of the condition of, or lack of space in, their home during lockdown".[8]

The lack of private outdoor space and the closure of public spaces has exacerbated the mental health issues associated with reduced physical activity.

One TalkLondon respondent said: *"It would be good if large organisations like Kew Gardens and the National Trust opened their grounds for people to walk and if the police didn't make it hard for people to get green exercise by shutting parks and carparks in parks. [It is] very bad for people's mental and physical health."* (Talk London Member, Male, over 65, White British from Hammersmith & Fulham)

The London Assembly Housing Committee surveyed Londoners in August, finding that 14 per cent of respondents wanted to leave the city as a result of the pandemic, 33 per cent wanted to move to a new home, and that private outdoor space and proximity to parks and public gardens have become increasingly important factors for Londoners when thinking about their living situation.[9]

Communication

During the first wave of the pandemic, the criteria for which groups needed to shield due to an existing health problem was unclear. A lack of clear communication on this issue resulted in worsening of people's anxieties.

"If we are going to be asking people with serious long-term health conditions to start shielding again, we have got an opportunity to do a much better job of it. What we found the first time around was there was very little clarity as to who should be on the shielded patients' list. We were given very broad categories by the NHS, but that did not account for the very significant differences between different medications that people are taking and different severity levels of their illness."

(Sarah MacFadyen, Head of Policy and External Affairs, British Lung Foundation and Asthma UK)[10]

In addition, we heard that those with chronic health conditions experienced mental health effects due to fears about the impact that COVID-19 could have on their physical health. As the pandemic evolves, communication regarding vulnerable individuals needs to improve so they feel more assured in leaving the house, knowing that appropriate measures are in place to keep them safe.

[8] National Housing Federation, Housing issues during lockdown: health, space and overcrowding, August 2020.

[9] London Assembly Housing Committee, Half of Londoners wanting to move home want out of London, August 2020

[10] London Assembly Health Committee, COVID-19 The Effect of Lockdown on Londoners, Page 3, August 2020.

"Something that would help people feel more reassured would be more communications and messaging going out about the things that are being done which will make them safer when they are out in the community, whether that be messages about social distancing and reinforcing the need to wear masks in appropriate places, or communications aimed at the general population in London, to make sure people understand that there still are people who are at high risk and therefore that is why we all need to be taking these steps to look after each other. That would be helpful and would reassure people that their condition is still being taken seriously."

(Sarah MacFadyen, Head of Policy and External Affairs, British Lung Foundation and Asthma UK)[11]

Financial concerns

People with long-term chronic illness, both physical and mental, may need to remain at home indefinitely. We heard that these people are suffering economic hardship, as a result can be emotionally vulnerable, and that the Government needs to offer these people support.

"From the Government's point of view, we all know that there is likely to be a small number of people who just cannot go back to the job they were doing before. Examples of that could be jobs where there is a lot of customer-facing or public-facing contact, possibly some healthcare workers who could be exposed to a lot of infected people. There is a real gap there in the Government's plans around what will actually happen to those people when the furlough scheme comes to an end in October [2020]."

(Sarah MacFadyen, Head of Policy and External Affairs, British Lung Foundation and Asthma UK)[12]

It is vital that the Mayor advocates on behalf of those who will be unable to return to work in the near future due to their pre-existing condition, to ensure they are financially supported.

Access to services

We heard that during lockdown people were not accessing mental health support through existing pathways such as Improving Access to Psychological Therapy (IAPT) services or Child and Adolescent Mental Health Services (CAMHS). Referrals had decreased although need had increased.[13] In particular, concerns were raised about the coordination between hospitals and community mental health provision. Ahead of the first wave, patients were discharged from hospital settings with no apparent mental health support available in the community. As the

[11] London Assembly Health Committee, COVID-19 The Effect of Lockdown on Londoners, Page 10, August 2020

[12] London Assembly Health Committee, COVID-19 The Effect of Lockdown on Londoners, Page 4, August 2020

[13] London Assembly Health Committee, COVID-19 The Effect of Lockdown on Londoners, page 2, August 2020

pandemic evolves there needs to be adequate community resource for people to access mental health support locally.

"We saw a lot of people essentially thrown out of hospital into the community, but the community services, there was hardly anything left [of them] because the staff had been pulled out to go and work in the acute trusts and the services had pretty much closed down in some areas. If we are going to remove people from hospitals because we want to avoid them catching COVID, we have to make sure the community support is there."

(Vicki Nash, Head of Policy and Campaigns, Mind)[14]

As one Talk London respondent told us there were issues surrounding their access to support services during the lockdown.

