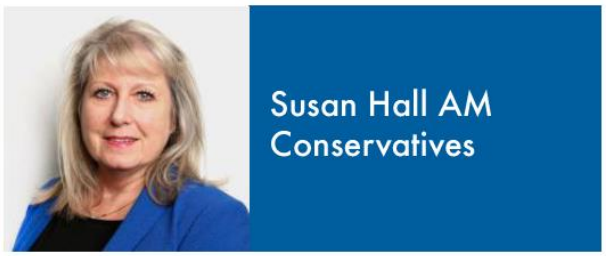
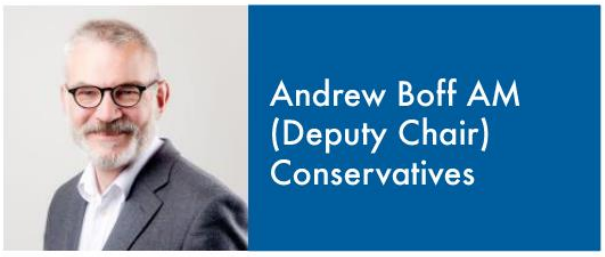
Pathways to healthcare: GP experience, COVID-19 and BAME Londoners

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.

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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

如您需要这份文件的简介的翻译本，
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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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