"I suffer from severe depression and anxiety, have tried suicide twice over the years and since I am not able to visit people, not allowed on public transport or to go anywhere unless it's absolutely vital I am basically housebound. I can't walk far due to a severely damaged spine and fibromyalgia so can't go anywhere without severe pain. There is no mental health help available to physically see anyone except A&E who are probably busier than usual." (Talk London Member, Male, 44-54, White British from Richmond Upon Thames)

Throughout the pandemic, a shift to digital healthcare services has been necessary to enable people to continue to access the services they need safely.[15] However, we heard that access to mental healthcare services online will not always be the best option, as people experiencing mental health issues, particularly severe or significant ones, often need multiple options for accessing these types of services. Those who are already digitally excluded will fall out of contact with the vital services they need.[16] Londoners, through the Talk London forum, proposed that there should be greater access to face-to-face mental health support services, recognising that many people will benefit more from face-to-face support and may have personal living circumstances that make online and telephone support impossible.[17]

As one Talk London respondent expressed, there are multiple factors that undermine the value of accessing mental health services online.

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[14] London Assembly Health Committee, COVID-19 The Effect of Lockdown on Londoners, page 2, August 2020.

[15] Healthcare IT News, Riding the digital wave through COVID-19, August 2020

[16] Centre for Mental Health, Covid-19: understanding inequalities in mental health during the pandemic, June 2020

[17] Talk London Respondent

"I think there should be places in the community where people can go to access talking therapies e.g. pods or a room which is cleaned often. Many people are experiencing [mental health] issues exacerbated by their living situation, and are being put off by the idea that any phone or video call talking therapy - in which they would have to talk about the issues with their living situation and how that is impacting their [mental health] - would take place in the very space (and with the same people) they might end up talking about." (Talk London Member, Female, 25-34, White British from Wandsworth)

Older people's mental health

We heard that there is a longstanding attitude that older people will inevitably suffer from poor mental health due to physical illness, isolation and bereavement as they get older. This should not be seen as an inevitability and must be addressed.

"In society, we often think that mental distress is normal in ageing, and that needs to be changed. It is not normal in ageing, and people need to access mental health services in the same way they would do at any other age." **(Nikki Morris, Chief Executive Officer, Age UK Camden)**[18]

As one Talk London respondent noted: *"I can't tell the effect this is having on the mental health of tens of thousands seniors in the capital. We volunteer when we can, but we feel locked away and forgotten. We are very careful when we go out, but very frightened as designated the most in danger. I cry every day."* (Talk London Member, Female, over 65, White British from Islington")[19]

Putting mental health at the heart of the recovery

Mental health charity Mind stated in June that mental health must be at the centre of recovery plans,[20] and in the Health Committee's meeting, Professor Kevin Fenton highlighted the importance of building people's physical and mental resilience ahead of a second wave of infection. It is critical, therefore, that mental health remains a core priority throughout the ongoing pandemic response and future recovery work in London.

We heard about the critical role which the charity sector played in responding to a rise in mental health related problems during the first wave. The third sector organisations that gave evidence to our investigation stated that they had not been involved in any discussions related to London's recovery. The Committee welcomes and recognises the Health Equity sub-group of the London Health Board, which has been set up to focus London's recovery efforts. It is reassuring to see that

[18] London Assembly Health Committee, COVID-19 The Effect of Lockdown on Londoners, page 2, August 2020

[19] Talk London Respondent

[20] Mind: The mental health emergency. June 2020

one of its key recovery missions will focus on mental health and wellbeing.[21] The Mayor, who chairs the London Health Board, should ensure that mental health charities and organisations are included in the ongoing pandemic response and future recovery work.

[21] London Assembly, Agenda Health Committee, item 6: Mayor's response to Health Inequalities Strategy letter, 20th, October 2020.

Methodology and Contributions

Over the course of the summer of 2020 the Health Committee investigated the impacts of COVID-19 on the lives of Londoners during the first wave of the pandemic. The investigation comprised of two Committee meetings and a call for evidence.

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- Lynette Charles, the CEO of Mind in Haringey
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Lessons learned from the first wave of COVID-19: Supporting Londoners' mental health

Health Committee

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LONDONASSEMBLY

HEALTH COMMITTEE BRIEFING

Lessons learned from the first wave of COVID-19: Protecting London's health and care workforce

Executive summary

Existing pressures on the NHS and social care in London were exacerbated throughout the first wave of the COVID-19 pandemic. Many staff reported feeling that they weren't adequately protected to deliver care. Disproportionate outcomes for Black and Minority Ethnicity (BAME) employees, which make up 48 per cent of London's health and social care workforce,[1] became apparent within weeks of the pandemic.

The London Assembly Health Committee has investigated what lessons must be learned from the first wave of COVID-19 by consulting experts, calling for evidence, and undertaking research, to understand how to best support London through the ongoing pandemic.

Key findings

- There were issues with personal protective equipment (PPE) across all professions, including the amount, type, and consistency of supply of PPE.
- Systemic discrimination within the health and care workforce is (at least partly) responsible for the disproportionately poor health outcomes for BAME health and care workers.
- There were considerable issues with the offer of risk assessments to healthcare staff.
- Systemic weaknesses in the care system were revealed by COVID-19: poor pay, poor working conditions and precarious employment led to staff continuing to work when they should have been self-isolating.

Recommendation

- The Mayor should inform the Committee of what steps he is taking to:
  a) Ensure the continual strategic oversight of London's health and social care workforce;
  b) Ensure that lessons learned from the first wave are implemented to address issues in the second wave of the pandemic;
  c) Ensure that key issues are identified and tackled as soon they arise in the second wave of the pandemic.

[1] The Health Foundation, Black and minority ethnic workers make up a disproportionately large share of key worker sectors in London, May 2020

Accountability and timeliness

Throughout the Health Committee's investigation, we explored in more detail the findings from Public Health England's report *"Beyond the data: Understanding the impact of COVID-19 on BAME groups."*[2] Our investigation heard repeatedly that accountability for the urgent delivery of actions across all aspects of the COVID-19 response is vital to address the disproportionate health impact of COVID-19 on BAME groups, coordinated across levels of governance and with measurable outcomes.

We therefore include the following accountability and timeliness recommendations alongside all other recommendations made by the investigation:

- There need to be clear lines of **accountability** for the delivery of all recommendations in PHE's report *"Beyond the data: Understanding the impact of COVID-19 on BAME groups"*.[3] Adequate resource is also required to ensure delivery.

"The report is silent on accountability"

(Professor Gurch Randhawa, Professor of Diversity in Public Health & Director of the Institute for Health Research, University of Bedfordshire)[4]

- Action on the recommendations needs to be urgently taken forward across **coordinated across all levels**: national, regional and local.

"There are some really key messages at an NHS London level to which it may need to at least feel itself to be accountable across the system. From an NHS London perspective, it needs to be speaking to the mental health trust, the acute trusts and GPs and asking them what they are doing in response to the recommendations."

(Dr Somen Banerjee, Director of Public Health, London Borough of Tower Hamlets)[5]

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[2] Public Health England, Beyond the data: Understanding the impact of COVID-10 on BAME groups, 16 June 2020

[3] Public Health England, Beyond the data: Understanding the impact of COVID-10 on BAME groups, 16 June 2020

[4] London Assembly Health Committee, COVID-19: The Experiences of BAME Londoners, Page 15, 11 August 2020

[5] London Assembly Health Committee, COVID-19: The Experiences of BAME Londoners, Page 15, 11 August 2020

- The recommendations presented by PHE's report are not new. They represent known issues related to health inequalities, ethnicity, social class, age and gender. This time **measurable** action, not just words and reports, is required.

"I am quite simplistic around this. If you look at this across London, a very valid question for every key public sector organisation is about what it is doing in response to these recommendations and to have some kind of accountability around that. It would be perfectly reasonable for us as a Council to be asked, "There was this very powerful report in June [2020]. What are you doing around these recommendations?"

(Dr Somen Banerjee, Director of Public Health, London Borough of Tower Hamlets)[6]

[6] London Assembly Health Committee, COVID-19: The Experiences of BAME Londoners, Page 14, 11 August 2020

Throughout the first wave of the pandemic the health and care workforce faced numerous challenges. We explored the specific impacts of national issues on London's health and care workforce.

Personal protective equipment (PPE)

It is well documented that, across the country, significant concerns were raised regarding the provision of PPE to frontline health workers throughout the first wave. Early on, the British Medical Association queried the appropriateness of the PPE provided.[7] Due to significant shortages of PPE, PHE issued new guidance, which focused on alternative measures that should be taken to ensure that health and care staff are appropriately protected from COVID-19, where items of PPE were unavailable.[8] Several membership organisations, including the Royal College of Nursing and the UK's anaesthetic and intensive care representative bodies, criticised this temporary guidance, stating that concern about PPE was so great, that some members would have to take increasingly difficult decisions about whether to provide care.[9] In response to the Committee's call for evidence, in June the Royal College of Physicians (RCP) highlighted issues with accessing PPE:

"Despite improvements in provision, access to PPE still remains 'a significant issue'. (Royal College of Physicians)[10]

The RCP's submission also informed the Committee that in a recent survey *"52% of clinicians in London reported that they had not been fit-tested for the PPE they are using".*[11]

The issues with PPE were also reported by other medical sectors.

"There were mixed messages regarding fit testing. Most staff needed FFP3-18 masks as they had failed with FFP3-16 masks but the FFP3-18 masks were in shorter supply and there was a necessity to move over to either a non-fit-tested brand of FFP3 mask or one which was known not to provide an adequate seal. We moved from fit testing to fit checking and then back to fit testing which did little for staff confidence." (The Faculty of Intensive Care Medicine)[12]

Social care providers noted the challenges they experienced in trying to procure essential PPE for their staff and people they support. Given the disparate and varied nature of social care services, which involve 152 local authorities and 18,000 independent providers, there have been concerns raised about whether a centralised body, such as the NHS, is best placed to be in charge of procurement and planning.[13] Hospices and personal assistants directly employed by disabled

[7] BMA: BMA warns that without protective equipment, doctors and Covid-19 patients will die 25 March 2020

[8] PHE: COVID-19 personal protective equipment (PPE). 8 June 2020

[9] ICM Anaesthesia COVID-19: Joint statement from UK anaesthetic and intensive care bodies in response to updated PPE guidance. 19 April 2020

[10] Call for evidence submission, Royal College of Physicians, June 2020.

[11] Call for evidence submission, Royal College of Physicians, June 2020

[12] Call for evidence submission, Royal College of Physicians, June 2020

[13] The King's Fund: Integrating health and social care in the Covid-19 (coronavirus) response. 3 April 2020

people are amongst those in care settings which noted challenges in accessing PPE.[14] UNISON's Assistant General Secretary, Christina McAnea, stated in May that the Government's advice on PPE for the care sector was "inconsistent and confusing."[15]

During our Committee meeting, UNISON (the union which represents the care sector), highlighted the personal experiences faced by many of their members in the care workforce in London.

"We only have one mask per 10-hour shift with seeing more than 20 clients. I brought my own as three weeks ago we did not have any of them and they were not issued to us." (UNISON member)[16]

"Towards the beginning of the pandemic lockdown, I went to the office to get some masks and gloves as I had some visits to do. There were no face masks available and only small sized gloves and I needed medium." (UNISON member)[17]

BAME inequality in mortality

Throughout the first wave of the pandemic the BAME health and care workforce was disproportionately affected by COVID-19. In the initial months of the pandemic, reports emerged which quickly shone a light on the disparity in mortality rates of the BAME workforce.

- The British Medical Association (BMA) found that every one of the first 14 doctors reported to have died by 18 April was from an ethnic minority.
- 48 per cent of the London's health and care workforce are BAME individuals,[18] however on 1 May 2020 data emerged from the Health Service Journal which showed that 63 per cent of the 106 health and social care staff known to have died with the virus by that point were Black or Asian. Similarly, analysis by The Guardian published on 25 May found that 61 per cent of the first 200 healthcare workers that had died due to COVID-19 were from BAME backgrounds.[19]

In similarity to the disproportionate health outcomes amongst the general population, socioeconomic factors may be playing a part. Numerous surveys of the BAME workforce report common beliefs about the underlying causes of increased susceptibility to the virus, including an

[14] Hospice UK: Hospices in desperate need of personal protective equipment (PPE) amid COVID-19 outbreak. 1 April 2020

[15] Nursing Times: Covid-19 death rate 'significantly higher' in social care workers. 11 May 2020

[16] London Assembly Health Committee, *Quotes from care workers on the lack of supply of PPE in the care sector provided by Gavin Edwards (Senior National Officer- Social Care, Unison), page 21, June 2020.

[17] London Assembly Health Committee, *Quotes from care workers on the lack of supply of PPE in the care sector provided by Gavin Edwards (Senior National Officer- Social Care, Unison), page 21, June 2020.

[18] The Health Foundation, Black and minority ethnic workers make up a disproportionately large share of key worker sectors in London, May 2020

[19] The Guardian: Six in 10 UK health workers killed by Covid-19 are BAME. 25 May 2020

overrepresentation of BAME people on the frontline of the health and care workforce, and the role of co-morbidities.[20,21] However, the BMA also suggested that other systemic factors are likely to be playing a role, such as the fact that BAME doctors are twice as likely not to raise complaints about safety in the workplace as they have far greater fear of facing recriminations or reprisals.[22]

> **24% of BAME nursing staff said they had no confidence in their employer to protect them from COVID-19, compared with just 11% of white British respondents**[23]

According to the British Medical Association *"Three times as many BAME doctors responded saying they felt under pressure to see patients without adequate protection, compared to their white colleagues."*[24]

Risk assessments

Enhanced risk assessments have been put in place to identify NHS employees who are potentially more at risk due to their "race and ethnicity, age, weight, underlying health condition, disability, or pregnancy".[25] Measures would allow such personnel to be redeployed to areas or services where they would have less chance of becoming infected. A survey conducted by the Royal College of Physicians on 13 and 14 May on the availability of risk assessments, before enhanced risk assessment guidance was published, found that only 18 per cent of the doctors who responded had received an assessment of their risk of contracting COVID-19.[26] During our investigation we heard from the BMA that 30 per cent of doctors were not aware of their trust offering a risk assessment.[27]

The Royal College of Physicians pointed to the fact that large proportion of doctors are from BAME backgrounds:

> In London, 55 per cent of consultants and 59 per cent of higher specialty trainees (HSTs) are not of white UK ethnicity:

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[20]GM, BAME healthcare workers and COVID-19, 17 June 2020

[21] NCBI, Emerging public health challenge in UK: perception and belief on increased COVID19 death among BAME healthcare workers, July 3 2020

[22] The Guardian: Failure to record ethnicity of Covid-19 victims a 'scandal', says BMA chief. 18 April 2020

[23] Royal College of Nursing, Second Personal Protective Equipment Survey of UK Nursing Staff Report: Use and availability of PPE during the COVID-19 pandemic, May 2020.

[24] London Assembly Health Committee, COVID-19: London's Response, Inequalities, and the Health and Care Workforce, Page 23, 25 June 2020

[25] NHS Employers: Risk assessments for staff. 28 May 2020

[26] Royal College of Physicians, What are we learning from the workforce about the impacts of COVID-19?, May 2020

[27] London Assembly Health Committee, COVID-19: London's Response, Inequalities, and the Health and Care Workforce, Page 25, 25 June 2020

- 29 per cent of consultants are Asian/Asian British, 3 per cent are Black/Black British and 2 per cent are mixed ethnicity
- Of the 12 per cent of HSTs that graduated outside of the UK, 40 per cent graduated in Asia, 12 per cent graduated in Africa, and 3 per cent in South and Central America[28]

As such, The Royal College of Physicians called for those at highest risk to be risk assessed urgently:

"It is vital that national guidance is developed and issued as soon as possible for employers to carry out workplace risk assessments. Risk assessments must be individual in order to adequately protect all staff, particularly members of the BAME community." (Royal College of Physicians)[29]

Workforce challenges

It is well documented that the NHS and social care workforces were understaffed before COVID-19. Prior to the pandemic, in November 2019 there were over 100,000 NHS vacancies reported by trusts in England, and 122,000 workforce shortages in adult social care.[30,31] The Health Foundation recommended in 2019 that the government would need to initiate a major drive in international recruitment to fill NHS and social care vacancies, and would need to increase pay for social care workers.[32]

The Royal College of Nursing also noted that before the pandemic hit, London already had a deficit of over 9,000 registered nurses – a vacancy rate of 13.1 per cent, the highest regional rate in England.[33] This placed significant pressure on nurse staffing levels in the capital and hampered the ability of the health system to respond to COVID-19 due to a shortage of critical care nursing staff. COVID-19's impact worked to highlight how the significant gaps in the nursing workforce in London restricted the health system's ability to provide safe and effective care for patients. The Committee heard that due to constraints on the system during COVID-19, care delivery in intensive care shifted to a model of one nurse for up to six patients.

"In intensive care you normally have one nurse to one patient. What we found during the pandemic was that we changed that model to one nurse to up to six patients. I am an intensive care nurse by background. That seems completely alien to me. I was always taught, and it was the culture, that it

[28] Call for evidence submission, Royal College of Physicians, June 2020

[29] Call for evidence submission, Royal College of Physicians, June 2020

[30] The Health Foundation: NHS staff shortages put long-term vision for primary and community care at risk. 12 February 2019.

[31] The Health Foundation: Health and social care workforce: Priorities for the new government. 27 November 2019

[32] The Health Foundation: Health and social care workforce: Priorities for the new government. 27 November 2019

[33] NHS Digital, NHS Vacancy Statistics England February 2015 - March 2020, Experimental Statistics, May 2020.

was one nurse to one patient because they were so unwell." (Lisa Elliot, London Regional Director, Royal College of Nursing)[34]

In response to the Committee's call for evidence both the Royal College of Obstetricians and Gynaecologists, and the Royal College of Physicians, noted the impact of staff shortages that existed before the pandemic, and the pressures this placed on the ability of services to respond. The pandemic required significant redeployment of roles to manage the immediate clinical needs of those affected by the virus. The redeployment placed further pressure on an already strained workforce.

"We heard from 26 London trusts, 22 of which reported redeployment of junior grade trainees, including locally employed doctors, outside the maternity service. In 13 trusts, between 75 per cent and 100 per cent of junior grade trainees were deployed elsewhere. In 15 trusts, junior grade trainees were redeployed within the hospital without reference to specialty requirements.

Consultants and middle grade doctors have been placed under increased and unsustainable stress running a core service without a valuable part of the workforce. More than a third of respondents in London reported significantly longer hours for those available to work, compared to a quarter of respondents nationwide." (Royal College of Obstetricians and Gynaecologists)[35]

Health and wellbeing of the workforce

Mental health and the wellbeing of the health and care workforce is a significant issue. Polling published on 23 April by YouGov and the IPPR thinktank found that 50 per cent of 996 healthcare workers questioned across the UK said their mental health had deteriorated since the virus began taking its toll. Other issues raised included worries about family safety because a lack of testing and PPE, and a concern about their ability to ensure patients receive high quality care.[36] Concerns have also been raised over burnout and long-term impacts of COVID-19 on the workforce, with 21 per cent of those questioned reporting that the situation had made them more likely to stop working in health: the IPPR has estimated that the NHS in England alone could lose 300,000 of its 1.5 million-strong workforce as a result.[37]If that calculation holds for the approximately 217,000 NHS employees in London, it would mean over 40,000 people leaving their job.

The Committee believes that the call for evidence submissions and evidence taken from our guests make clear the gravity of the issues faced by London's health and social care workforce during the

[34] London Assembly Health Committee, COVID-19: London's Response, Inequalities, and the Health and Care Workforce, Page 28, 25 June 2020

[35] Call for evidence submission, Royal College of Obstetricians and Gynaecologists, June 2020.

[36] IPPR, Covid-19: One in five healthcare workers could quit after pandemic unless urgent government action is taken, IPPR warns, April 2020

[37] IPPR, Covid-19: One in five healthcare workers could quit after pandemic unless urgent government action is taken, IPPR warns, April 2020

first wave. It is vital that these are addressed, and that, as the pandemic evolves, the Mayor works with partners to ensure continual identification and oversight of key challenges facing the health and care workforce in London.

Methodology and contributions

Over the course of the summer of 2020 the Health Committee investigated the impacts of COVID-19 on the lives of Londoners during the first wave of the pandemic. The investigation comprised of two Committee meetings and a call for evidence.

The first Committee meeting, held in June, heard from an expert panel of guests and examined the immediate impact of COVID-19 on London's population and health and care workforce.

- Professor Kevin Fenton, PHE London Regional Director and Statutory Health Advisor to the Mayor
- Dr Vin Diwakar, NHS Regional Medical Director for London
- Dr Chaand Nagpaul, Chair of the Council of the British Medical Association
- Lisa Elliott, London Regional Director, Royal College of Nursing
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To build our understanding of the effect of COVID-19 on London's health and social care workforce, we also received written submissions from the following medical organisations:

- London Regional Council, British Medical Association
- The Faculty of Intensive Care Medicine
- The Royal College of Obstetricians and Gynaecologists
- Royal College of Physicians
- Royal College of Pathologists

The second Committee meeting was split into two parts. In the first, we focused in more depth on the experiences of BAME Londoners, with particular attention on the issues of racism, stigma, discrimination, fear and trust. Evidence was provided by:

- Dr Somen Banerjee, Director of Public Health, London Borough of Tower Hamlets
- Professor Gurch Randhawa, Professor of Diversity in Public Health & Director of the Institute for Health Research, University of Bedfordshire

In the second part we looked at the effects of lockdown on Londoner's mental health, supplemented by additional evidence and views from Talk London Respondents. We heard from:

- Vicki Nash, Head of Policy and Campaigns, Mind
- Lynette Charles, the CEO of Mind in Haringey
- Nikki Morris, Chief Executive Officer of Age UK Camden
- Sarah MacFadyen, Head of Policy and External Affairs, British Lung Foundation and Asthma UK

Lessons learned from the first wave of COVID-19: Protecting London's health and care workforce

Health Committee

About the London Assembly Health Committee

The London Assembly is the 25-member elected body that represents Londoners and holds the Mayor to account. The Health Committee reviews health and wellbeing issues for Londoners, particularly public health issues. It also keeps a close eye on how well the Mayor's Health Inequalities Strategy is doing.

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LONDONASSEMBLY

HEALTH COMMITTEE BRIEFING

Lessons learned from the first wave of COVID-19: The importance of public health

Executive summary

Supporting people to stay well, and addressing the wider determinants of ill health, helps to reduce individual risk from the virus.[1] In the short-term pandemic response there is a need to adopt a public health model that prioritises prevention and seeks to understand and protect against underlying causes and susceptibilities, to help affected communities stay resilient; in the medium to long-term it is necessary to adopt this model to take more sustained action on the wider factors that influence health outcomes such as housing, education and employment.[2]

The London Assembly Health Committee has investigated what lessons must be learned from the first wave of COVID-19 by consulting experts, calling for evidence, and undertaking research – to understand how to best support London through the ongoing pandemic.

Key findings

- A 'whole systems approach' is necessary to ensure that recovery from COVID-19 does not exacerbate inequalities.
- Poor housing conditions contribute to poorer health outcomes from COVID-19.

Recommendations

- Given the vital need for both short, medium and long-term action to prevent the widening of inequalities, the Mayor should inform the Committee of the intended timelines for the delivery of a 'health in all policies' approach in London. This includes the development of metrics to track progress towards minimising the impacts of health inequalities in London.
- The Mayor should inform the Committee of ongoing plans to review housing policies, with particular respect to overcrowding and insecure housing, including his plans to embed the latest research and evidence emerging on best practice in planning and home creation for healthy homes.

[1] NCBI, The COVID-19 pandemic and health inequalities, June 2020

[2] UCL Institute of Health Equity, Fair Society, Healthy Lives, The Marmot Review, February 2020

Accountability and timeliness

Throughout the Health Committee's investigation, we explored in more detail the findings from Public Health England's report *"Beyond the data: Understanding the impact of COVID-19 on BAME groups."*[3] Our investigation heard repeatedly that accountability for the urgent delivery of actions across all aspects of the COVID-19 response is vital to address the disproportionate health impact of COVID-19 on BAME groups, coordinated across levels of governance and with measurable outcomes.

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"The report is silent on accountability"

(Professor Gurch Randhawa, Professor of Diversity in Public Health & Director of the Institute for Health Research, University of Bedfordshire)[5]

- Action on the recommendations needs to be urgently taken forward across **coordinated across all levels**: national, regional and local.

"There are some really key messages at an NHS London level to which it may need to at least feel itself to be accountable across the system. From an NHS London perspective, it needs to be speaking to the mental health trust, the acute trusts and GPs and asking them what they are doing in response to the recommendations."

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"I am quite simplistic around this. If you look at this across London, a very valid question for every key public sector organisation is about what it is doing in response to these recommendations and to have some kind of accountability around that. It would be perfectly reasonable for us as a Council to be asked, "There was this very powerful report in June [2020]. What are you doing around these recommendations?"

(Dr Somen Banerjee, Director of Public Health, London Borough of Tower Hamlets)[7]

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[7] London Assembly Health Committee, COVID-19: The Experiences of BAME Londoners, Page 14, 11 August 2020

Taking a public health approach

During the investigation we heard about the benefits of adopting a public health approach in both the immediate response to the crisis and to address the wider implications of the pandemic. Experts we took evidence from widely expressed views which supported the assertion that the impact of a pandemic tends to mirror the structural inequalities in any society. The wider determinants of health, such as education, housing, transport and air quality, play a key role in determining health inequalities and health outcomes.[8]

"The impact of a pandemic tends to mirror the structural inequalities in any society." (**Professor Gurch Randhawa Professor of Diversity in Public Health; and Director of the Institute for Health Research, University of Bedfordshire)**[9]

COVID-19 has exacerbated inequalities and worsened outcomes for already disadvantaged groups in society. The inequalities which exist have both increased individuals' exposure and susceptibility to the disease, leading to wider and more entrenched inequalities.

The Committee is aware that the Mayor's 'health in all policies' approach is in ongoing development, of which a portion is being taken forward as part of London's recovery through the Health Equity Group of the London Health Board.[10]

Population inequalities

Within London there is clear evidence of stark health inequalities. In 2018, 875,000 Londoners were paid below the London Living Wage - one in five of London's working population.[11] Data from London's Poverty Profile shows that 1.3 million Londoners in poverty live as part of a working family, which equates to a 50 per cent increase over the last decade of families whose income is not enough to meet basic needs.[12,13] During the lockdown, those on low incomes are more likely to have continued going to work, increasing their exposure to the infection. Nationally, less than one in ten of the lower half of earners said they had the option to work from home during the lockdown, compared with half of the highest earners.[14] In addition, financial and social hardship is already being felt by the most deprived. Individuals on low wages are seven times as likely as high earners to have worked in a sector that has been shut down. Workers in shut down sectors also account for twenty-five per cent share of those in private rented accommodation, increasing the likelihood of housing insecurity for these people.[15]

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[8] UCL Institute of Health Equity, Fair Society, Healthy Lives, The Marmot Review, February 2020

[9] London Assembly Health Committee, COVID-19: The Experiences of BAME Londoners, Page 1, 11 August 2020

[10] London Assembly, Agenda Health Committee, item 6: Mayor's response to Health Inequalities Strategy letter, 20th October 2020

[11] London Datastore: Employees earning below the London Living Wage. No date

[12] Trust for London, London's Poverty Profile 2017, 2017

[13] Nuffield Foundation, In-Work Poverty in the UK: Problem, policy analysis and platform for action, May 2017

[14] The Health Foundation: Will COVID-19 be a watershed moment for health inequalities? 7 May 2020

[15] The Health Foundation: Will COVID-19 be a watershed moment for health inequalities? 7 May 2020

As pointed out by our expert guests, health and care interventions to minimise impact of inequality have limited effectiveness on their own; they must be complemented by addressing wider structural issues:

"Structural aspects are incredibly important to address the inequalities in outcomes, such as, clean air (linked to transport), promoting physical activity and active travel, high quality jobs and living wage." **(Professor Kevin Fenton, London Regional Director, PHE; and Statutory Health Advisor to the Mayor)**[16]

A 'whole systems approach' to wider inequalities

We heard about the vital importance of maintaining a sustained focus on inequality to ensure that inequality is not exacerbated by COVID-19. Long-term complications of surviving COVID-19 could worsen inequalities, as those experiencing the most severe complications are more likely to be from the most vulnerable and deprived communities.[17] It is widely acknowledged that tackling the structural factors that drive inequality requires a whole systems, cross-sector approach that involves multiple partners.[18]

For example, in Coventry, significant steps have been taken to reduce health inequalities through partnership working between fire and emergency services, several council departments, and PHE and the third sector.[19] In doing so the city has implemented an approach whereby they are working both cross-sector and across systems such as local authorities, Sustainability and Transformation Partnerships (STPs), health and wellbeing boards (HWBs), and accountable care organisations (ACOs).

"I would definitely urge the Mayor to take a public health-focused approach and to temper that with a parallel medical approach but not the other way around. We have to learn from those countries that have done really well, and they have definitely championed the public health approach." **(Professor Gurch Randhawa, Professor of Diversity in Public Health; and Director of the Institute for Health Research, University of Bedfordshire)**[20]

Housing

During the investigation, housing conditions in particular were highlighted as a key driver in poor outcomes from COVID-19. [21,22] We heard that crowded living conditions prevent people from

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[16] London Assembly Health Committee, COVID-19: London's Response, Inequalities, and the Health and Care Workforce, Page 5, 25 June 2020

[17] London Assembly Health Committee, COVID-19: London's Response, Inequalities, and the Health and Care Workforce, 25 June 2020

[18] Public Health England, Reducing health Inequalities system scale and sustainability, 2017

[19]UCL Institute of Health Equity, Coventry Marmot City Evaluation, 2020,

[20] London Assembly Health Committee, COVID-19: The Experiences of BAME Londoners, Page 4, 11 August 2020

[21]London Assembly Health Committee, COVID-19: London's Response, Inequalities, and the Health and Care Workforce, 25 June 2020

[22] London Assembly Health Committee, COVID-19: The Experiences of BAME Londoners, ,11 August 2020

people being unable to properly isolate.[23] In addition, research shows that stark differences in housing have already contributed to the unequal impact of COVID-19, including on people's mental health (see the Committee's briefing on mental health for more information). In May, analysis of Office of National Statistics (ONS) data found a correlation between the level of overcrowding in councils in England and Wales and their COVID-19 death rate.[24] In September 2020 the London Assembly called on the Mayor to review all planning and housing policies to tackle overcrowding and ensure that suitable provision is made for family-sized homes.[25]

"First, the social and economic backgrounds and realities of many of our minority communities in the UK and especially in England and these inequalities, which pre-existed COVID, may have been accelerated and enhanced by the COVID epidemic. This includes factors such as living in overcrowded households, multigenerational households." **(Professor Kevin Fenton, London Regional Director, PHE and Statutory Health Advisor to the Mayor)[26]**

The Committee recognises the work which the Mayor has undertaken through the COVID-19 Housing Delivery Taskforce to seek Government funding to address overcrowding and other health inequalities.[27] It is vital that the Mayor continually assesses his housing and planning policies in light of COVID-19, to ensure that they are working to reduce overcrowding and insecure housing.

We heard that as a result of the pandemic there are new opportunities to think differently about housing and planning and its potential to maximise health. Evidence is emerging on how planning and policy can be reviewed to ensure healthy home creation. The Mayor should ensure that new evidence which supports healthy homes is incorporated into his review of housing and planning policies.

"Certainly, from a health perspective and understanding how things will now evolve after this first phase of the pandemic, there should be new opportunities for us to think differently about housing and planning."
(Professor Kevin Fenton, London Regional Director, PHE; and Statutory Health Advisor to the Mayor)[28]

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[23] Ibid

[24] Inside Housing, The housing pandemic: four graphs showing the link between COVID-19 deaths and the housing crisis, May 2020.

[25] The London Assembly, Mayor must tackle overcrowding, 03 September 2020.

[26] London Assembly Health Committee, COVID-19: London's Response, Inequalities, and the Health and Care Workforce, Page 2, 25 June 2020

[27] London Assembly, Agenda Health Committee, item 6: Mayor's response to Health Inequalities Strategy letter, 20th October 2020.

[28] London Assembly Health Committee, COVID-19: London's Response, Inequalities, and the Health and Care Workforce, Page 11, 25 June 2020

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Health Committee

About the London Assembly Health Committee

The London Assembly is the 25-member elected body that represents Londoners and holds the Mayor to account. The Health Committee reviews health and wellbeing issues for Londoners, particularly public health issues. It also keeps a close eye on how well the Mayor's Health Inequalities Strategy is doing.

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